



OXFORD CITY COUNCIL Work Session Minutes

Tuesday, July 19, 2022

Roll Call

William Snavelly Mayor	Chantel Raghu Vice Mayor
Jason Bracken	Amber Franklin
Alex French	Glenn Ellerbe
David Prytherch	

A work session meeting of the Oxford City Council was called to order by Vice-Mayor Chantel Raghu on Tuesday, July 19, 2022 at 6:32 p.m. Members in attendance were Amber Franklin, Glenn Ellerbe, Alex French, David Prytherch, and Jason Bracken. William Snavelly was excused.

Staff Members in Attendance

Mr. Doug Elliott, City Manager; Ms. Jessica Greene, Assistant City Manager; Mr. Mike Dreisbach, Service Director; Mr. John Jones, Police Chief, and Ms. Heather Barbour, Clerk of Council.

Approval of the Agenda

Motion – To Adopt

(Voice Vote) 1st Ms. Franklin 2nd Ms. French

AYE #6

NAY #0

ABS #0

Presentation- Harm Reduction Program Review (All slides will be available online)

Ms. Amy Macechko, Health and Wellness Coordinator for the Talawanda School District, and Project Coordinator for the Coalition for a Healthy Community started off the presentation with a round of introductions. Ms. Joanna Lowry, Associate Executive Director of Alcohol & Drug Addiction Services of the Butler County Mental Health and Addiction Recovery Services Board. Mr. Daryl Hams RN, Project Director of the Regional Harm Reduction Collaborative. Mr. Jordan Meyer MPH, Harm Reduction Epidemiologist with Butler County General Health District. Ms. Tyrina Taylor MPH, Drug Overdose Prevention Coordinator for Butler County General Health District. Ms. Cecilie McGhehey, HRSA Grant Project Director Miami University. Ms. Macechko explained that this team makes up the Consortium for the federal HRSA Grant. To address rural opioid and substance use, from prevention, treatment, and recovery. Within the City of Oxford and Oxford Township.

Ms. McGhehey presented an update on what the team has been working on since the Council presentation in February. Ms. McGhehey spoke about what the next steps would look like. Ms. McGhehey shared slides and needs for Phase Three: Care Delivery.

Mr. Meyer presented slides and data that show support for establishing a syringe service program or SSP in Oxford. Mr. Meyer shared some of the benefits that these programs have already offered Butler County. Mr. Meyer offered to answer any questions.

Ms. Franklin asked what support from the City of Oxford would look like.

Ms. Taylor answered by referring to the data that was shared the Consortium deems it necessary to establish a bloodborne pathogen program. Ms. Taylor advised that a complete harm reduction program was shared during the February presentation to Council. Ms. Taylor and the Consortium request that a Resolution is amended, and approved by the City Council. Ms. Taylor shared a draft so that Council can make revisions, and recommendations suited to the City of Oxford. Ms. Taylor offered to answer any questions.

Mr. Elliott mentioned that he will share the draft Resolution with the Law Director depending on the majority of the Council's support for the program.

Mr. Bracken asked about fentanyl testing being a separate option from bloodborne pathogen testing. Ms. Taylor answered that it would be included, they can provide testing strips. Mr. Hams mentioned that one problem the team is facing is that fentanyl test strips are still classified as drug paraphernalia. Mr. Hams noted that two bills are stuck at the state level, so to distribute them they are covered under a bloodborne pathogen prevention program. Mr. Bracken asked about medication-assisted treatment. Mr. Hams answered that is part of the problem because they don't have people in Oxford, and the need to connect people to treatment. Mr. Hams referred to the data on how successful bloodborne pathogen programs can be when they have support. Ms. Macechko added the long-term goal would be a brick-and-mortar facility that could be shared with other social service agencies and other addiction recovery providers, to have a place to bring folks in once a week to provide these services. Ms. Macechko noted financial support would also be needed. Mr. Ellerbe asked what can the City provide resource-wise to help you reach that goal or the complete care goal. Mr. Hams answered they are having difficulty finding someone to invest in a bricks-and-mortar and take that risk. Mr. Hams mentioned funding issues as well. Mr. Ellerbe asked the City Staff what zoning rules apply to a facility like this? Mr. Elliott answered that commercial zoning would work, but staff would look into this. Ms. Franklin asked about the relationship between the harm reduction program and law enforcement, and best practices. Mr. Hams answered that harm reduction programs started as more of a grassroots type of program and has evolved. Mr. Hams noted that it would be good to figure out what that looks like and to develop a relationship. Chief Jones added that he would like to stop by when the harm reduction team is out there with the van, but the OPD purposely doesn't. Chief Jones noted the OPD would not want to deter anyone, and that relationship would take some time to build. Ms. Raghu asked if it is still fiscally responsible to help fund medication treatment vs incarceration. Mr. Hams answered that every dollar spent on harm reduction is around seven/ten dollars saved downstream healthcare funding. Chief Jones refocused on what the Consortium is asking for tonight a Resolution to start the program. Mr. Prytherch asked if the short term was the permission to start the mobile program and the long term was a facility. Mr. Hams answered yes, that is the request. Vice-Mayor Raghu thanked the Consortium for the presentation.

Adjournment

Motion to Adjourn Meeting at 7:06 p.m.

(Voice Vote) 1st Ms. Franklin 2nd Mr. Prytherch

AYE #6

NAY #0

ABS # 0



STUDENT LIFE

Hope Lives Here



Consortium Members



**Butler County
Mental Health
and Addiction
Recovery Service
Board**

**Talawanda
School District**

**Miami University
Coalition for a
Health
Community-
Oxford area**

**TriHealth
McCullough-Hyde
Memorial
Hospital**

**Epiphany
Community
Services**

Additional support:

The Regional Harm
Reduction
Collaborative

Butler County General
Health District

Phase One: Connection

- Pre COVID-19 meeting with City of Oxford
- Harm Reduction site
- Peer Recovery Specialist at TriHealth McCullough-Hyde
- Medication Take Back Days
- Permanent Medication Drop Box at Oxford Township
- Medication Deactivation Bags in Community
- Mental Health Guide Online
- Oxford Hope Campaign



Phase Two: Capacity

- Identifying providers and partners
- Growing the Peer Recovery community
- Offering HIV/HEP C testing
- Broadening the MH Guide to cover SUD
- Adapting to Oxford, Complete Harm Reduction

Phase Three: Care Delivery



BRICK & MORTAR

Identify accessible
building options



COMPLETE HARM REDUCTION

Meeting people where
they are



PROVIDERS

Solidifying and lowering
the stigma for substance
use care



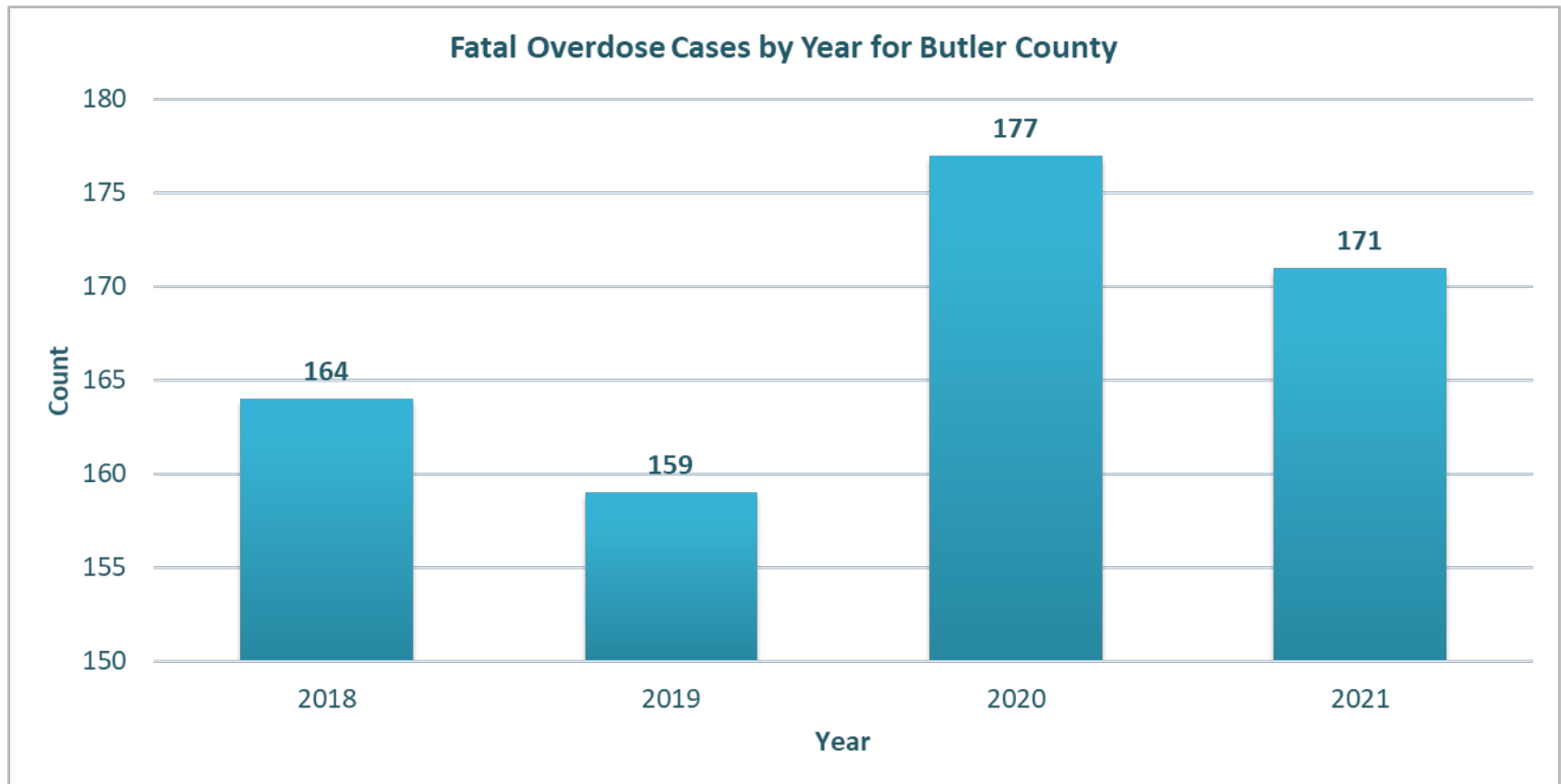
JOIN US!

Where do you see
yourself and Oxford in
the future?

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The Opioid Epidemic in Butler County, Ohio



Source: Butler County Coroner's Office, Data obtained March 18, 2022, Data is provisional and subject to change

Frequency of Primary Substances Contributing to Overdose Fatalities for Butler County in 2020 and 2021

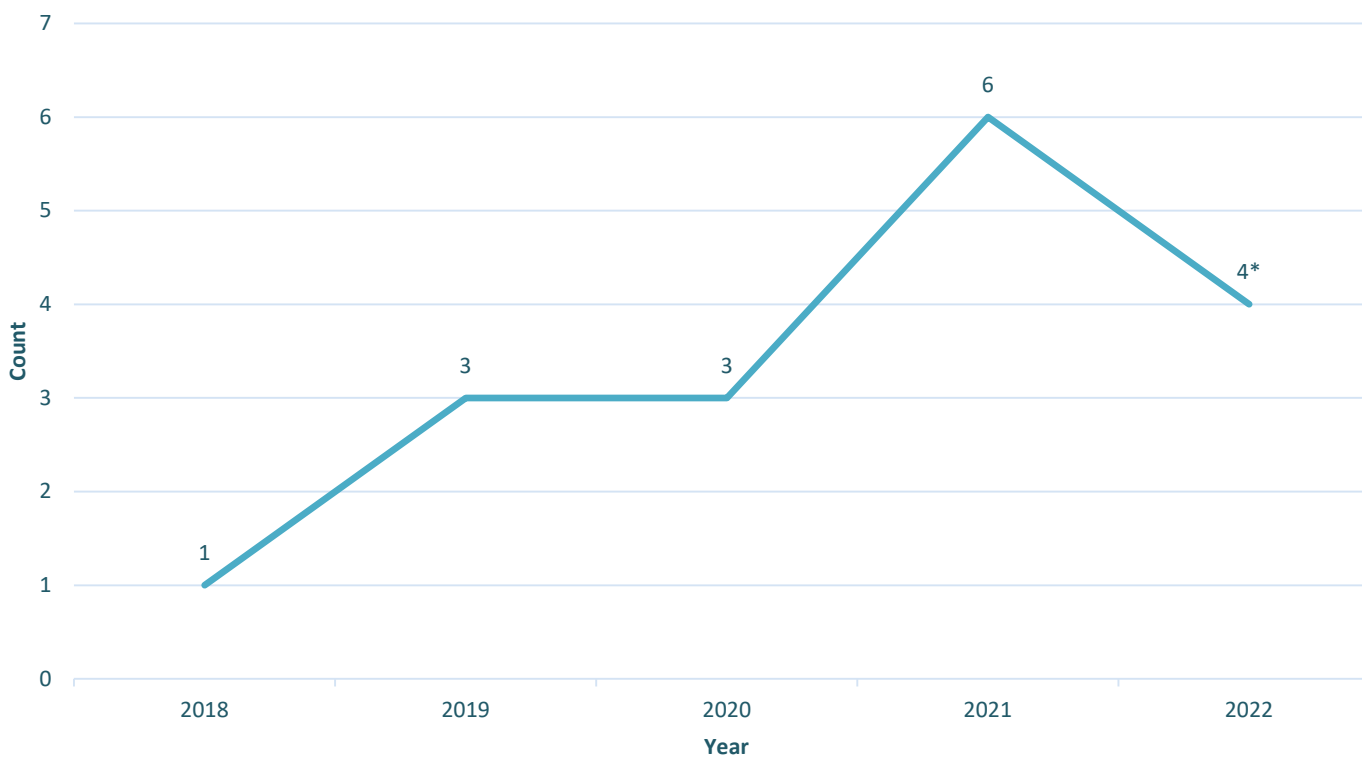
Substance	2020		2021	
	#	%	#	%
Amphetamine	7	3.95%	1	0.58%
Benzodiazepines (Alprazolam, Diazepam)	5	2.82%	3	1.75%
Cocaine	34	19.21%	28	16.37%
Ethanol	0	0.00%	4	2.34%
Fentanyl	155	87.57%	151	88.30%
Heroin	8	4.52%	2	1.17%
Methadone	3	1.69%	2	1.17%
Methamphetamine	54	30.51%	66	38.60%
Opiates, Other (Hydrocodone, Oxycodone, etc.)	13	7.34%	9	5.26%
Other Substances (MDMA, Xylazine, Kratom)	8	4.52%	0	0.00%
Total	177		171	



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Fatal Overdose Incidents Occuring in Oxford City/Township by Year for Butler County



Source: Butler County Coroner's Office, Data obtained July 5, 2022, Data is provisional and subject to change



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Frequency of Primary Substances Contributing to Overdose Fatalities For Oxford City/Township from 2018 - 2021

Substance	2018		2019		2020		2021	
	#	%	#	%	#	%	#	%
Fentanyl	0	0.00%	3	100.00%	3	100.00%	6	100.00%
Heroin	1	100.00%	1	33.33%	1	33.33%	0	0.00%
Methamphetamine	0	0.00%	1	33.33%	0	0.00%	3	50.00%
Morphine	0	0.00%	0	0.00%	1	33.33%	0	0.00%
Total Overdoses	1		3		3		6	

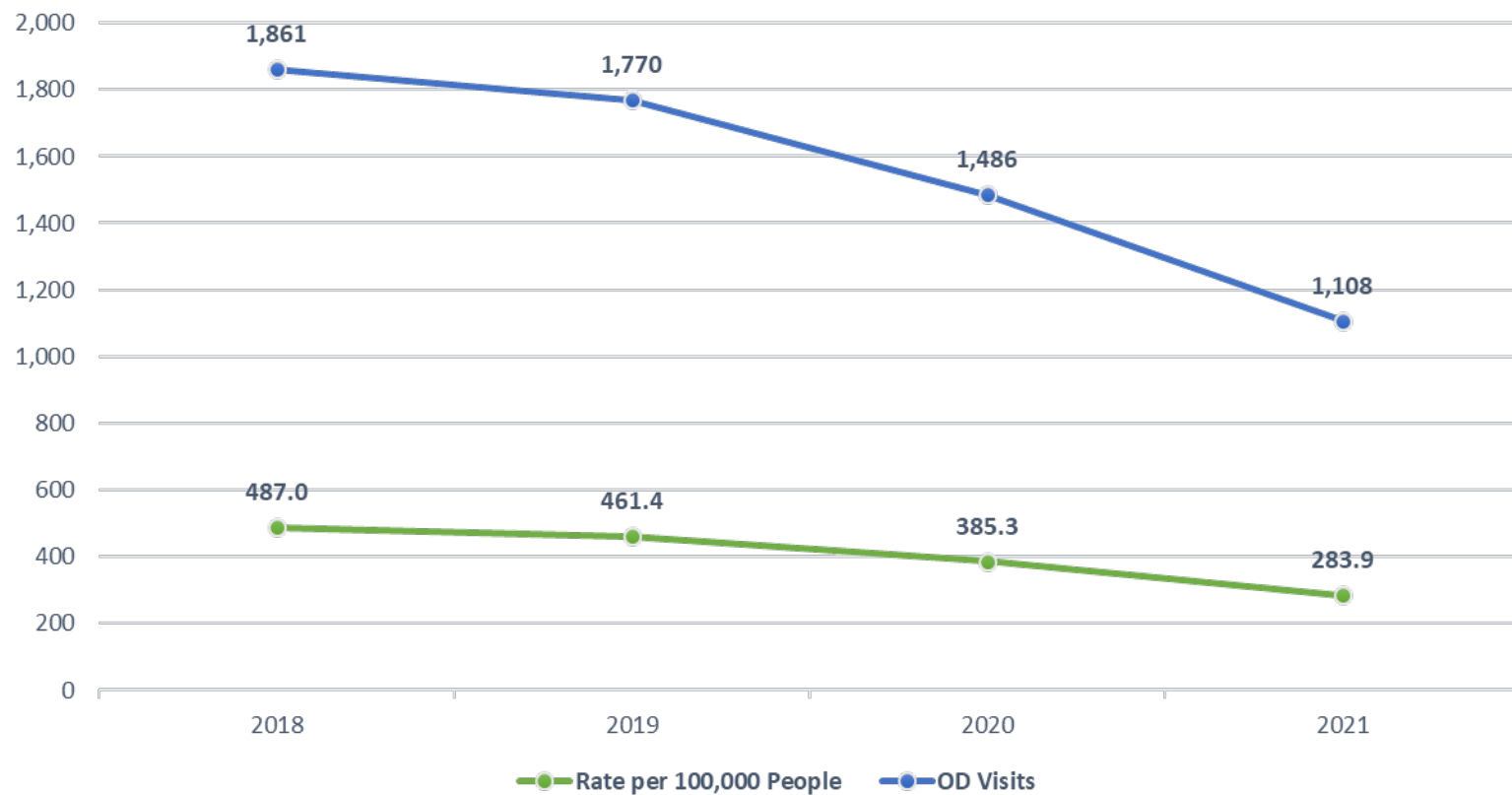
Source: Butler County Coroner's Office, Data obtained March 18, 2022, Data is provisional and subject to change



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Hospital Admissions for a Suspected Drug Overdose by Year for Butler County Residents

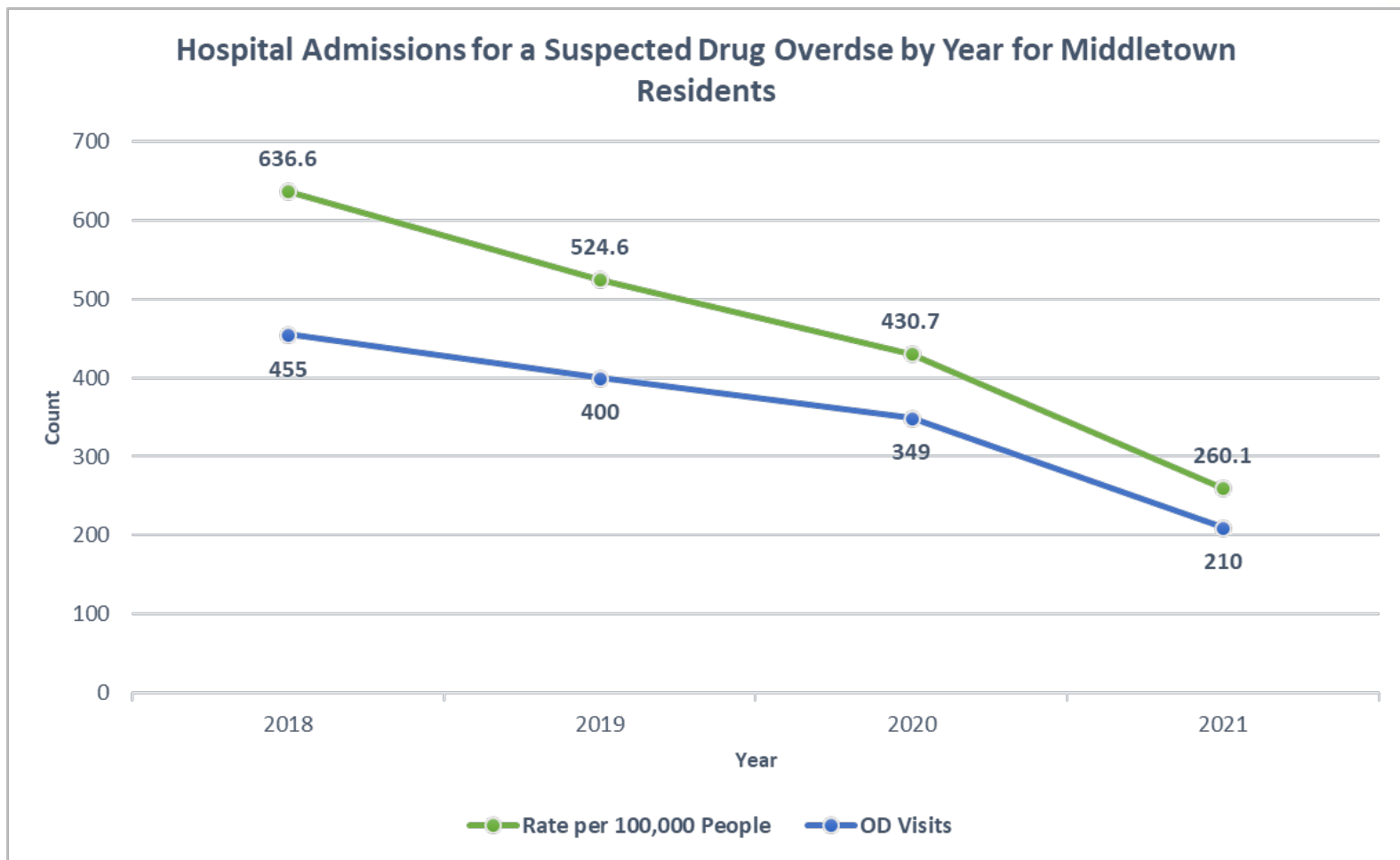


Source: Ohio Department of Health – Ohio Disease Reporting System, Data obtained May 2, 2022, Data is provisional and subject to change



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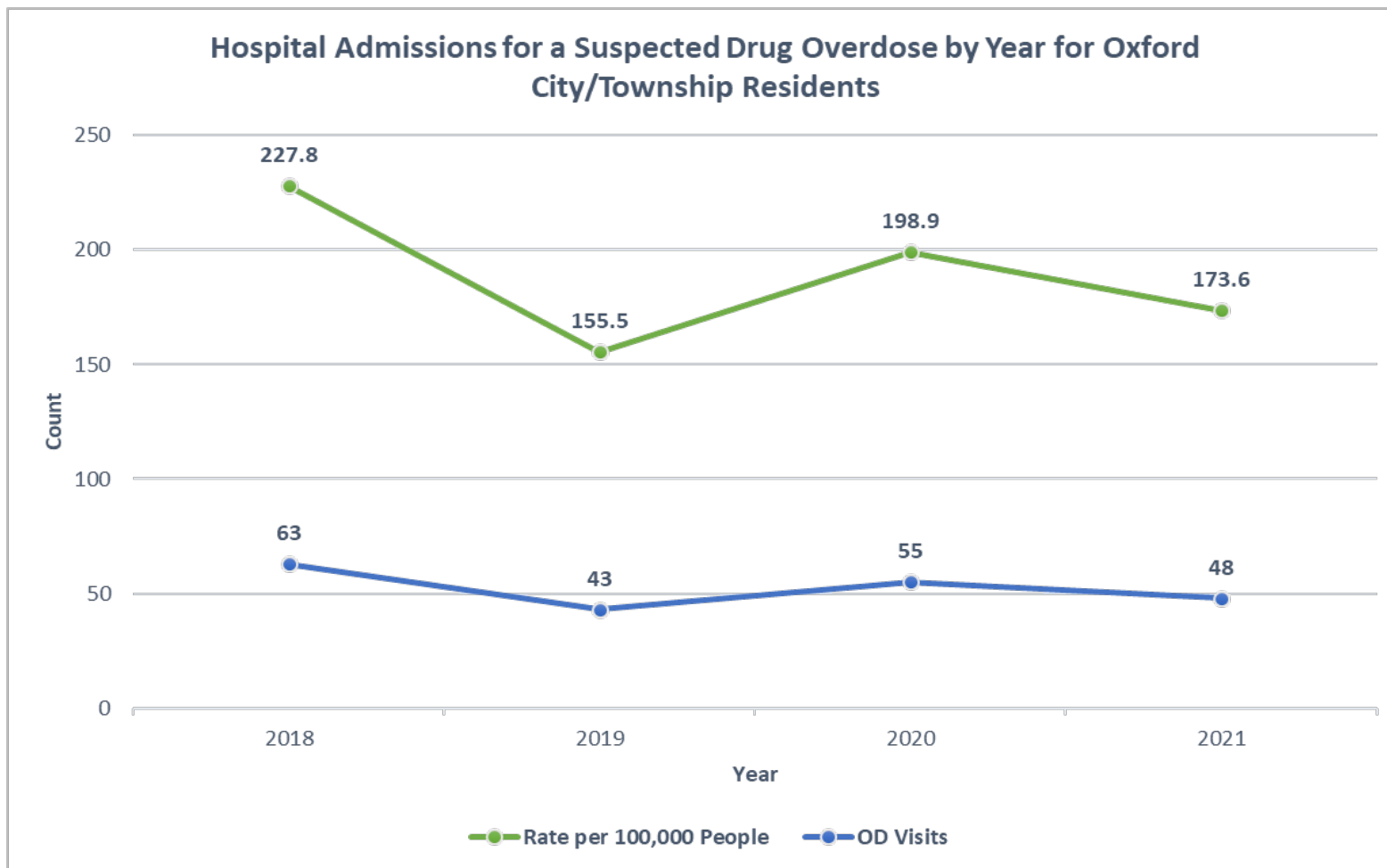


Source: Ohio Department of Health – Ohio Disease Reporting System, Data obtained May 2, 2022, Data is provisional and subject to change



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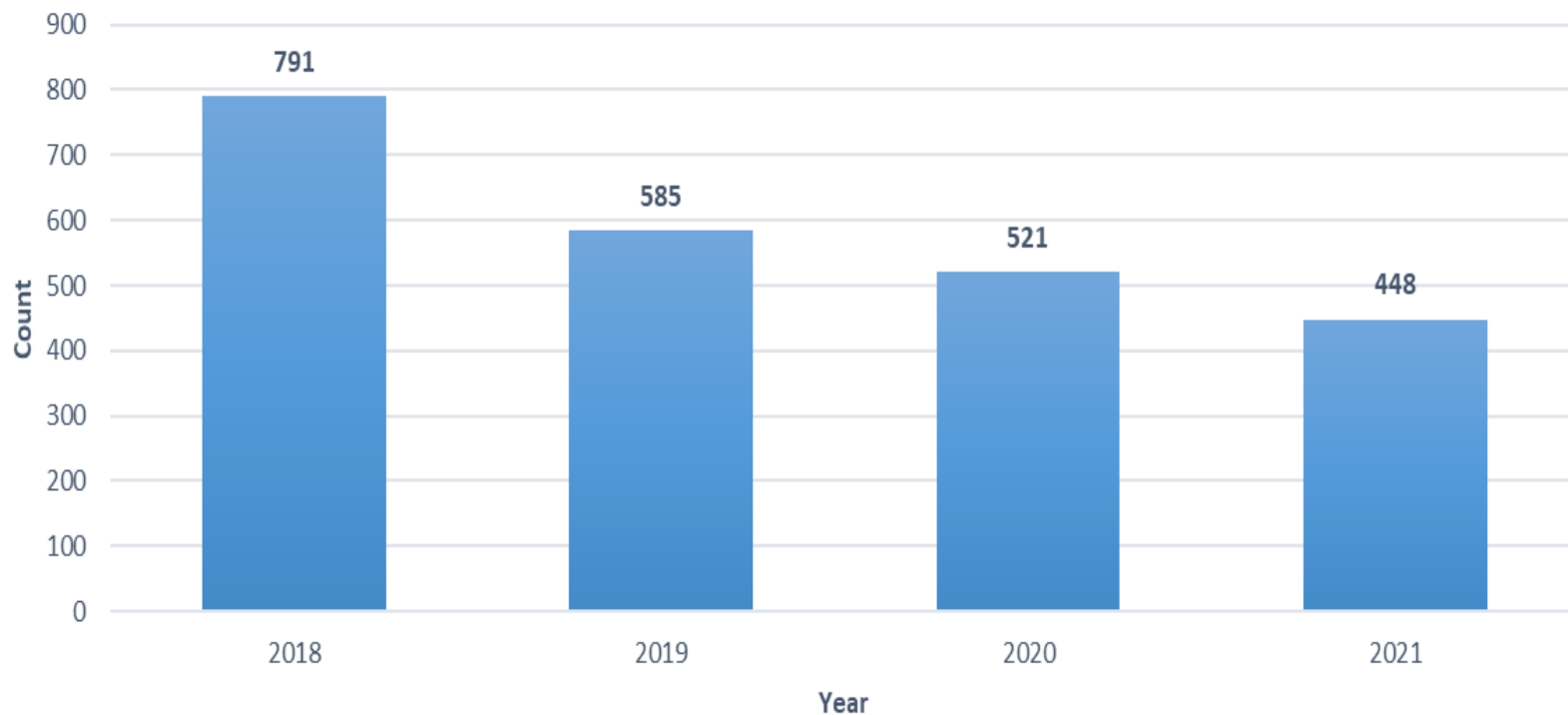
Source: Ohio Department of Health – Ohio Disease Reporting System, Data obtained May 2, 2022, Data is provisional and subject to change



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Newly Diagnosed Hepatitis C Cases by Year for Butler County



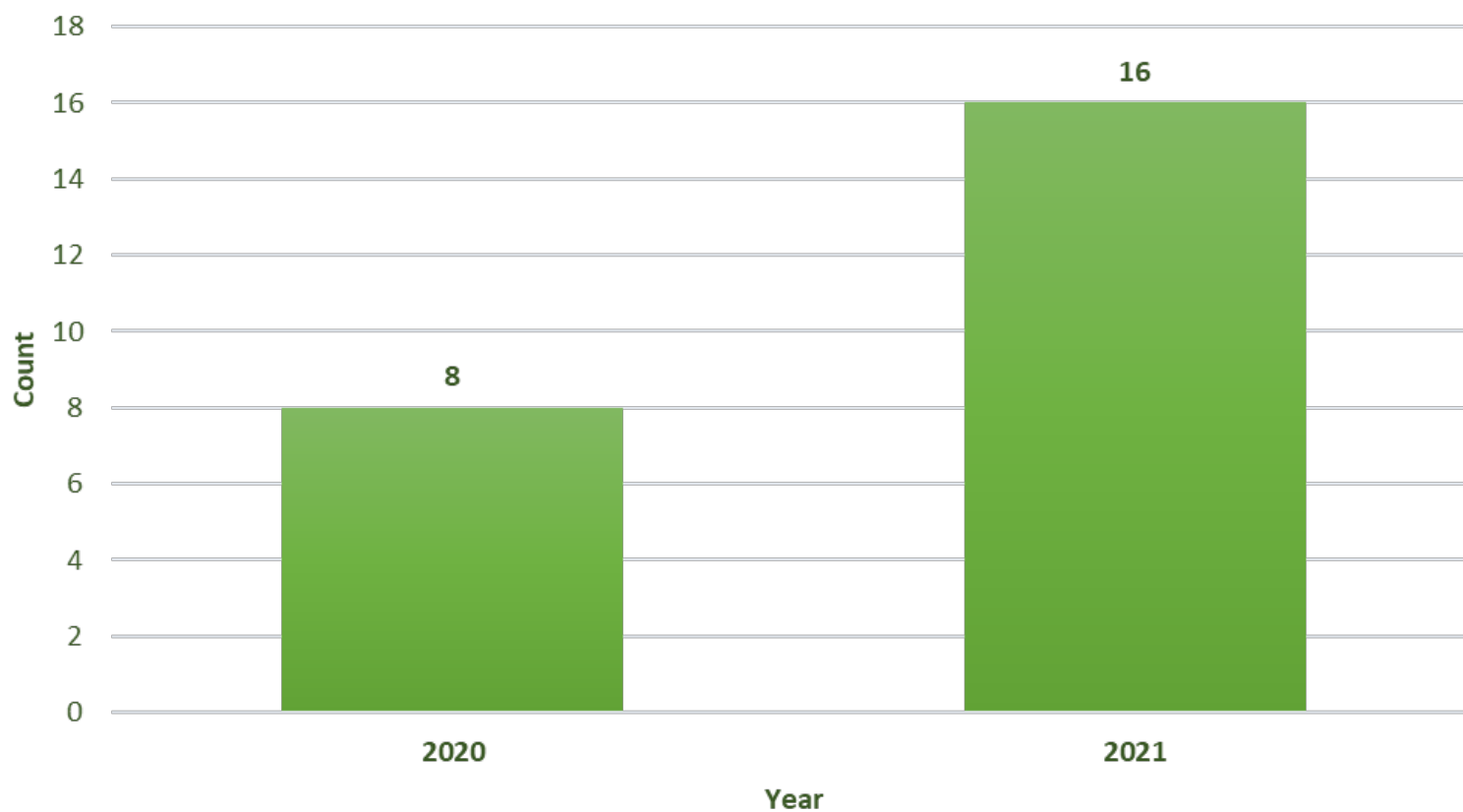
Source: Ohio Department of Health – Ohio Disease Reporting System, Data obtained May 2, 2022, Data is provisional and subject to change



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Newly Diagnosed Hepatitis C Cases Among Oxford Residents

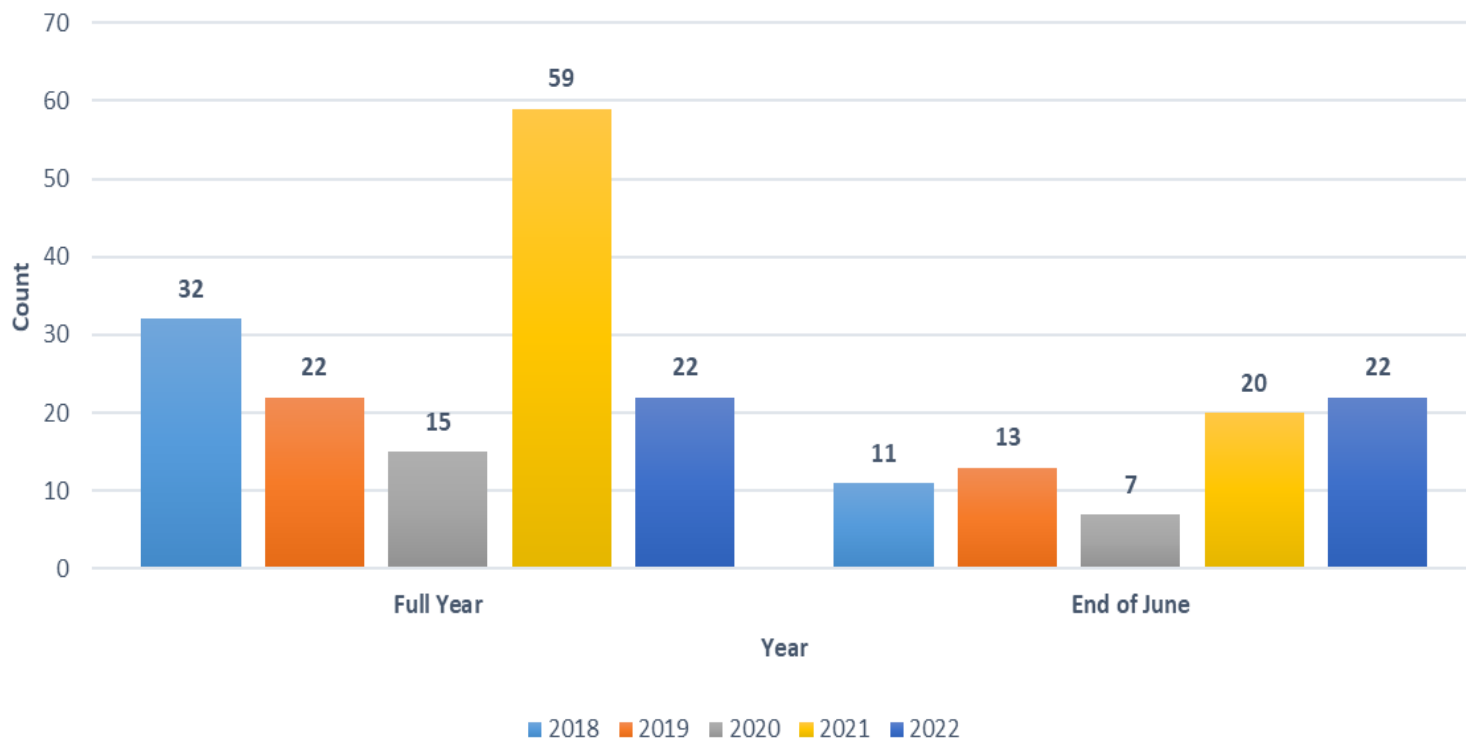


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Source: Ohio Department of Health – Ohio Disease Reporting System, Data obtained May 2, 2022, Data is provisional and subject to change

Newly Diagnosed HIV Cases for Butler County by Year and Through the End of June



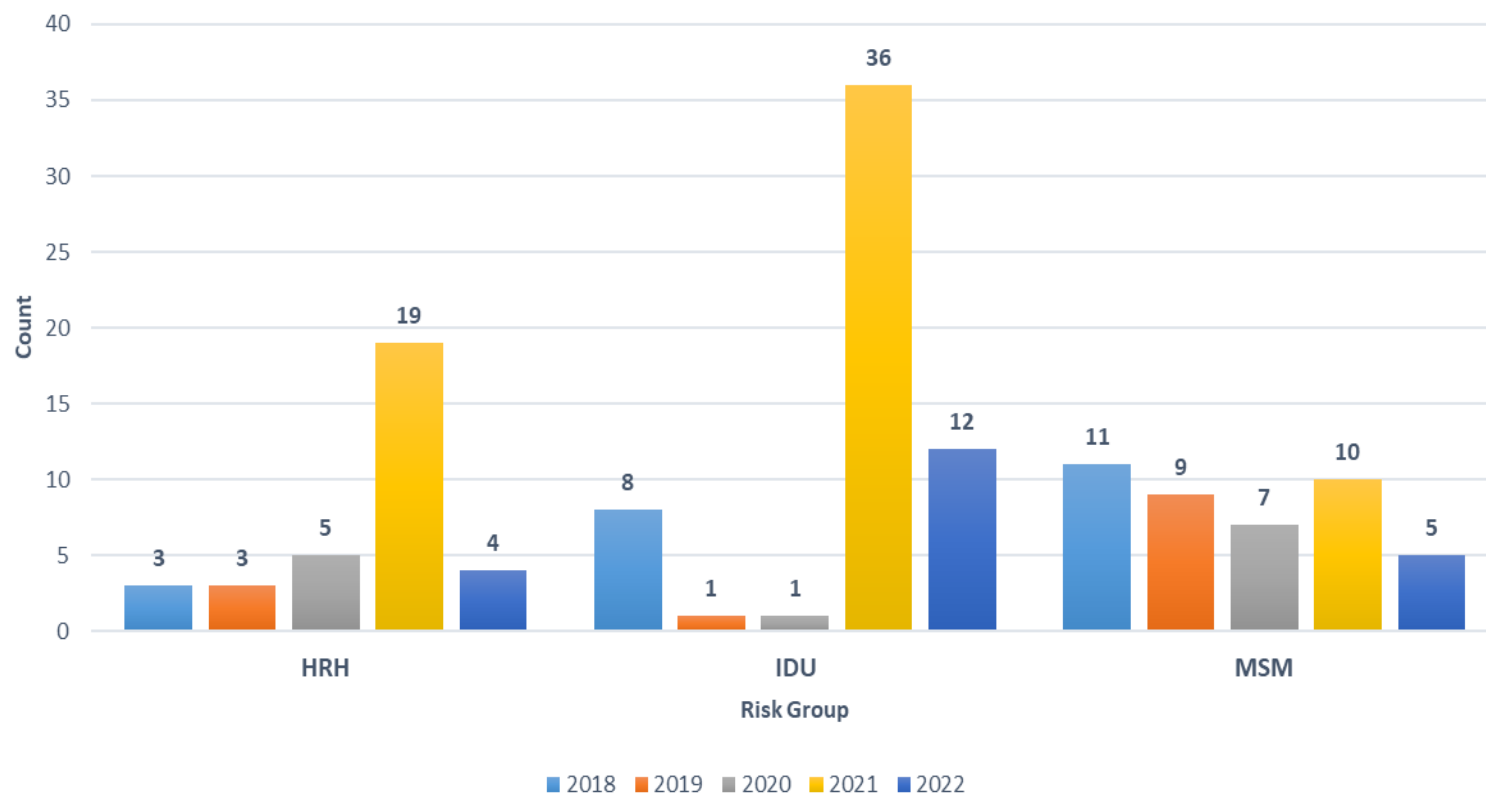
Source: Ohio Department of Health – Ohio Disease Reporting System, Data obtained July 5, 2022, Data is provisional and subject to change



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Newly Diagnosed HIV Cases by Risk Group and Year for Butler County



Source: Ohio Department of Health – Ohio Disease Reporting System, Data obtained July 5, 2022, Data is provisional and subject to change



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Legal requirements to set up a Bloodborne Pathogen Program *(according to ORC 3707.57)*

- Board of Health must approve the establishment of a BBPP
- Program must meet certain established standards (existing program meets the standards)
- Funding must be found
- Certain individuals/groups must be consulted
- Location must be secured
- City, township or village where BBPP will be located must be notified by the Board of Health
- Political and other forces must be in agreement
- Populace must be in agreement

Contact Info

Erik Balster, MPH, REHS, RS, Health Commissioner
Tyrina Taylor, MPH, Drug Overdose Prevention Coordinator
Jordan Meyer, MPH, Harm Reduction Epidemiologist
Katie Brehm, Harm Reduction Specialist

Butler County General Health District
513-863-1770
www.butlercountyoio.org/health



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Questions?



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Summary of Information on the Safety and Effectiveness of Syringe Services Programs (SSPs)

Background

The nation is currently experiencing an opioid crisis involving the misuse of prescription opioid pain relievers as well as heroin and fentanyl.^{1,2} The increase in substance use has resulted in concomitant increases in injection drug use across the country.³ This has caused not only large increases in overdose deaths,⁴ but also tens of thousands of viral hepatitis infections annually⁵ and is threatening recent progress made in HIV prevention.⁶ The most effective way for individuals who inject drugs to avoid the negative consequences of injection drug use is to stop injecting.^{7,8} However, many people are unable or unwilling to do so, or they have little or no access to effective treatment. Approximately 775,000 Americans report having injected a drug in the past year.⁹ In 2017, 14% of high school students reported using opioids without a prescription and 1.5% reported having ever injected drugs.¹⁰

Syringe services programs (SSPs) are proven and effective community-based prevention programs that can provide a range of services, including access to and disposal of sterile syringes and injection equipment, vaccination, testing, and linkage to infectious disease care and substance use treatment.^{8, 11} SSPs reach people who inject drugs, an often hidden and marginalized population. Nearly 30 years of research has shown that comprehensive SSPs are safe, effective, and cost-saving, do not increase illegal drug use or crime, and play an important role in reducing the transmission of viral hepatitis, HIV and other infections.^{11,12} Research shows that new users of SSPs are five times more likely to enter drug treatment and about three times more likely to stop using drugs than those who don't use the programs.¹³ SSPs that provide naloxone also help decrease opioid overdose deaths. SSPs protect the public and first responders by facilitating the safe disposal of used needles and syringes.



Appropriations language from Congress in fiscal years 2016-2018 permits use of funds from the Department of Health and Human Services (HHS), under certain circumstances, to support SSPs with the exception that funds may not be used to purchase needles or syringes.¹⁴ State, local, tribal, or territorial health departments must first consult with CDC and provide evidence that their jurisdiction is experiencing or at risk for significant increases in hepatitis infections or an HIV outbreak due to injection drug use.¹⁵ CDC has developed guidance and consults with state, local, or tribal and territorial health departments on determining if they have adequately demonstrated need according to federal law. Decisions about use of SSPs to prevent disease transmission and support the health and engagement of people who inject drugs are made at the state and local level.



**U.S. Department of
Health and Human Services**
Centers for Disease
Control and Prevention

Prevention of Infectious Diseases

Viral hepatitis, HIV, and other blood-borne pathogens can spread through injection drug use if people use needles, syringes, or other injection materials that were previously used by someone who had one of these infections. Injecting drugs can also lead to other serious health problems, such as skin infections, abscesses and endocarditis. The best way to reduce the risk of acquiring and transmitting disease through injection drug use is to stop injecting drugs. For people who do not stop injecting drugs, using sterile injection equipment for each injection can reduce the risk of infection and prevent outbreaks.

During the last decade, the United States has seen an increase in injection drug use — primarily the injection of opioids. Outbreaks of hepatitis C, hepatitis B and HIV infections have been correlated with these injection patterns and trends.^{16,17} The majority of new hepatitis C virus (HCV) infections are due to injection drug use, and the nation has seen a 3.5-fold increase in reported cases of HCV from 2010 to 2016, reaching a 15- year high.⁵ New HCV virus infections are increasing most rapidly among young people, with the greatest incidence among individuals under 30.

Until recently, CDC had observed a steady decline since the mid-1990s in HIV diagnoses attributable to injection drug use. However, recent data show progress has stalled. Notably, new HIV infections among white people who inject drugs, the group most affected by the expanding



opioid epidemic, increased 10% from 2014 to 2015.¹⁸ The estimated lifetime cost of treating one person living with HIV is near \$450,000.¹⁹ Hospitalization in the US due to substance-use related infections alone costs over \$700 million annually.²⁰ In the United States, the estimated cost of providing health care services for people living with chronic HCV infection is \$15 billion annually.²¹ SSPs can help reduce these healthcare costs by preventing viral hepatitis, HIV, endocarditis and other infections.

SSPs are a tool that can help reduce transmission of viral hepatitis, HIV, and other blood-borne infections. SSPs are associated with an approximately 50% reduction in HIV and HCV incidence.¹¹ When combined with medications that treat opioid dependence (also known as medication-assisted treatment) HIV and HCV transmission is reduced by more than two-thirds.^{22,23}



Users of SSPs were **three times more likely** to stop injecting drugs.



Linkage to Substance Use Treatment, Naloxone, and Other Healthcare Services

Syringe services programs serve as a bridge to other health services including, HCV and HIV diagnosis and treatment and MAT for substance use.²⁴ The majority of SSPs offer referrals to MAT,²⁵ and people who inject drugs who regularly use an SSP are more than five times as likely to enter treatment for a substance use disorder and nearly three times as likely to report reducing or discontinuing injection as those who have never used an SSP.^{13,26,27} SSPs facilitate entry into treatment for substance use disorders by people who inject drugs.^{26,28} People who use SSPs show high readiness to reduce or stop their drug use.²⁹ There is also evidence that people who inject drugs who work with a nurse at an SSP or other community-based venue are more likely to access primary care than those who don't,³⁶ also increasing access to MAT.³⁰ Many comprehensive community-based SSPs offer a range of preventative services including vaccination, infectious disease testing, and linkage to healthcare services.

Syringe service programs can reduce overdose deaths by teaching people who inject drugs how to prevent and respond to a drug overdose, providing them training on how to use naloxone, a medication used to reverse overdose, and providing naloxone to them. Many SSPs provide "overdose prevention kits" containing naloxone to people who inject drugs.^{31,32} SSPs have partnered with law enforcement, providing naloxone to local police departments to help them keep their communities safer.³³



Public Safety

Syringe services programs can benefit communities and public safety by reducing needlestick injuries and overdose deaths, without increasing illegal injection of drugs or criminal activity. Studies show that SSPs protect first responders and the public by providing safe needle disposal and reducing community presence of needles.^{34–38} As many as one in every three officers may be stuck by a used needle during his or her career.³⁹ Needle stick injuries are among the most concerning and stressful events experienced by law officers.^{40,41} A study compared the prevalence of improperly disposed of syringes and self-reported disposal practices in a city with SSPs (San Francisco) to a city without SSPs (Miami) and found eight times as many improperly disposed of syringes in Miami, the city without SSPs.³⁴ People who inject drugs in San Francisco also reported higher rates of safe disposal

practices than those in Miami. Data from CDC's National HIV Behavioral Surveillance system in 2015 showed that the more syringes distributed at SSPs per people who inject drugs in a geographic region, the more likely people who inject drugs in that region were to report safe disposal of used syringes.⁴²

Evidence demonstrates that SSPs do not increase illegal drug use or crime.^{43,44} Studies in Baltimore⁴⁴ and New York City⁴³ have found no difference in crime rates between areas with and areas without SSPs. In Baltimore, trends in arrests were examined before and after a SSP was opened and found that there was not a significant increase in crime rates. The study in New York City assessed whether proximity to an SSP was associated with experiencing violence in an inner city neighborhood and found no association.

SSP Implementation

Not all SSPs are alike. Programs differ in size, scope, geographic location, and delivery venue (e.g., mobile vs. fixed sites). Community acceptance and legality also impact program success. Prior to establishing an SSP, it is important for public health agencies (or others) to assess the needs of potential clients, their families, key stakeholders, law enforcement, and the community at large.

The decision to incorporate SSPs as part of a comprehensive prevention program is made at the state and local level. Laws vary by state and can either increase or reduce access to SSPs. CDC created a guidance document to aid state and local health departments in managing HIV and hepatitis C outbreaks among people who inject drugs, which provides best practices to consider when establishing an SSP.⁴⁵ Conducting a needs assessment prior to the establishment of an SSP, developing evaluation tools, and careful planning of the operational tasks can increase the chances the SSP will be successful in a community.

HHS guidance states that SSPs should be part of a comprehensive service program that includes, as appropriate,⁴⁶

- Provision of sterile needles, syringes, and other drug preparation equipment (purchased with non-federal funds) and disposal services.

- Education and counseling to reduce sexual, injection and overdose risks.
- Provision of condoms to reduce risk of sexual transmission of viral hepatitis, HIV or other sexually transmitted diseases.
- Provision of HIV, viral hepatitis, STD and tuberculosis screening.
- Provision of naloxone to reverse opioid overdoses.
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention, treatment, and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), prevention of mother-to-child transmission, and partner services.
- Referral and linkage to hepatitis A virus (HAV) and hepatitis B virus vaccination.
- Referral and linkage to and provision of substance use disorder treatment, including MAT for opioid use disorder, which combines drug therapy (e.g., methadone, buprenorphine, or naltrexone) with counseling and behavioral therapy.
- Referral to medical care, mental health services, and other support services.

SSPs save lives by lowering the likelihood of deaths from overdose.



Emerging Issues

In addition to the concerning increases in hepatitis and HIV rates, CDC has also identified additional emerging infectious disease risks related to injection drug use, including increases in methicillin-resistant staphylococcus aureus (MRSA) infection rates, which increased 124% between 2011 and 2016 among people who inject drugs.⁴⁷ In addition, people who inject drugs are 16 times as likely as other people to develop invasive MRSA infections.

Rates of endocarditis, a life-threatening infection of the heart valves that can occur in people who inject drugs, has also increased. For example, in North Carolina alone, the rate of hospital discharge diagnoses for endocarditis related to drug dependence increased more than 12-fold from 2010 to 2015, with unadjusted hospital costs increasing from \$1.1 million in 2010 to over \$22 million in 2015.⁴⁸ Identifying and responding to these emerging infectious disease threats is critical to alleviate the subsequent harms of opioid misuse and abuse. These infections have been linked to frequency of injecting and to syringe sharing.⁴⁹ SSPs may help reduce bacterial infections by providing sterile injection equipment and linkage to substance use treatment.



Endnotes

1. What is the U.S. Opioid Epidemic? Retrieved from <https://www.hhs.gov/opioids/about-the-epidemic/index.html>
2. Office of National Drug Control Policy. (n.d.) Prescription opioid misuse, heroin and fentanyl. Retrieved from <https://www.whitehouse.gov/ondcp/key-issues/prescription-opioid-misuse/>
3. Zibbell, J. E., Asher, A. K., Patel, R. C., Kupronis, B., Iqbal, K., Ward, J. W., & Holtzman, D. (2018). Increases in Acute Hepatitis C Virus Infection Related to a Growing Opioid Epidemic and Associated Injection Drug Use, United States, 2004 to 2014. *Am J Public Health*, 108(2), 175-181. doi:10.2105/aajph.2017.304132
4. Centers for Disease Control and Prevention. (2018). Drug overdose death data. Retrieved from <https://www.cdc.gov/drugoverdose/data/statedeaths.html>
5. Centers for Disease Control. (2018). *Surveillance for Viral Hepatitis — United States, 2016*. Retrieved from <https://www.cdc.gov/hepatitis/statistics/2016surveillance/commentary.htm>
6. Centers for Disease Control and Prevention. (2016). *Vital signs: HIV and injection drug use*. Retrieved from <https://www.cdc.gov/vitalsigns/pdf/2016-12-vitalsigns.pdf>
7. MacArthur, G. J., Minozzi, S., Martin, N., Vickerman, P., Deren, S., Bruneau, J., . . . Hickman, M. (2012). Opiate substitution treatment and HIV transmission in people who inject drugs: systematic review and meta-analysis. *Bmj*, 345, e5945. doi:10.1136/bmj.e5945
8. Martin, N. K., Hickman, M., Hutchinson, S. J., Goldberg, D. J., & Vickerman, (2013). Combination interventions to prevent HCV transmission among people who inject drugs: modeling the impact of antiviral treatment, needle and syringe programs, and opiate substitution therapy. *Clin Infect Dis*, 57 Suppl 2, S39-45. doi:10.1093/cid/cit29
9. Lansky, A., Finlayson, T., Johnson, C., Holtzman, D., Wejnert, C., Mitsch, A., . . . Crepaz, N. (2014). Estimating the number of persons who inject drugs in the United States by meta-analysis to calculate national rates of HIV and hepatitis C virus infections. *PLoS ONE*, 9(5), e97596. <http://doi.org/10.1371/journal.pone.0097596>
10. National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: Division of Adolescent and School Health Centers for Disease Control and Prevention. *Youth Risk Behavior Survey Data Summary & Trends Report 2007-2017*.
11. Aspinall, E. J., Nambiar, D., Goldberg, D. J., Hickman, M., Weir, A., Van Velzen, E., . . . Hutchinson, S. J. (2014). Are needle and syringe programmes associated with a reduction in HIV transmission among people who inject drugs: a systematic review and meta-analysis. *Int J Epidemiol*, 43(1), 235-248. doi:10.1093/ije/dyt243
12. Bernard, C. L., Owens, D. K., Goldhaber-Fiebert, J. D., & Brandeau, M. L. (2017). Estimation of the cost-effectiveness of HIV prevention portfolios for people who inject drugs in the United States: A model-based analysis. *PLoS Med*, 14(5). doi:10.1371/journal.pmed.1002312
13. Hagan H, McGough JP, Thiede H, Hopkins S, Duchin J, Alexander ER, "Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors", *Journal of Substance Abuse Treatment*, 2000; 19:247–252.
14. Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 (P.L. 115-245)
15. Centers for Disease Control and Prevention. (2018). Syringe service program determination of need. Retrieved from <https://www.cdc.gov/hiv/risk/ssps-jurisdictions.html>
16. Comer M, Matthias J, Nicholson G, Asher A, Holmberg S, Wilson C. Notes from the field: Increase in acute hepatitis B infections — Pasco County, Florida, 2011–2016. *MMWR Morb Mortal Wkly Rep* 2018;67:230–231. DOI: <http://dx.doi.org/10.15585/mmwr.mm6707a6>
17. Harris AM, Iqbal K, Schillie S, et al. Increases in acute hepatitis B virus infections — Kentucky, Tennessee, and West Virginia, 2006–2013. *MMWR Morb Mortal Wkly Rep* 2016;65:47–50. DOI: <http://dx.doi.org/10.15585/mmwr.mm6503a2>
18. Centers for Disease Control and Prevention. HIV Surveillance Report, 2016; vol. 28. <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published November 2017. Accessed 7/30/2018.
19. Farnham PG et al. Updates of lifetime costs of care and quality of life estimates for HIV-infected persons in the United States: Late versus early diagnosis and entry into care. *JAIDS* 2013; 64: 183-189. Estimates updated to 2017
20. Ronan, M., & Herzig, S. (2016). Hospitalizations related to opioid abuse/dependence and associated serious infections increased sharply, 2002–12. *Health Affairs*, 35(5), 832-837. <https://doi.org/10.1377/hlthaff.2015.1424>
21. Chahal, H. S., Marseille, E. A., Tice, J. A., Pearson, S. D., Ollendorf, D. A., Fox, R. K., et al. (2016, January). Cost-effectiveness of early treatment of hepatitis C virus genotype 1 by stage of liver fibrosis in a U.S. treatment-naïve population. *The Journal of the American Medical Association*, 176(1), 65–73. Retrieved October 25, 2017, from <http://archinte.jamanetwork.com/article.aspx?articleid=2471608>
22. Platt L, Minozzi S, Reed J, Vickerman P, Hagan H, French C, Jordan A, Degenhardt L, Hope V, Hutchinson S, Maher L, Palmateer N, Taylor A, Bruneau J, Hickman M. Needle syringe programmes and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs. *Cochrane Database of Systematic Reviews* 2017, Issue 9. Art. No.: CD012021. DOI: 10.1002/14651858.CD012021.pub2
23. Fernandes, R. M., Cary, M., Duarte, G., Jesus, G., Alarcao, J., Torre, C., . . . Carneiro, A. V. (2017). Effectiveness of needle and syringe programmes in people who inject drugs - An overview of systematic reviews. *BMC Public Health*, 17(1), 309. doi:10.1186/s12889-017-4210-2
24. *HIV and Injection Drug Use: Syringe Services Programs for HIV Prevention*. (2016). CDC Vital Signs.
25. Des Jarlais D., Nugent A., Solberg A. Syringe service programs for persons who inject drugs in urban, suburban, and rural areas — United States, 2013 *MMWR Morb Mortal Wkly Rep* 2015;64: 1337-1341
26. Strathdee, S.A., Celentano, D.D., Shah, N., Lyles, C., Stambolis, V.A., Macal, G., Nelson, K., Vlahov, D., "Needle-exchange attendance and health care utilization promote entry into detoxification", *J Urban Health* 1999; 76(4):448-60.
27. Heimer, R. (1998). Can syringe exchange serve as a conduit to substance abuse treatment? *Journal of Substance Abuse Treatment* 15:183–191.
28. Bluthenthal, R.N., Gogineni, A. Longshore, D., Stein, M. (2001). Factors associated with readiness to change drug use among needle-exchange users. *Drug & Alcohol Dependence* 62:225-230.
29. Artenie, Andreea & Jutras-Aswad, D & Roy, É & Zang, G & Bamvita, J-M & Lévesque, Annie & Bruneau, J. (2015). Visits to primary care physicians among persons who inject drugs at high risk of hepatitis C virus infection: Room for improvement. *Journal of Viral Hepatitis*. 22. 10.1111/jvh.12393.
30. Chou R, Korthuis PT, Weimer M, et al. Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016 Dec. (Technical Briefs, No. 28.) Available from: <https://www.ncbi.nlm.nih.gov/books/NBK402352/>
31. Seal, KH, Thawley R, Gee L, Bamberger J, Kral AH, Ciccarone D, Edlin BR (2005). "Naloxone distribution and cardiopulmonary resuscitation training for injection drug users to prevent heroin overdose death: A pilot intervention study", *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 2005; 82(2):, 303–311.

Endnotes

32. Leece PN, Hopkins S, Marshall C, Orkin A, Gassanov MA, Shahin RM, "Development and implementation of an opioid overdose prevention and response program in Toronto, Ontario", *Canadian Journal of Public Health*, 2013;104(3):e200-4.
33. Childs, R. Law Enforcement and Naloxone Utilization in the United States [PowerPoint slides]. Retrieved from <https://www.fda.gov/downloads/Drugs/NewsEvents/UCM454810.pdf>
34. Tookes HE, Kral AH, Wenger LD, Cardenas GA, Martinez AN, Sherman RL, Pereyra M, Forrest DW, Laota M, Metsch LR, "A comparison of syringe disposal practices among injection drug users in a city with versus a city without needle and syringe programs", *Drug and Alcohol Dependence*, 2012 ;123(1-3):255-9
35. Riley ED, Kral AH, Stopka TJ, Garfein RS, Reuckhaus P, Bluthenthal RN, "Access to sterile syringes through San Francisco pharmacies and the association with HIV risk behavior among injection drug users", *Journal of Urban Health*, 2010; 87(4):534-42
36. Klein SJ, Candelas AR, Cooper JG, Badillo WE, Tesoriero JM, Battles HB, Plavin HA, "Increasing safe syringe collection sites in New York State", *Public Health Reports*, 2008; 123(4):433-40.
37. de Montigny L, Vernez Moudon A, Leigh B, Kim SY, "Assessing a drop box programme: a spatial analysis of discarded needles", *International Journal of Drug Policy*, 2010; 21(3):208-14. Doherty MC, Junge B, Rathouz P, Garfein RS, Riley E, Vlahov D, "The effect of a needle exchange program on numbers of discarded needles: a 2-year follow-up", *American Journal of Public Health*. 2000 Jun; 90(6):936-9.
38. Bluthenthal RN, Anderson R, Flynn NM, Kral AH, "Higher syringe coverage is associated with lower odds of HIV risk and does not increase unsafe syringe disposal among syringe exchange program clients", *Drug and Alcohol Dependence*, 2007; 89(2-3):214-22
39. Lorentz, J., Hill, L., & Samimi, B. (2000). Occupational Needlestick Injuries. *American Journal of Preventive Medicine*, 18(2), 146-150. [https://doi.org/10.1016/S0749-3797\(99\)00137-3](https://doi.org/10.1016/S0749-3797(99)00137-3)
40. Cepeda, J. A., Beletsky, L., Sawyer, A., Serio-Chapman, C., Smelyanskaya, M., Han, J., Sherman, S. G. (2017). Occupational Safety in the Age of the Opioid Crisis: Needle. *Journal of Urban Health*, 94(1), 100-103. <https://doi.org/10.1007/s11524-016-0115-0>
41. Davis, C., Johnston, J., de Saxe Zerden, L., Clark, K., Castillo, T., & Childs, (2014). Attitudes of North Carolina law enforcement officers toward syringe. *Drug and Alcohol Dependence*, (144), 265-269. <http://doi.org/10.1016/j.drugalcdep.2014.08.007>.
42. Centers for Disease Control and Prevention. HIV Infection, Risk, Prevention, and Testing Behaviors among Persons Who Inject Drugs—National HIV Behavioral Surveillance: Injection Drug Use, 20 U.S. Cities, 2015. HIV Surveillance Special Report 18. Revised edition. <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published May 2018. Accessed 7/30/2018.
43. Galea, S., Ahern, J., Fuller, C., Freudenberg, N., & Vlahov, D. (2001). Needle exchange programs and experience of violence in an inner city neighborhood. *Journal of Acquired Immune Deficiency Syndromes*, (28), 282-288.
44. Marx, M. A., Crape, B., Brookmeyer, R. S., Junge, B., Latkin, C., Vlahov, D., & Strathdee, S. A. (2000). Trends in crime and the introduction of a needle exchange program. *American Journal of Public Health*, 90(12), 1933-1936.
45. Centers for Disease Control and Prevention. Managing HIV and hepatitis C outbreaks among people who inject drugs—A guide for state and local health departments. March 2018. Available at: <https://www.cdc.gov/hiv/pdf/programresources/guidance/cluster-outbreak/cdc-hiv-hcv-pwid-guide.pdf>
46. *Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs*, 2016. (2016, March). Department of Health and Human Services.
47. Jackson KA, Bohm MK, Brooks JT, et al. Invasive Methicillin-Resistant *Staphylococcus aureus* Infections Among Persons Who Inject Drugs — Six Sites, 2005–2016. *MMWR Morb Mortal Wkly Rep* 2018; 67:625–628. DOI: <http://dx.doi.org/10.15585/mmwr.mm6722a2>
48. Fleischauer, A. T., Ruhl, L., Rhea, S., & Barnes, E. (2017). Hospitalizations for Endocarditis and Associated Health Care Costs Among Persons with Diagnosed Drug Dependence - North Carolina, 2010-2015. *MMWR Morb Mortal Wkly Rep*, 66(22), 569-573. doi:10.15585/mmwr.mm6622a1
49. Dahlman, D., Hakansson, A., Kral, A., Wenger, L., Ball, E., & Novak, S. (2017). Behavioral characteristics and injection practices associated with skin and soft tissue infections among people who inject drugs: A community-based observational study. *Substance Abuse*, 38(1), 105-112. <https://doi.org/10.1080/08897077.2016.1263592>



Ohio Revised Code

Section 3707.57 Bloodborne infectious disease prevention programs.

Effective: July 1, 2017

Legislation: Senate Bill 319 - 131st General Assembly

(A) As used in this section:

(1) "Bloodborne pathogens" means the human immunodeficiency virus (HIV), hepatitis B virus, and hepatitis C virus.

(2) "Board of health" means the board of health of a city or general health district or the authority having the duties of a board of health under section 3709.05 of the Revised Code.

(B) A board of health may establish a bloodborne infectious disease prevention program. The cost of the program is the responsibility of the board of health.

(C) A board of health that establishes a bloodborne infectious disease prevention program shall determine the manner in which the program is operated and the individuals who are eligible to participate. The program shall do all of the following:

(1) If resources are available, provide on-site screening for bloodborne pathogens;

(2) Provide education to each program participant regarding exposure to bloodborne pathogens;

(3) Identify health and supportive services providers and substance abuse treatment programs available in the area served by the prevention program and, as appropriate, develop and enter into referral agreements with the identified providers and programs;

(4) Encourage each program participant to seek appropriate medical care, mental health services, substance abuse treatment, or social services and, as appropriate, make referrals to health and supportive services providers and substance abuse treatment programs with which the prevention program has entered into referral agreements;



(5) Use a recordkeeping system that ensures that the identity of each program participant remains anonymous;

(6) Comply with applicable state and federal laws governing participant confidentiality;

(7) Provide each program participant with documentation identifying the individual as an active participant in the program.

(D) A bloodborne infectious disease prevention program may collect demographic information about each program participant, including the zip code applicable to the participant's address, and the participant's comorbidity diagnosis, if any. The program may report the information to the department of mental health and addiction services.

(E)(1) Before establishing a bloodborne infectious disease prevention program, the board of health shall consult with all of the following:

(a) Interested parties from the health district represented by the board, including all of the following:

(i) Law enforcement representatives;

(ii) Prosecutors, as defined in section 2935.01 of the Revised Code;

(iii) Representatives of community addiction services providers whose alcohol and drug addiction services are certified under section 5119.36 of the Revised Code;

(iv) Persons recovering from substance abuse;

(v) Relevant private, nonprofit organizations, including hepatitis C and HIV advocacy organizations;

(vi) Residents of the health district;

(vii) The board of alcohol, drug addiction, and mental health services that serves the area in which the health district is located.



(b) Representatives selected by the governing authority of the city, village, or township in which the program is proposed to be established.

(2) If the board of health, after consulting with the interested parties and representatives listed in division (D)(1) of this section, decides to establish a bloodborne infectious disease prevention program, the board shall provide written notice of the proposed location to the governing authority of the city, village, or township in which the program is to be located. The governing authority retains all zoning rights.

(F)(1) If carrying out a duty under a component of a bloodborne infectious disease prevention program would be considered a violation of any of the following, an employee or volunteer of the program, when carrying out the duty, is not subject to criminal prosecution for the violation:

(a) Section 2923.24 of the Revised Code;

(b) Section 2925.12 of the Revised Code;

(c) Division (C)(1) of section 2925.14 of the Revised Code regarding the prohibition against illegal possession of drug paraphernalia;

(d) Division (C) or (D) of section 3719.172 of the Revised Code regarding the prohibition against furnishing a hypodermic needle to another person.

(2) If participating in a component of a bloodborne infectious disease prevention program would be considered a violation of any of the following, a program participant who is within one thousand feet of a program facility and is in possession of documentation from the program identifying the individual as an active participant in the program is not subject to criminal prosecution for the violation:

(a) Section 2923.24 of the Revised Code;

(b) Section 2925.12 of the Revised Code;



(c) Division (C)(1) of section 2925.14 of the Revised Code regarding the prohibition against illegal possession of drug paraphernalia.

(G) A board of health that establishes a bloodborne infectious disease prevention program shall include details about the program in its annual report prepared under section 3707.47 of the Revised Code.