Community Services Board Substance Use Community Board Meeting

10/12/23 3-4:30pm

Subcommittee Member Attendees: Diane Arneth, Adrienne Abbate, Felecia Pullen, Soteri Polydorou, Sarah Church, Sonia Lopez, Jon Giftos

Attendees: Ellenie Tuazon, Brooke Gasdaska, Winnie Ho, Alex Harocopos, Hiawatha Collins, Melissa Moore, Mike Selick, Nirah Johnson, Sean Walker, Chief Terri Tobin, Julia DeWalt, Shivani Mantha

Mortality Data Presentation

- Ellenie Tuazon, Director of Surveillance, presented unintentional drug overdose mortality data for the year 2022.
- 3,026 drug overdose deaths in 2022, for a rate of 43.3 per 100,000 residents.
- Fentanyl was the most common substance involved in overdose deaths, found in 81% of overdose deaths citywide.
- Data were presented by age, race/ethnicity, sex, as well as by age + race/ethnicity combinations.
- Data were also presented by borough of residence.
- DOHMH also discussed structural and contextual factors contributing to the overdose crisis.
- **Points of emphasis:**
    - Increase in deaths among older Black New Yorkers.
    - Newly released data on setting of overdose

Discussion:

- Sarah Church: On November 11th, the rule to waive the initial first visit in-person by the DEA may go back into place at a time when MAT is really needed. If older Black New Yorkers are less likely to get MAT, that may also increase overdose risk. What can the city do to press the Feds to allow for continued virtual access to bupe?
- Jon Giftos: Are we missing something by only focusing on OUD patients? What about those who do not have opioid tolerance and end up using fentanyl? Or those whose opioid use may not qualify them for MOUD treatment?
- Felecia Pullen: Need more messaging to address overdoses in public spaces and cocaine involvement in overdoses.
    - Clarification from Jon Giftos: In our data, overdose deaths involving both cocaine and fentanyl don't necessarily indicate that fentanyl was in the cocaine.
- Melissa Moore: Suggestion to think about opportunities to assess for cardiovascular health, especially among Black men and people with long-term stimulant use. Also seeing overdose as an issue of increasing concern in maternal mortality.
- Soteri Polydorou:
    - Important to not get desensitized to these numbers and to realize this is a drug overdose crisis, not just an opiate crisis.
    - Telehealth bupe is important, but there are lots of other barriers too – e.g., reimbursement rates are different for telehealth vs. in-person care.

    - Lack of CLIA-waived fentanyl test is a big issue for providers. Could improve provider ability to respond to patients and offer appropriate treatment. Can be used in a way that's totally separate from mandatory, punitive drug testing.
        - JG: How are drug tests used currently for treatment? Ex. is evidence of dependence mandatory for methadone treatment?
        - Often use self-report for this.
        - SP: If patient doesn't show withdrawal signs, that can factor into clinical decisions. Fentanyl tests could impact provider decisions around dosing, etc. in a way that benefits the patient (controlling withdrawal, providing more efficacious doses, etc.)
        - MM: Oversurveillance via drug testing can really harm provider-patient relationship – hears lots of stigmatizing encounters with providers. Regardless of intention, information is now in the patient's chart and can be used by other people with negative consequences.
        - Sonia Lopez: Tests can be helpful for vivitrol treatment – has had two patients with negative fentanyl tests who then experienced precipitated withdrawal. Can also be useful to inform patients who aren't intentionally using opioids.
        - SP: Problem is that right now, providers don't have this ability at all – always have to wait a few days for results.
        - Mike Selick: Agree with Melissa, also focusing heavily on one thing that has potential for harm and little potential for reducing overdose risk isn't a good use of resources.
- Sarah Church: Do we know how many people who have overdosed are engaged with a PCP? Could have an important impact on strategies
    - Ellenie Tuazon: There are some matching projects going on currently to match overdose data with other datasets, ex., Medicaid, ED/inpatient data. Will help us understand what proportion of people intersected with these systems.
    - SC: Would be interesting to see how many of them are getting bupe – would give us a better sense of whether they had an OUD and whether it was being treated or not.
    - ET: State DOH is looking at whether they can match overdose data and prescription data.
    - Jon Giftos: We published an EDB in the fall with Relay program data. Revealed that many people who experienced NFOD were not engaged in treatment or involved with an SSP – may not be injecting or engaged with traditional harm reduction services. Our current framework for reducing risk isn't currently reaching these people. Need to try new approaches
    - Number of people engaged in methadone and bupe treatment is going down -- is it because access or demand is lower, or does it mean we need to be working with people who don't have OUD?
- Diane Arneth: Do we know how many past NFODs these individuals have had? In SI, often see people who go away (armed forces, tx that decreases tolerance, etc.) come back with no aftercare plans when they return.
    - ET: Ongoing data matching projects would help us understand this.

- ?: There's no incentive or mandate for treatment providers to do a warm handoff to harm reduction or recovery support services. Need to explore how to build bridges between treatment and harm reduction/recovery support services, especially ones that are peer-run/driven
- Diane: SI has a 24/7 support center with peers, CRPAs, workforce development, benefits specialist, etc. They ask treatment providers to make the center part of aftercare plans, but don't see many people coming in after completing treatment. Could be a valuable safety net for people newly in recovery. Maybe something like an OASAS mandate is the best way to make that happen

<u>Community Updates</u>

- Shernet Neufville-Gray (ACS): Working with Odyssey House to provide SBIRT, contingency management, family engagement.
- Adriane Abbate: Exploring idea of creating more formal linkages. Organization is part of a coalition that does a lot of education, and new data on overdose settings is important for messaging. Organization does a lot of work to ensure community access to naloxone and test strips, worked with CHASI to make and display posters in hotspots where people are using. Tested pull-off harm reduction kits to make naloxone more accessible in places where people are using in public.
- Question: Can naloxone kits be mailed by the City? My organization mails naloxone kits, but it would be amazing if the City could do that.
    - Shivani Mantha: We mail naloxone kits to those who attend a virtual naloxone training, so you can refer people you work with to the website.
    - MM: NEXT Distro also mails naloxone and other harm reduction supplies, could be a useful model
    - Providers could tap into this – would be great if providers could do the training with their clients/patients and then send DOHMH the mailing info to mail them the kit.
- SP: Also have to think about training. Do we need the same training we used from back when this wasn't so straightforward? Can we streamline the training?
    - Julia Dewalt: DOHMH has a short video on our website, though not linked directly to getting a kit. Can think about a better way to share all these resources, like a menu of all the ways to get naloxone.
    - SNG: Important that trainings are engaging and accessible and that there are a lot of options.
- JG: Widespread naloxone distribution plus reducing unwitnessed overdose is the most effective way to reduce overdose deaths. If there's no responder, can't use naloxone. Need to think about ways to reduce unwitnessed overdose.
    - DA: SI Hotspotting project, which IDs people at highest risk of overdose and gives them lots of services, has shown some real promise. Reduces hospital utilization, overdose, etc. Would be good to discuss the data in this group.
    - SL: Main problem with naloxone is you can't give it to yourself. People who go to detox come out with no tolerance, sometimes don't want to use methadone or bupe. Trying to think about how to handle those scenarios.

- MM: DPA conference is next week, will have virtual streaming options for some sessions: https://www.reformconference.org/virtual-conference-schedule-program
- Nirah Johnson: DHS launched a two-year harm reduction strategic plan. Working on variety of overdose prevention trainings for staff, developing a toolkit and disseminating within agency to improve overdose prevention and linkage to care, hiring dedicated staff to address substance use and support linkage to care in shelters. Encountering challenges with resident uptake of risk reduction support/linkage to services, but think incentives or transport to services could be helpful. Some people who accept services continue to engage in riskier drug use behaviors – seems like the best option for this group might be safe supply, but not accessible.
- Felecia Pullen: The PILLARS is collaborating with NADAP, Mount Sinai, and RevCore to support pregnant PWUD and PWUD who are parenting a child under one year of age. Providing diapers, SNAP benefits, Medicaid, Medicare, and holistic care both at home and in community. Program launching at end of month.
- Adrienne Abbate: Re: older people and cardiovascular health – are there any opportunities for cross-divisional work in DOHMH, e.g., BADUPCT and hypertension programs?

Closing

- Next meeting is slated for December 7th 3:00-4:30pm, date to be confirmed in late November.