

HARM REDUCTION EDUCATION AND TECHNICAL ASSISTANCE

INTERIM FINDINGS AND NEXT STEPS



Nursing



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This project was funded by the New Hampshire Department of Health and Human Services through funds received from the Centers for Disease Control.

Project Overview

The Harm Reduction Education and Technical Assistance (HRETA) project provided academic detailing on evidence-based practices to reduce drug-related harms in areas throughout New Hampshire. These brief, one-on-one interactions took place between a trained team member and individuals across New Hampshire who interact on a professional level with people who use drugs. Detailing sessions were conducted in all 10 New Hampshire counties. Following the academic detailing sessions, individuals could request additional technical assistance in the form of in-person trainings, additional resources, or case conferencing sessions. Individuals were sent a follow up survey after the academic detailing session to collect information on how they perceived the session, how frequently they interact with clients who inject drugs, and to request additional technical assistance if needed.

This interim report details the HRETA project activities April - November 2019 and recommendations for Phase 2 beginning December 2019. Overall, we conducted a total of 202 visits to individual providers across 63 practice settings, and of those, 71.8% requested technical assistance.

Phase 1: Best Practices Disseminated

Resources were provided during detailing sessions to accomplish the following four aims of the project. Some of the resources were created by our team, as appropriate external resources were not identified.



Follow safe opioid prescribing and tapering guidelines



Routinely screen for substance use



Engage individuals who inject drugs to reduce drug related harms



Provide compassionate care to individuals with opioid use disorder

Follow safe opioid prescribing and tapering guidelines

This CDC resource was selected to specifically address background information on safe opioid prescribing and tapering

ASSESSING BENEFITS AND HARMS OF OPIOID THERAPY

THE EPIDEMIC

The United States is in the midst of an epidemic of prescription opioid overdose deaths, which killed more than 14,000 people in 2014 alone.

Since 1999, sales of prescription opioids—and related overdose deaths—have quadrupled.

Since 1999, there have been more than **165,000** deaths from overdose related to prescription opioids.

GUIDANCE FOR OPIOID PRESCRIBING

The CDC Guideline for Prescribing Opioids for Chronic Pain provides up-to-date guidance on prescribing and weighing the risks and benefits of opioids.

- Before starting and periodically during opioid therapy, discuss the known risks and realistic benefits of opioids.
- Also discuss provider and patient responsibilities for managing therapy.
- Within 1-4 weeks of starting opioid therapy, and at least every 3 months, evaluate benefits and harms with the patient.

ASSESS BENEFITS OF OPIOID THERAPY

Assess your patient's pain and function regularly. A 30% improvement in pain and function is considered clinically meaningful. Discuss patient-centered goals and improvements in function (such as returning to work and recreational activities) and assess pain using validated instruments such as the 3-item PEG Assessment Scale:

- What number best describes your pain on average in the past week? (from 0=no pain to 10=pain as bad as you can imagine)
- What number best describes how, during the past week, pain has interfered with your enjoyment of life? (from 0=does not interfere to 10=completely interferes)
- What number best describes how, during the past week, pain has interfered with your general activity? (from 0=does not interfere to 10=completely interferes)

If your patient does not have a 30% improvement in pain and function, consider reducing dose or tapering and discontinuing opioids. Continue opioids only as a careful decision by you and your patient when improvements in both pain and function outweigh the harms.

*Recommendations do not apply to pain management in the context of active cancer treatment, palliative care, and end-of-life care.

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

LEARN MORE | www.cdc.gov/drugoverdose/prescribingguideline.html

Routinely screen for substance use

The NH Center for Excellence created this resource for the state of NH on routine screening for substance use

SCREEN & INTERVENE
NEW HAMPSHIRE SBIRT

WHAT IS S-BI-RT?

S-BI-RT – Screening, Brief Intervention and Referral to Treatment – is a simple, cost-effective evidence-based approach to systematic universal screening for problematic alcohol and drug use and the routine steps taken to address screening results. SBIRT is recognized as a best practice to address substance misuse for a wide range of populations, and S-BI-RT services are reimbursed by both private and public health insurance. SBIRT is a standardized public health approach to early identification and intervention for persons with substance use disorders, as well as those who are at risk of developing them, particularly for those who are not seeking help for substance misuse. SBIRT represents a process of discrete components that build on the previous ones, as needed.^{1,2}

MAJOR COMPONENTS OF S-BI-RT

- SCREENING:** Universal, using a standardized and valid screening tool to assess patient's level of risk.
- BRIEF INTERVENTION:** Brief clinical conversation about risk and motivational change using Motivational Interviewing techniques and tools.
- REFERRAL TO TREATMENT:** Further assessment for those with a probable diagnosis and high risk current use and behavior, and link to appropriate services.

***FOLLOW-UP:** An essential component that includes any contact with a patient that closes the loop with the primary care provider regarding screening results, BI, or referral for further assessment.

WHY DOES NH NEED S-BI-RT?

New Hampshire has some of the highest substance misuse rates in the US, significantly higher ($p < 0.05$) than the US across all age groups in past 30-day use of alcohol, binge alcohol, and marijuana use.³

Current Alcohol Use, Binge Alcohol Use, and Current Marijuana Use by Age Group: NH - US

Bar chart showing percentages for Current Alcohol Use, Current Binge Alcohol Use, and Current Marijuana Use across age groups (18-24, 25-34, 35-44, 45-54, 55-64, 65+). NH is compared to US.

CENTER FOR EXCELLENCE
NEW HAMPSHIRE CHARITABLE FOUNDATION

Engage individuals who inject drugs to reduce drug related harms

We developed this resource with the NH Harm Reduction Coalition to encourage harm reduction goal setting with clients

Engaging Individuals who Inject Drugs to Reduce Harm

Establish yourself as a resource for people who inject drugs (PWID)

- Open conversations support people "where they are at":**
 - Encourage risk reduction and highlight opportunities for education.
 - Keep people engaged in health care to increase access to substance use services.
- Minimize assumptions, be open to everyone's unique experience:**
 - PWID are interested in and capable of making changes to improve their health and safety.
 - Strong provider relationships lead to honest discussions, advice adoption, and seek timely care.
- Accept ambivalence, untimely pushes for abstinence are alienating:**
 - Readiness is key to substance use treatment efficacy.
 - Conversations about reducing harm do not condone drug use, but demonstrate compassionate pragmatism.

Ensure PWID are comfortable returning for care or additional resources.

Have compassion as PWID's health care experiences may include betrayals of trust, denial of care, or engagement of police.

PWID who feel judged or condemned are unlikely to honestly discuss drug use.

Overdose Prevention

ASK "Do you have naloxone (Narcan) available in the case of an overdose?"

Good Samaritan laws in NH protect those that call 911 for an overdose.

Naloxone is available in NH at:
The Downways Recovery Organizations
Pharmacies (no prescription needed)
Syringe Service Programs

Syringe Service Programs in New Hampshire

NHHRCE

Provide compassionate care to individuals with opioid use disorder

We created this resource with the NH Harm Reduction Coalition to distribute evidence-based best practices on providing care to people with opioid use disorder

Compassionate Care: Medications Save Lives

Key Findings from the National Academy of Sciences, Engineering, and Medicine Consensus Study Report Conclusions on the current state of Medications for OUD.

- Medications for OUD are effective and save lives.
- Long-term retention on medications is associated with improved outcomes.
- Most who could benefit from OUD medication do not receive it, and access is inequitable.
- Withholding or failing to have all classes of OUD medications is denying medication treatment.
- Confronting major barriers is critical to address the OUD crisis.
- OUD medication should not be withheld if behavioral interventions are lacking.

Benefits of Medication Assisted Treatment (MAT) for OUD:

- Opioid related overdose death, particularly with buprenorphine.
- Illicit opioid use.
- Criminal activity.
- Infectious disease transmission (HIV and Hepatitis C).
- Social functioning and retention in treatment.

MAT REDUCES HEROIN OD DEATHS

Line graph showing Opioid Overdose Deaths (per 100,000) from 2000 to 2015. MAT (red line) shows a significant decrease compared to no MAT (blue line).

Resources for MAT and Buprenorphine Waiver Training

Providers Clinical Support System (PCSS) <https://pcss.nh.gov>

- Training on OUD and chronic pain, educational resources, and clinical mentoring

Buprenorphine Waiver Trainings:

- Substance Abuse and Mental Health Services Administration (SAMHSA) <https://www.samhsa.gov/medication-assisted-treatment>
- New Hampshire Medical Society <https://www.nhms.org/buprenorphine-waiver-training>

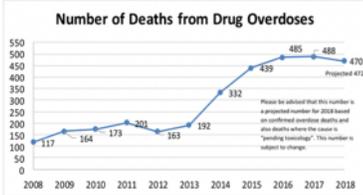
NHHRCE

Background information on drug use in New Hampshire and reducing stigma

We created this resource to provide context on the importance of this project. It gives background information on drug harms in New Hampshire and how harm reduction approaches encourage destigmatizing care for clients

Drug-Related Harms in New Hampshire

In 2017, New Hampshire had the 3rd highest rate of fatal opioid overdoses of all US states ¹

Number of Deaths from Drug Overdoses

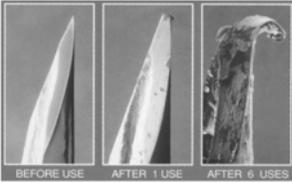
Year	Number of Deaths
2008	117
2009	164
2010	173
2011	201
2012	163
2013	192
2014	332
2015	439
2016	485
2017	488
2018	472 (Projected)

Source: New Hampshire Office of Chief Medical Examiner's Drug Death Data Report ²

75% of NH people who inject drugs lack easy access to clean syringes & 67% have shared needles in the past 30 days ³

*Sampling conducted in select towns in western NH

Reusing syringes damages the needle, leading to damage to veins ⁴



BEFORE USE AFTER 1 USE AFTER 6 USES

Microscopic view of the needle bevel before and after syringe reuse ⁵

Injecting drugs presents additional risks beyond the risks of the drugs themselves including

- HIV ⁶
- Hepatitis B and C ⁷
- Cellulitis and Abscess ⁸ (infections of the skin)
- Endocarditis ⁹ (infection of the heart)
- Overdose ⁴ (greater risk than snorting or swallowing drugs)

Methamphetamine Deaths by Year

Year	Total # of Deaths Involving Meth	Solely Meth	Meth and other drugs (non-opioids)	Meth and other drugs (non-opioids)
2018	22	4	17	1
2017	15	3	11	1
2016	13	4	8	1
2015	2	1	1	0
2014	3	0	3	0
2013	2	1	1	0
2012	1	0	1	0

NH Office of Chief Medical Examiner's Drug Death Data Report ²

Methamphetamine use is on the rise in New Hampshire. It is commonly injected or smoked but can be snorted or swallowed. Methamphetamine can be deadly used alone or in conjunction with opioids. ¹⁰



Being a Non-Judgmental Resource Will Address our Drug Use Epidemic

Be a Resource to People Who Use Drugs ¹¹

	ATTITUDE	RECEPTION	ACTION	OUTCOME
	"I know the right thing for you." <i>I have the right to determine what is best for you</i>		<ul style="list-style-type: none"> Narrow scope of care Lost opportunities 	Individual might disconnect from care
	"Here's what you should do -- how does that sound?" <i>I will "give" you an opportunity to participate in my decision</i>		<ul style="list-style-type: none"> "Sell" a particular product or idea Narrow scope of options 	Individual may say what they think the provider wants to hear, instead of reality
	"You know better than me. Let me help you decide/improve/get where you want you to be." <i>I can learn from you</i>		<ul style="list-style-type: none"> Educating Aligning 	Individual and provider share in goal setting
				

Use Person-First Language to Reduce Stigma ¹²

SAY THIS	NOT THAT
Person with a substance use disorder	Addict, junkie, druggie
Person in recovery	Ex-addict
Person living with an addiction	Battling / suffering from an addiction
Person arrested for a drug violation	Drug offender
Chooses not to at this point	Non-compliant / bombed out
Medication is a treatment tool	Medication is a crutch
Had a setback	Relapsed
Maintained recovery	Stayed clean
Positive drug screen	Dirty drug screen

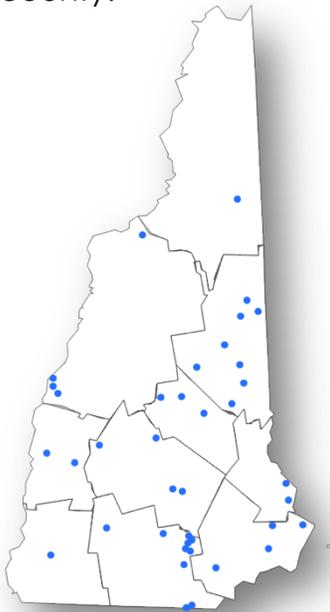
IN YOUR CONVERSATIONS

Frame the conversation as a health issue
Use examples of people who have reached long-term recovery
Discuss the fact that people can and do change
Share hope!



Phase 1: Broad State-Wide Detailing Sessions

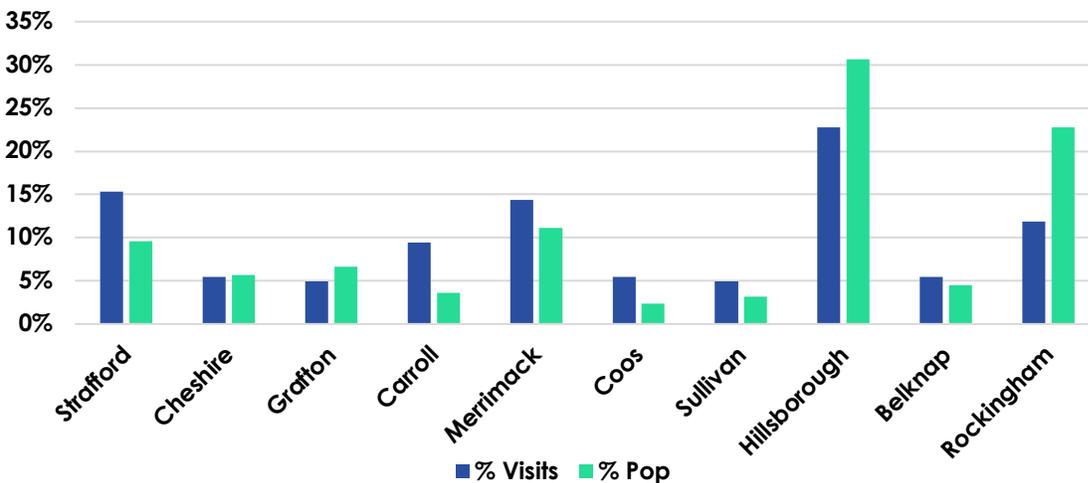
The HRETA Project's 7 trained academic detailers provided educational outreach to 202 people across New Hampshire. Below is a map showing where detailing sessions were held and a chart displaying the number of detailing visits per county.



County	Detailing Visits
Belknap	11
Carroll	19
Cheshire	11
Coos	11
Grafton	10
Hillsborough	46
Merrimack	29
Rockingham	24
Strafford	31
Sullivan	10

Made with Infogram

Detailing Visits by County Population



The above graph shows the percent of detailing visits compared to the population percentage of each New Hampshire county as of 2017 (US Census). Our goal was to detail a minimum of 10 providers per county, but some counties had more detailing sessions to remain consistent with their relative population.

Phase 1: Technical Assistance

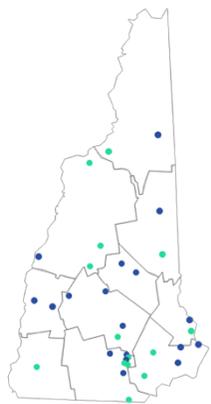
Following the academic detailing sessions, individuals could request additional technical assistance in the form of resources, in-person trainings, or case conferencing sessions. The table below shows technical assistance requests received during or following detailing sessions. Additionally, all training requests were followed up with, but not all training requests resulted in actual trainings. Most trainings declined were due to scheduling difficulties.

Technical Assistance Request	Requested	Complete	Pending
Resources	60	59	15*
Training	79	35	37
Case Conferencing	6	0	0
Total	145	94	45

*15 pending resource requests were partially completed, see Resources section for details

Project Goal 1: Ensure eighty percent (80%) of the trainings result in follow-up TA, specific to the use of harm reduction strategies.

Result: Of the 202 detailing sessions, there were 145 technical assistance requests (71.8%). Of these 145 technical assistance requests, 94 were completed (64.8%). The remaining pending requests are for trainings that have been unable to be set up and resources which were unavailable.



The map to the left notes where technical assistance occurred during the project. The green dots note trainings and the blue dots note resources.

Project Goal 2: Ensure eighty percent (80%) of academic detailing sessions result in evaluation results that reflect an intended change in practice to integrate harm reduction strategies into client services.

Result: Of the 202 detailing sessions, 158 visits resulted in practice change goals (78.2%).

Resources

The majority of resource requests were for client information on harm reduction tips and syringe service program locations that could be distributed in the office setting. The first resource below was created to address these requests. These 'Stay Safe Tips' were adapted by the NH Harm Reduction Coalition and include contact information for NH Syringe Service Programs on the back. The second resource, created by the US Department of Health and Human Services, was shared with 6 participants to address technical assistance requests for support on discontinuing long-term opioid use.



Stay Safe Tips for People who Inject Drugs and New Hampshire Syringe Service Programs

Use sterile injecting supplies
You can prevent harm to yourself and others by using injection supplies once, never sharing them, and disposing them properly afterward. Connect with a Syringe Service Program for sterile injecting materials, disposal containers, and to drop off used materials.

Take care of your veins
Use arms when possible. Start low and work your way up the vein in the direction of your heart. Switch up veins each day. Avoid arteries (wrist, neck, groin) and feet. Make sure you can see the hole in the needle as you inject.

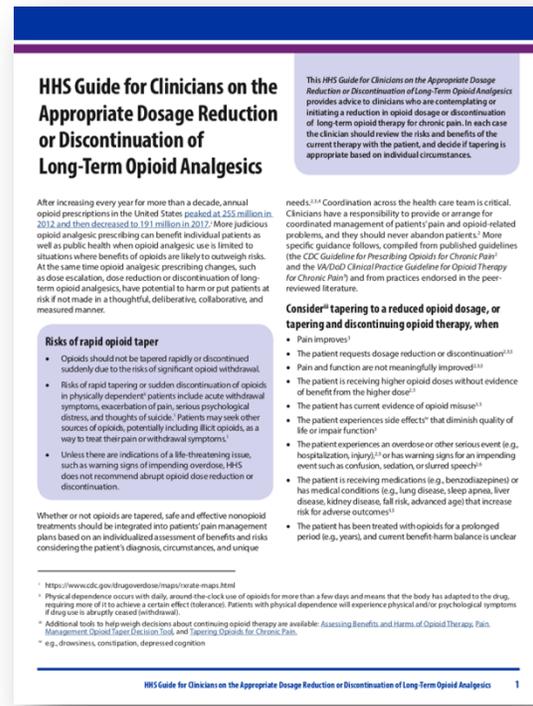
Take your time
Fear causes mistakes. Mistakes can be deadly. Take control by taking your time. **Use a tiny tester amount first.** You can always put more in, but you can't squeeze it out.

Carry Naloxone (Narcan)
You can save a life. Naloxone (brand name Narcan) is **legal and safe** to have and use for a suspected opioid overdose. Make sure others know how to use it. For free naloxone connect with a Syringe Services Program or check <https://thedorway.nh.gov/avoid-overdose>.

Call 911 if you suspect and overdose
Seconds count. The NH Good Samaritan law protects callers and overdose victims from arrest for small amounts of drugs in paraphernalia at the scene of an overdose.

Don't use alone
Nobody can help you if they don't know you're there.

Seek care and challenge yourself
If you're hurt, vulnerable, or want to make a change, speak up for yourself. You deserve safety, health, and happiness. Check out the resources on the back to connect with a Syringe Service Program and/ or The Doorways, locations listed at <https://thedorway.nh.gov>.



HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics

This HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics provides advice to clinicians who are contemplating or initiating a reduction in opioid dosage or discontinuation of long-term opioid therapy for chronic pain. In each case the clinician should review the risks and benefits of the current therapy with the patient, and decide if tapering is appropriate based on individual circumstances.

After increasing every year for more than a decade, annual opioid prescriptions in the United States peaked at 255 million in 2012 and then decreased to 191 million in 2017. More judicious opioid analgesic prescribing can benefit individual patients as well as public health when opioid analgesic use is limited to situations where benefits of opioids are likely to outweigh risks. At the same time opioid analgesic prescribing changes, such as dose escalation, dose reduction or discontinuation of long-term opioid analgesics, have potential to harm or put patients at risk if not made in a thoughtful, deliberative, collaborative, and measured manner.

needs.^{1,2} Coordination across the health care team is critical. Clinicians have a responsibility to provide or arrange for coordinated management of patients' pain and opioid-related problems, and they should never abandon patients.³ More specific guidance follows, compiled from published guidelines (the CDC Guideline for Prescribing Opioids for Chronic Pain⁴ and the VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain⁵) and from practices endorsed in the peer-reviewed literature.

Consider⁶ tapering to a reduced opioid dosage, or tapering and discontinuing opioid therapy, when

- Pain improves⁷
- The patient requests dosage reduction or discontinuation¹⁰
- Pain and function are not meaningfully improved¹⁰
- The patient is receiving higher opioid doses without evidence of benefit from the higher dose¹
- The patient has current evidence of opioid misuse¹¹
- The patient experiences side effects¹² that diminish quality of life or impair function¹³
- The patient experiences an overdose or other serious event (e.g., hospitalization, injury)¹⁴ or has warning signs for an impending event such as confusion, sedation, or slurred speech¹⁵
- The patient is receiving medications (e.g., benzodiazepines) or has medical conditions (e.g., lung disease, sleep apnea, liver disease, kidney disease, fall risk, advanced age) that increase risk for adverse outcomes¹⁶
- The patient has been treated with opioids for a prolonged period (e.g., years), and current benefits/harm balance is unclear

Risks of rapid opioid taper

- Opioids should not be tapered rapidly or discontinued suddenly due to the risks of significant opioid withdrawal.
- Risks of rapid tapering or sudden discontinuation of opioids in physically dependent patients include acute withdrawal symptoms, exacerbation of pain, serious psychological distress, and thoughts of suicide.¹⁷ Patients may seek other sources of opioids, potentially including illicit opioids, as a way to treat their pain or withdrawal symptoms.¹⁸
- Unless there are indications of a life-threatening issue, such as warning signs of impending overdose, HHS does not recommend abrupt opioid dose reduction or discontinuation.

Whether or not opioids are tapered, safe and effective nonopioid treatments should be integrated into patients' pain management plans based on an individualized assessment of benefits and risks considering the patient's diagnosis, circumstances, and unique

¹ <https://www.cdc.gov/drugoverdose/maps/locate-maps.html>

² Physical dependence occurs with daily, around-the-clock use of opioids for more than a few days and means that the body has adapted to the drug, requiring more of it to achieve a certain effect (tolerance). Patients with physical dependence will experience physical and/or psychological symptoms if drug use is abruptly ceased (withdrawal).

³ Additional tools to help weigh decisions about continuing opioid therapy are available: *Assessing Benefits and Harms of Opioid Therapy*, *Pain Management: Opioid Safer Use Decision Tool*, and *Tapering Opioids for Chronic Pain*.

⁴ e.g., drowsiness, constipation, depressed cognition

HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics | 1

Examples of additional resources provided as part of technical assistance are naloxone administration client handouts, overdose prevention resources for shelters, evidence on SSPs, resources with strategies for destigmatizing conversations, and substance use screening (Screening, Brief Intervention, and Referral to Treatment [SBIRT]) implementation resources for adult, pediatric, and perinatal settings.

Resources that were requested but unable to be developed during Phase 1 were 1. a resource with local pharmacies that sell syringes to clients (9 requests) and 2. a guide to starting a syringe service program in New Hampshire (6 requests).

Training

Academic detailing resulted in 79 requests for training which led to 27 trainings across the state. Each training request was followed up with by the project team. Despite interest in training, follow up contact to schedule trainings often went unanswered or practice schedules were unable to fit in trainings. Of the 79 training requests, 8 were declined during follow up, and 37 are still pending. The number of requests is the number of individuals who were detailed interested in setting up a training and not the number of practice sites interested in training. Of the 37 pending training requests, these represent 17 different practice sites.

The trainings were provided by the New Hampshire Harm Reduction Coalition and CEU approved by Southern New Hampshire Area Health Education Center (SNHAHEC). The most frequently requested/ provided training was "Enhancing Provider Skills in Serving Active Substance Users." Additional trainings provided were entitled "Routine Screening for Substance Use in Primary Care" and "Stigma as Discrimination."

Project Goal 3: Ensure eighty percent (80%) of training participants set SMART (specific, measurable, achievable, relevant, time-bound) goals.

Result: 27 trainings were conducted during this project. Of the 405 people who attended trainings, as of November 2019 we have evaluation results for 313. Of the 313, 68.7% or 215 set SMART goals. Two of the trainings were offered at regional meetings in November 2019. We do not yet have evaluation results from those meetings but estimate 92 attendees between those two meetings.

Goal setting was incorporated into the CEU evaluation, but many participants reported they did not need CEUs or did not complete the evaluation. As a result, many initial goals were missed. An additional barrier to assessing goal setting was that certain health systems would only allow their own educational committee to approve CEUs and did not follow up readily with goals from those evaluations.

Evaluation summaries from the trainings are not yet available from SNHAHEC.

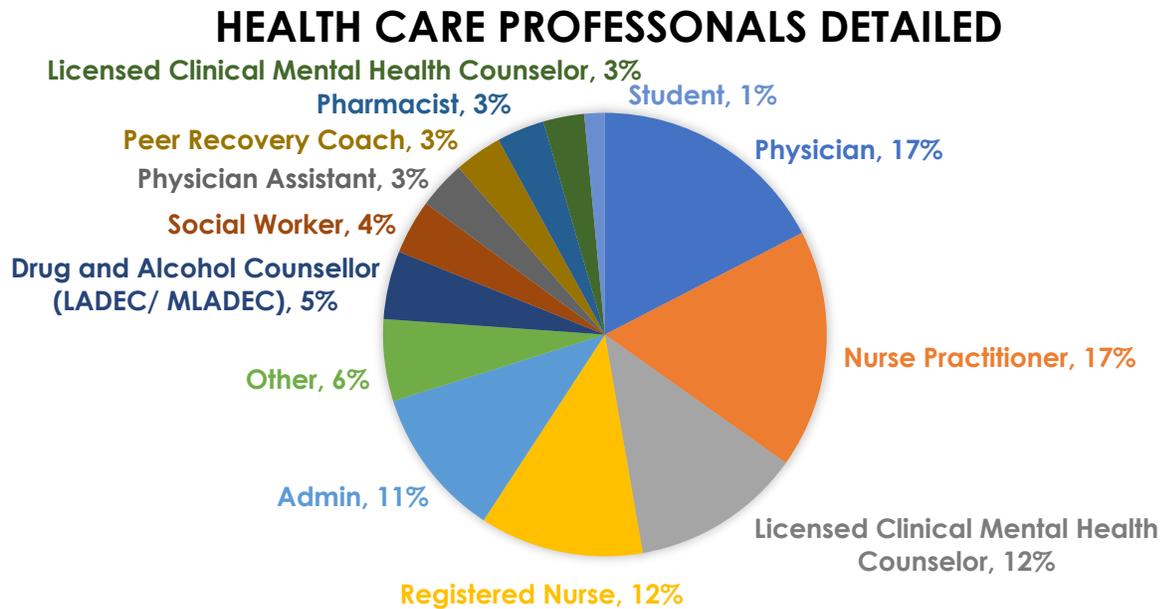
Additional training and support was provided by NHHRC to new and developing Syringe Service Programs in the state. Support for the SSPs included training of staff/ volunteers in harm reduction and data tracking and reporting support.

Case Conferencing

Although case conferencing was offered and thought to be a valuable resource for champions working to reduce drug related harms, attempts to engage participants in case conferencing were unsuccessful. Of the 6 participants who requested case conferencing, all declined due to time or other barriers.

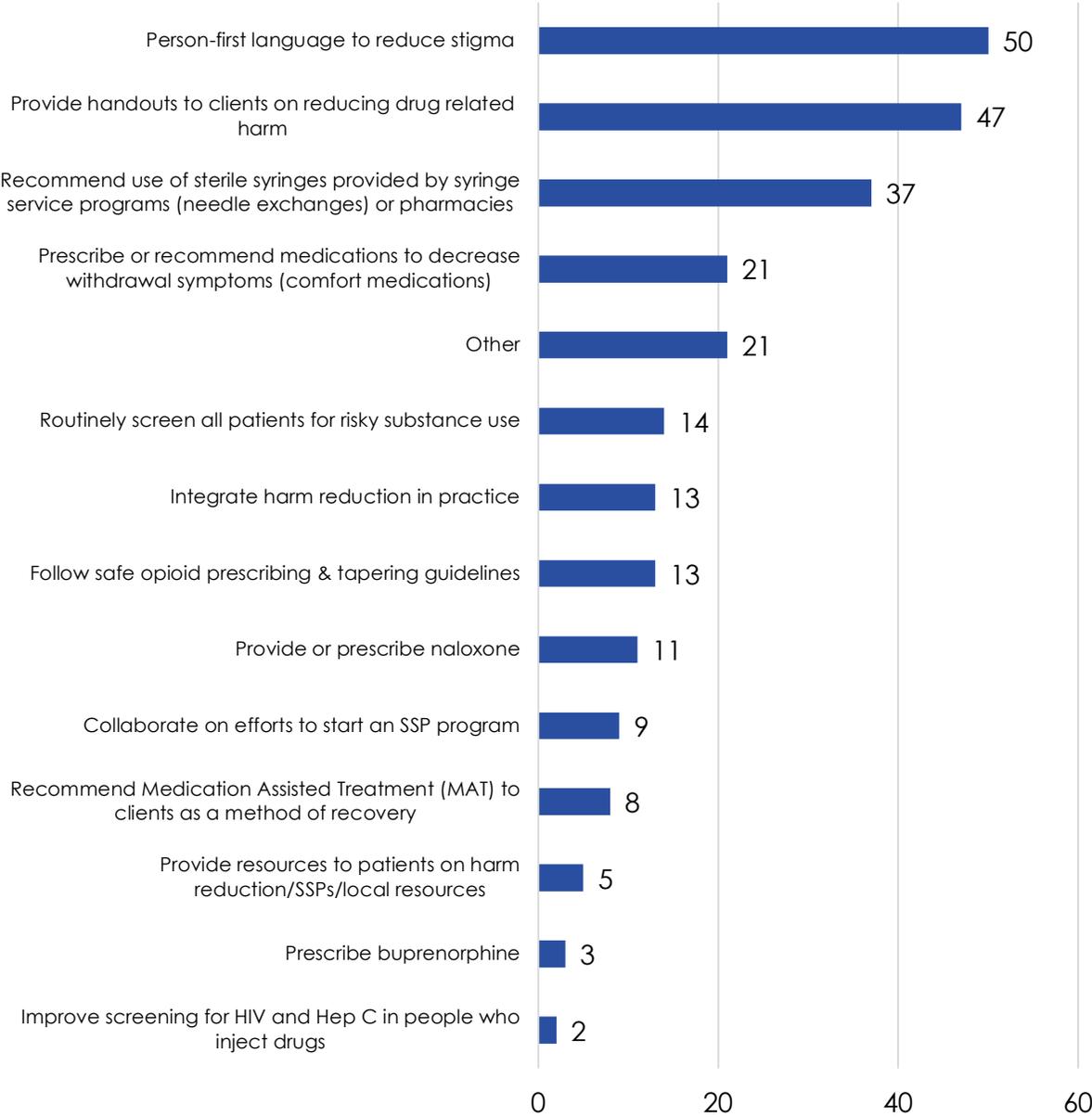
Phase 1: Outcomes

The graph below shows the percentage of types of health care professionals who were detailed during this project. These 202 individuals were from 63 sites, including primary care, recovery community organizations, hospitals, homelessness service organizations, and more. The most prevalent health care professionals were physicians, nurse practitioners, mental health counsellors, and registered nurses. Within the project, we also provided education to administrative staff, as they were often identified as the leaders of change in policy and/ or practice by office staff.



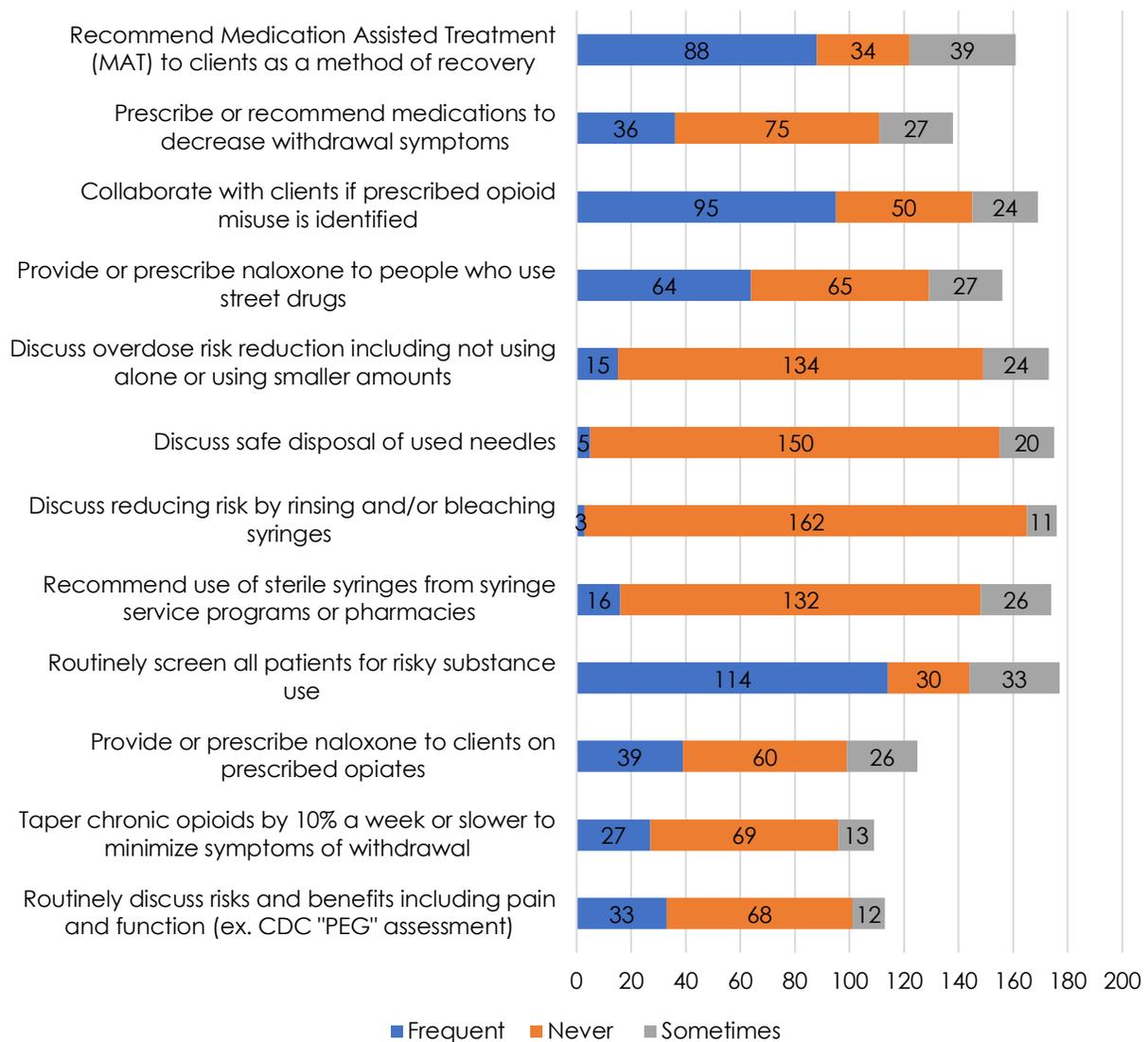
Practice change goals were discussed during detailing sessions. The graph below shows the most common practice change goals that were set during the detailing session. Of note, some participants set multiple goals during their detailing session. The most common goal was to incorporate person first language into their communication. Somewhat surprisingly, the advice to incorporate harm reduction strategies into practice was incredibly well received. Approximately a quarter of those we detailed set goals to provide their clients with information on staying safe through harm reduction strategies.

Provider Practice Change Goals



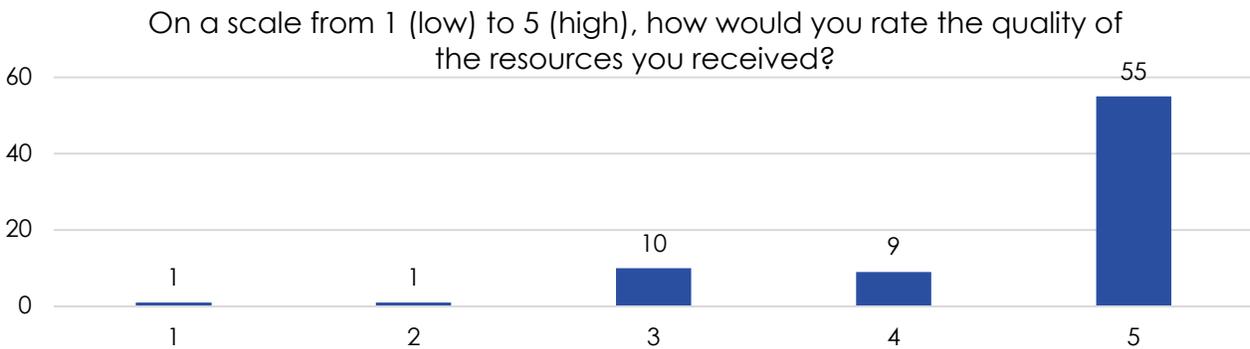
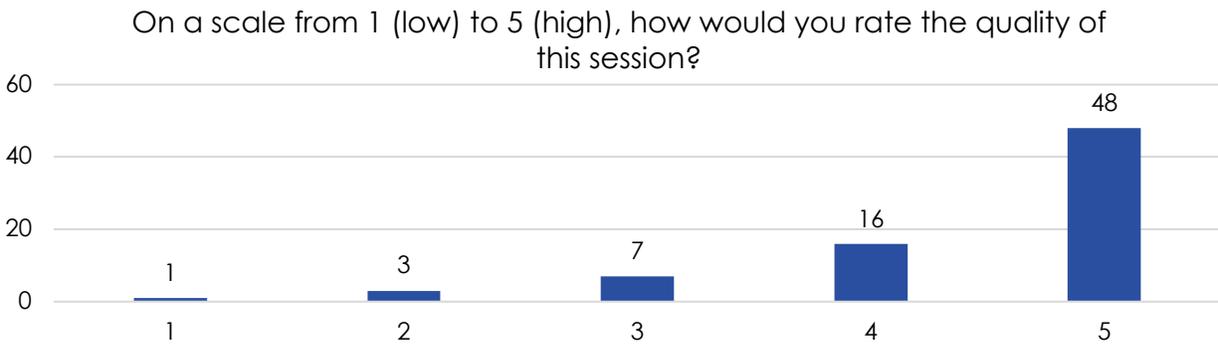
During their visits, detailers assessed current use of the harm reduction best practices of interest. Ideally academic detailing focuses on dissemination of 1-2 best practices. As this project incorporated 12 best practices, detailers focused their conversations on 1-5 best practices that were pertinent to the provider. Throughout their session, providers discussed how often they were using the discussed strategies. The best practices that were most often reported as 'frequent' use were routinely screening for substance use, collaborate with clients if opioid misuse is identified, and recommending MAT to clients. The least utilized strategies were rinsing or bleaching syringes, safe disposal discussion, behavioral overdose prevention, and recommending syringe service programs.

Harm Reduction Best Practices Discussed at Academic Detailing Visits



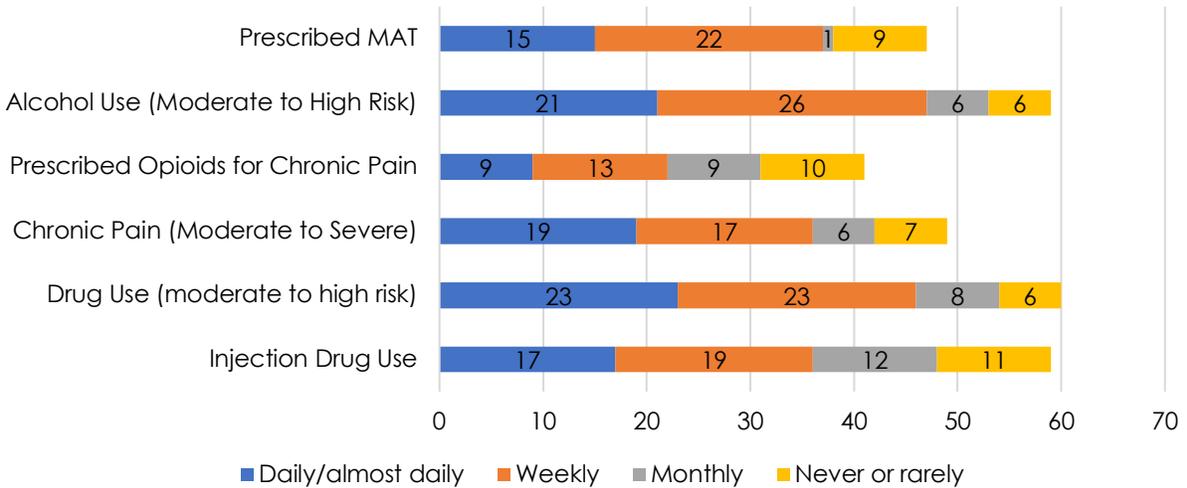
For all academic detailing participants, we sent follow up surveys to assess their satisfaction with the detailing session and request additional information/ technical assistance. Despite at least 3 attempts to encourage completion we received 75 responses for a total response rate of 37%.

Participants were asked to rank the quality of the detailing session they participated in and the resources they received. Below are the results from those who completed the survey. Overall participants rated both the quality of the session and the quality of the resources as high.



To better understand whether we detailed care providers who saw clients for chronic pain, opioid use disorder, and/ or substance use, we asked how frequently they had seen clients for related conditions. The majority of providers saw clients at least weekly for alcohol use (n=52, 69%) and for moderate to high risk drug use (n=46, 61.3%).

Over the last 30 days, how often have you seen clients for the following?



*Note total sample size was 75, N/A responses not show in chart

Recommendations for Phase 2

1. Pharmacy Focused Detailing

A primary practice change goal for 37 participants was to recommend syringe access at pharmacies/ SSPs. The small sample of detailing at pharmacies indicated that few pharmacies are offering to sell syringes. This represents an opportunity to provide focused education and support to reduce drug related harms. Additionally, a common request in Phase 1 of the HRETA project was a list of local pharmacies that sold syringes.

As of November 2019, there are 5 operating syringe service programs in the state, all with limited hours. NH has approximately 300 retail pharmacies distributed across the state which may be a more feasible access point. Since 2018, pharmacies have been allowed to sell an unlimited amount of syringes without a prescription to those 18 and older (RSA 318:52-c). Despite this, health care providers have reported as part of our project that few local pharmacies will sell syringes. Other barriers to harm reduction noted by our detailing participants relative to pharmacies include clients experiencing stigma in filling MAT and difficulty accessing naloxone. We also heard from a few practitioners that some pharmacies were refusing to fill Suboxone or would frequently question dosing. Future work is recommended with pharmacists to further train on harm reduction.

2. Emergency Room Focused Dissemination of Syringe Access Resources

Accessing emergency departments (EDs) within Phase 1 was challenging given the high pressure nature and the burden of many incorporating new substance use related projects. For the last 3 years, the Foundation for Healthy Communities has been convening a learning collaborative to support improved substance use care in EDs including urgent access to MAT through EDs. Creation of a harm reduction resource to distribute to clients who inject drugs that includes local pharmacies offering syringe sales is of great interest to many hospitals involved in the learning collaborative. Unfortunately, traditional detailing of many providers in an ED has been described as infeasible. Through collaboration with the Foundation for Healthy Communities, additional detailing could provide education and support to 1 or 2 harm reduction champions within New Hampshire EDs. These champions could help integrate harm reduction approaches and resources into their departments. Feedback has indicated that resources that include local pharmacy syringe access would be a great compliment to current initiatives.

3. Support of New and Developing Syringe Service Programs

We had many detailing participants in Phase 1 interested in receiving resources on starting an SSP. Although we were able to provide them with some national resources, we believe a NH-specific guide would go a long way to encourage and support establishment of new SSPs. Given the legislation allowing SSPs to operate in the state started in 2017, a comprehensive resource and technical assistance by NHHRC will support evidence-based SSP program development in NH.

Additionally, we are concerned that with assessment there may be relatively few pharmacies who provide syringe access and easy naloxone access. After creating this resource, we would disseminate it to anyone in our Phase 1 detailing who expressed interest. Additionally, after assessing pharmacy syringe access, we would target distribution of this new resource to NH areas with inadequate syringe access.

These components are critical to harm reduction education sustainability through supporting organizational development of agencies that will continue to provide and promote harm reduction services.