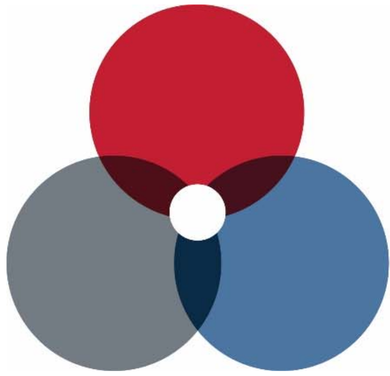

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Federal and State Changes Raise Possibility of New or Expanded Syringe Services Programs in Ohio

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Background

As the opiate crisis continues to take a toll on Ohio and the need for addiction recovery services outpaces capacity, syringe services programs (SSPs), or syringe exchanges, have become a more common topic of discussion as an intervention to reduce harm for people who inject drugs (PWID). SSPs are a proven public health strategy to reduce communicable infections associated with injecting drugs and sharing needles. Recent changes to state and federal law have elevated this discussion.

Within the last 18 months, changes to federal and state laws related to SSPs have brought increased attention to the development of new programs. Federal funding is now permitted to be used to support syringe services programs, as long as the funding does not pay for the actual syringes. In order to demonstrate need for funding to the Centers for Disease Control and Prevention (CDC), communities must show that they are currently experiencing increased incidence of hepatitis or HIV due to injection drug use or are at risk of increases in hepatitis or HIV due to injection drug use. The state law now allows communities to establish a program without declaring a public health emergency, but there is still a required process.

Syringe Services Programs in Ohio

Up until 2015, a city health district, under home rule authority granted by Ohio's Constitution, could declare a public health emergency related to bloodborne pathogens in order to create a syringe services program. This emergency authority led to the creation of programs in Cleveland (1995), Portsmouth (2011), Cincinnati (2014), Dayton (2015), and Gallia County (2015).

The latest state budget bill (FY 2016-2017), Amended Substitute House Bill 64, changed Ohio law to allow local boards of health to establish a bloodborne infectious disease prevention program to reduce the transmission of infectious diseases without declaring a public health emergency.[1] In order for a local board of health to use the new process to establish a program, it is required to consult:

- local law enforcement agencies and prosecutors;
- community addiction services providers;

- persons in recovery;
- hepatitis C and HIV advocacy organizations;
- the local alcohol, drug addiction and mental health services board;
- representatives of the city, village, or township where the program is to be established; and
- local residents.

Local zoning laws also apply to the establishment of program sites. This allows communities, through their planning process, to determine the best location for the program that meets local zoning laws or to change local zoning laws to determine the best location for the program. This planning process to garner community buy-in was identified as a key piece of program development by individuals involved in operating the current programs in the state. This process will be examined further in this report.

The provision in the state budget also requires that a SSP identify health and supportive services providers and substance abuse treatment programs, develop and enter into referral agreements with those providers and programs, and refer program participants to them. This incorporates the lessons of existing SSPs that see additional services and/or referrals as key pieces of their programs. There are several state laws that prohibit the possession and use of tools for illegal drug use. The recently passed legislation provides legal protection for program staff or volunteers who distribute hypodermic needles as part of the program as long as they are distributing needles to someone who is within 1,000 feet of a program facility and who has documentation identifying the individual as a program participant. Program participants are also provided this protection within 1,000 feet of where a program is operating as a mobile unit.

After the state budget was enacted and this new provision went into effect, stakeholders in Columbus announced plans for a bloodborne pathogen prevention program. In early 2016, the state's sixth SSP began in Columbus. Other communities are considering initiating programs as well.

Federal Changes

Given the scope and impact of the drug epidemic, specifically heroin, some policymakers previously opposed to SSPs have come to understand the positive public health impact that these programs can make. This change was partially spurred by a recent HIV outbreak in Scott County in Southeast Indiana due to needle sharing for injection drug use. A SSP was established in Scott County soon after the beginning of the outbreak. Until the end of 2015, there was a total ban on federal funding of syringe exchanges. Congressional action changed the law to allow federal funding to operate a

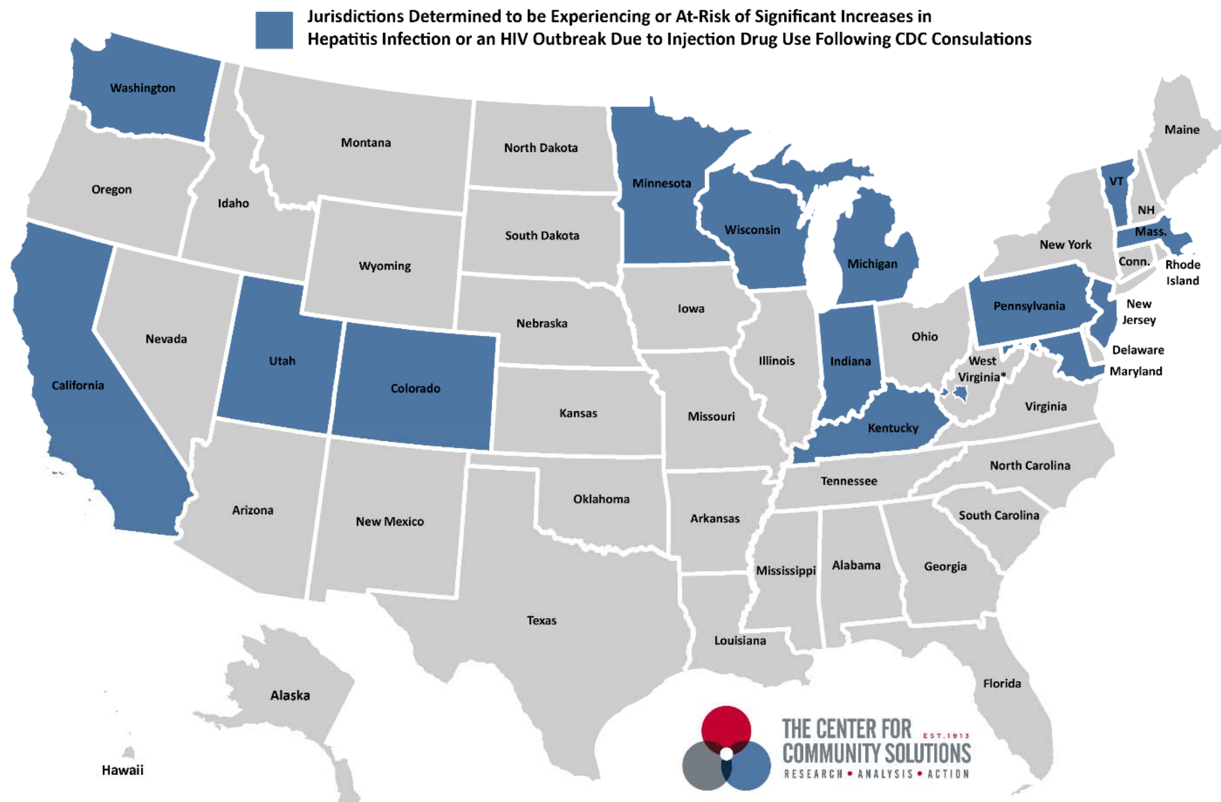
SSP, which includes staff and supplies, but maintained the ban on funding for the actual needles. At the time of the law change, there was no specific funding stream identified for SSPs.[2]

Determination of Need

In the spring of 2016, the federal government released guidance for states and localities (jurisdictions) for submission of a "determination of need" to the CDC,[3] required in order to be awarded any federal funding for syringe services programs. The guidance lays out the process for demonstrating need if a jurisdiction is currently experiencing or at risk of increases in hepatitis or HIV due to injection drug use. The guidance specifically states that strong submissions will include the use of real-time data sources and evidence of collaborative data sharing among relevant stakeholders within the jurisdiction. The determination of need is submitted to the CDC, but, as explained in further detail below, funding sources through the CDC, the Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Administration (SAMHSA) are available for syringe services programs.

In Ohio, as the opiate crisis continues to take a toll and with the recent state law changes, communities are having conversations about establishing syringe services programs and exploring federal funding opportunities. The Ohio Department of Health, as the state public health agency, has been open to communicating with jurisdictions as they are considering submitting a determination of need.

Since the release of the HHS guidance, 17 jurisdictions across the country have been determined to be experiencing or are at-risk of increases in hepatitis or an HIV outbreak. Fourteen of these determinations were requested by state health departments and approved statewide for each. The other three determinations were approved for individual counties in West Virginia. Other jurisdictions have submitted determinations and are in consultation with the CDC.[4] Communities in Ohio—including Cuyahoga County—are considering or have submitted determinations. While the state department of health can apply for determination of need, local health districts can as well, with support from the state health department.



To gain insight into what the determination of need process might look like in Ohio, The Center for Community Solutions gathered information from lead employees of these projects at 12 health departments in other states that have successfully completed their CDC consultations and are eligible to use federal funds for SSPs. Consistently, these health departments reported that the process was straightforward and that they were successful in gaining CDC approval of their determinations by adhering closely to the recommendations laid out in the HHS guidance. Specifically, successful determinations of need employed the types of data sources suggested in the federal guidance that demonstrate compelling evidence that their jurisdictions are experiencing or bearing risk of significant increases in HIV or hepatitis infections due to injection drug use. For jurisdictions requesting a determination based on actually experiencing an HIV or hepatitis outbreak, supporting data typically come from state or local notifiable disease surveillance systems, indicating significant increases in infections over recent years. This data must also be paired with evidence that the increases are due to injection drug use, such as data on transmission category from case reporting or epidemiologic surveys of injection drug users. Annual HIV and hepatitis surveillance data at the individual county level are made publicly available by the Ohio Department of Health as well as some local health departments.

For jurisdictions requesting a determination based on *risk* of an HIV or hepatitis outbreak, the federal guidance provides a longer list of possible data sources and outcomes that can be combined to demonstrate risk. Data-supported outcomes commonly cited by states that have successfully consulted with CDC based on risk include:

- Increased demand for the services of local syringe services programs
- Increases in heroin-related admissions to substance-use disorder treatment programs
- Hospital discharge data indicating rising heroin-related emergency department visits
- Vital statistics records indicating increases in heroin overdose deaths
- Increased heroin exposures reported to state poison control centers
- Law enforcement data indicating increases in heroin-related arrests and seizures

Jurisdictions seeking determinations based on risk have been successful by compiling multiple data sources and providing summaries of how all of the data, when taken together, point to a likely rise in injection drug use in the community.

An important consideration for communities is that there is currently no new federal funding available dedicated to syringe services programs. There are certain sources of federal funding that can be redirected, which will be further detailed in the next section of this report. By and large, these sources of funding are already allocated. However, nearly every health department reported that their determination of need, approved through a CDC consultation, has not yet resulted in actual funding of SSP activities because the SSP eligible federal grants they had received for FY 2016 were already tied up in other programs and unable to be redirected. Only one state reported expecting to redirect federal FY 2016 funds to SSP activities, the result of an opportunity which arose from an extended staff vacancy that left a surplus in CDC grant funds. In general, completing the determination of need process was seen by state and local health departments as a proactive measure in case new SSP funding opportunities become available in the future. During federal budget deliberations, it will be important to monitor these funding sources, as well as new funding sources, for syringe services programs.

Sources of Federal Funds for SSPs

In addition to the federal guidance detailing the process of consulting with the CDC for a determination of need, CDC, HRSA, and SAMHSA each issued separate guidance identifying specific opportunities for their grantees to redirect FY 2016 funds to SSP activities.[5] These opportunities include the CDC's grants for comprehensive HIV prevention programs for health departments (funding opportunity announcement

PS12-1201) and hepatitis reduction among non-urban young persons who inject drugs (funding opportunity announcement PS14-004), along with SAMHSA's Substance Abuse Prevention and Treatment Block Grant and several grants under its Minority HIV/AIDS Initiative. HRSA does not identify specific funding opportunities in its guidance, leaving open the possibility for health departments to work with their HRSA project officer or contract officer to identify relevant sources of HRSA funding that may be redirected toward SSPs. Opportunities may exist with funding received by Federally Qualified Health Centers (FQHCs) as well as through rural health grants. An FQHC in Cleveland is currently in the process of including SSP in its scope of work.

Among the funding opportunities identified by CDC and SAMHSA as eligible to be redirected toward SSP activities, Ohio currently only sees funding from CDC's Comprehensive HIV Prevention Programs for Health Departments (PS12-1201) grant and SAMHSA's Substance Abuse Prevention and Treatment Block Grant. FQHCs throughout Ohio also receive substantial funding from HRSA's Health Center Program, which could be targeted for redirection toward SSP activities. Several institutions have also received funding HRSA's Rural Health programs, which could conceivably be used for SSP activities in the future.

The following table outlines the distribution of funds in Ohio from these grants in FY 2016:

Federal Agency	Funding Stream	Grantees	Amount Awarded FY 16*
CDC[6]	Comprehensive HIV Prevention Programs for Health Departments	Ohio Department of Health	$5,658,860
SAMHSA[7]	Substance Abuse Prevention and Treatment Block Grant	Ohio Department of Mental Health and Addiction Services (distributed among county MHAS Boards)	$33,094,293
HRSA[8]	Health Center Program	45 FQHCs across the state	$128,169,348
	Rural Health Care Services Outreach Grant Program	Ohio University, Ohio Northern University, & Trinity Hospital Twin City	$569,342
	Small Health Care Provider Quality Improvement Program	Holmes County General Health District & Trinity Hospital Twin City	$400,000

**CDC and HRSA award amounts are from Federal Fiscal Year 2016. SAMHSA SAPT Block Grant amounts reflect allocations made by ODMHAS to County MHAS Boards in State Fiscal Year 2016.*

CDC and HRSA each indicated in their SSP guidance that Funding Opportunity Announcements issued in FY 2017 will specifically indicate their eligibility to fund SSP activities. However, it is unclear whether new or increased funding opportunities will

become available, as none of the three agencies are expecting appropriations above FY 2016 levels in relevant program areas.[9]

Conclusion

Given the continuing impact of the opiate crisis, communities across Ohio should use the federal guidance and this document to help inform next steps in development of new or expansion of existing syringe services programs. With the changes coming at the federal level, with a new administration and changing priorities, it is important to stay up to date on this issue and be prepared if opportunities for available funding arise.

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[1] Ohio Revised Code 3707.57

[2] Congress Lifts the Ban on Federal Funding for Syringe Exchange Programs. http://www.huffingtonpost.com/tessie-castillo/congress-lifts-the-ban-on_b_9032362.html

[3] Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016. https://www.aids.gov/pdf/hhs-ssp-guidance.pdf

[4] CDC Consultations on Determination of Need Requests. http://www.cdc.gov/hiv/risk/ssps-jurisdictions.html. Current as of October 5, 2016.

[5] CDC, HRSA, & SAMHSA Issue Agency-Specific Guidance on Use of Federal Funds for SSPs. https://www.aids.gov/federal-resources/policies/syringe-services-programs/

[6] Tracking Accountability in Government Grants System. https://taggs.hhs.gov/SearchAward

[7] SAPT Board Allocation by Program. http://mha.ohio.gov/Portals/0/assets/Funding/Allocations/SPF2016/Attachment2-SFY2016-FINAL%207-10-15.pdf

[8] HRSA Data Warehouse. https://datawarehouse.hrsa.gov/Tools/FindGrants.aspx

[9] Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill, 2017. http://appropriations.house.gov/uploadedfiles/hrpt-114-hr-fy2017-laborhhsed.pdf

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