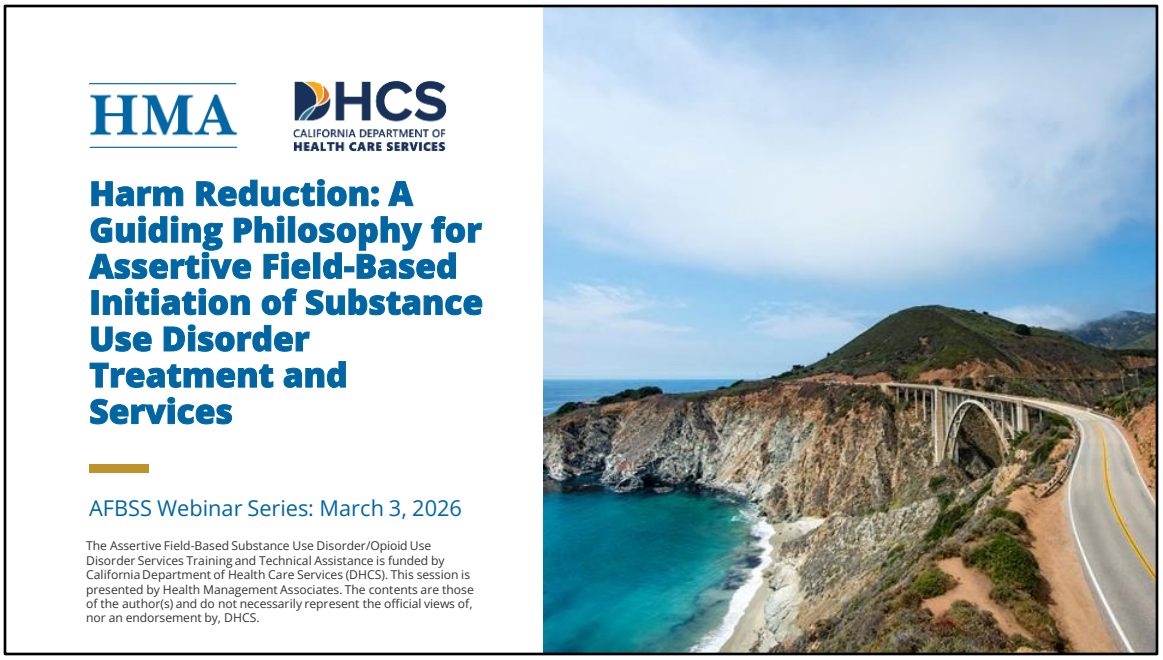

[Slide Image Description: This cover slide introduces the title of this webinar. It contains the logos for Health Management Associates.]

Disclaimer: This session is presented by Health Management Associates. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, California Department of Health Care Services.

Disclosures

Faculty	Nature of Commercial Interest
Anika Alvanzo, MD, MS, DFASAM, FACP	Dr. Alvanzo discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.
Debbi Witham, JD, LMSW	Ms. Witham discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients. Ms. Witham conducted research and analysis for Indivior.
Jeanene Smith, MD, MPH, CME Reviewer	Dr. Smith discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.

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[Slide Image Description: This slide shows Continuing Education disclosures.]

- Anika Alvanzo, MD, MS, DFASAM, FACP: Dr. Alvanzo discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.
- Debbi Witham, JD, LMSW: Ms. Witham discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients. Ms. Witham conducted research and analysis for Indivior.
- Jeanene Smith, MD, MPH: Dr. Smith discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients.

Presenters

Anika Alvanzo, MD, MS, FACP, DFASAM
Physician Principal
Health Management Associates
(HMA)

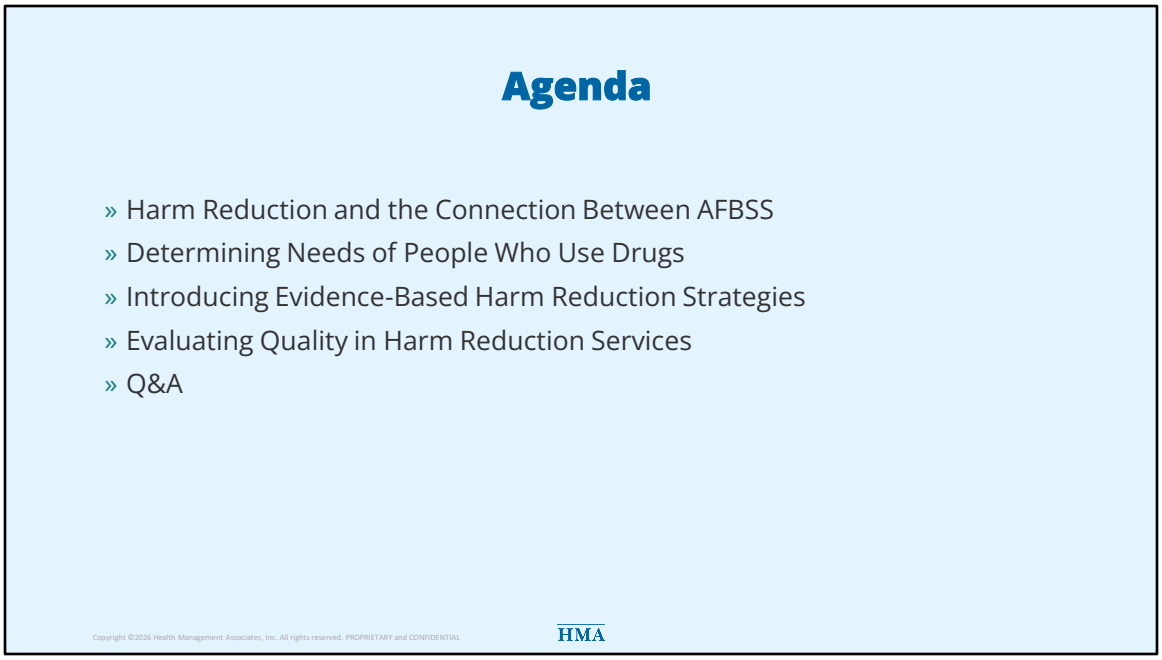
Debbi Witham, JD, LMSW
Principal
Health Management Associates
(HMA)

HMA

[Slide Image Description: This slide includes images of the presenters of this webinar on a light blue background.]

Dr. Anika Alvanzo is a distinguished health care executive with over 15 years of experience in specialty addiction treatment, behavioral health integration, and quality improvement. At Health Management Associates (HMA) Dr. Alvanzo's consulting has focused on supporting state and local jurisdictions in community needs assessment and strategic planning for behavioral health service delivery; provision of training, technical assistance and coaching to behavioral health providers; implementation of the American Society of Addiction Medicine (ASAM) Criteria; and advancing cultural humility in addiction treatment.

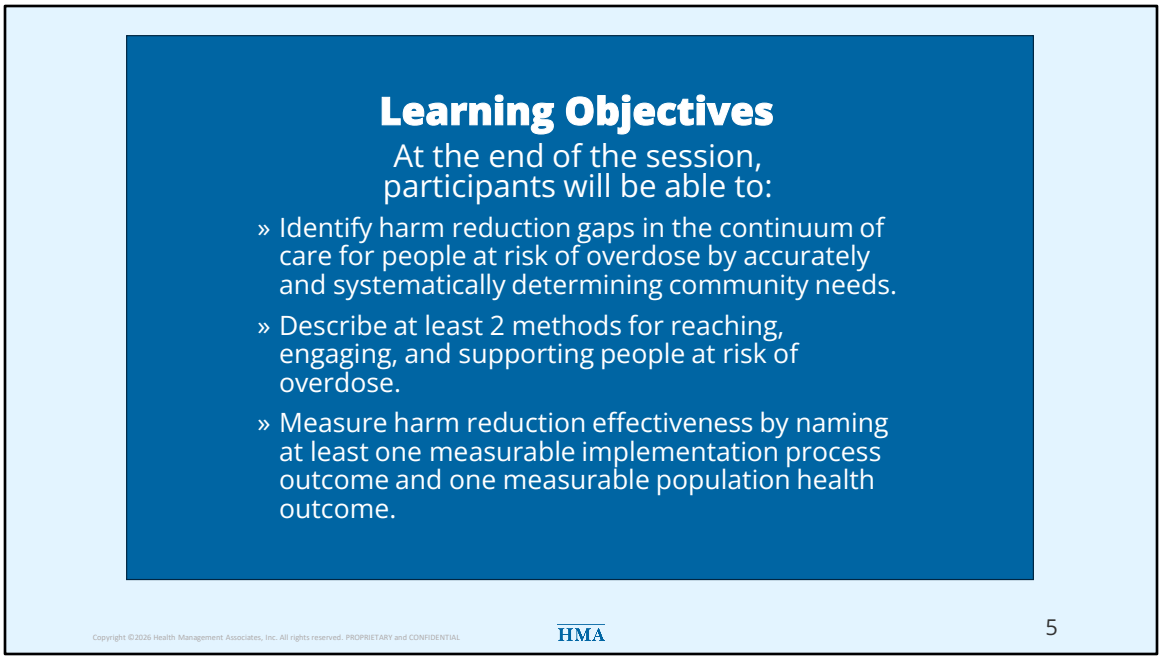
Debbi Witham is a seasoned executive with experience delivering high-quality, mission-driven healthcare and human services. She focuses on behavioral health, including mental health and substance use disorders; the integration of primary and behavioral health services; services for people living with HIV/AIDS; housing and social services; and child welfare.



[Slide Image Description: This slide shows the major sections of this webinar on a light blue background.]

Today's session will cover the following topics:

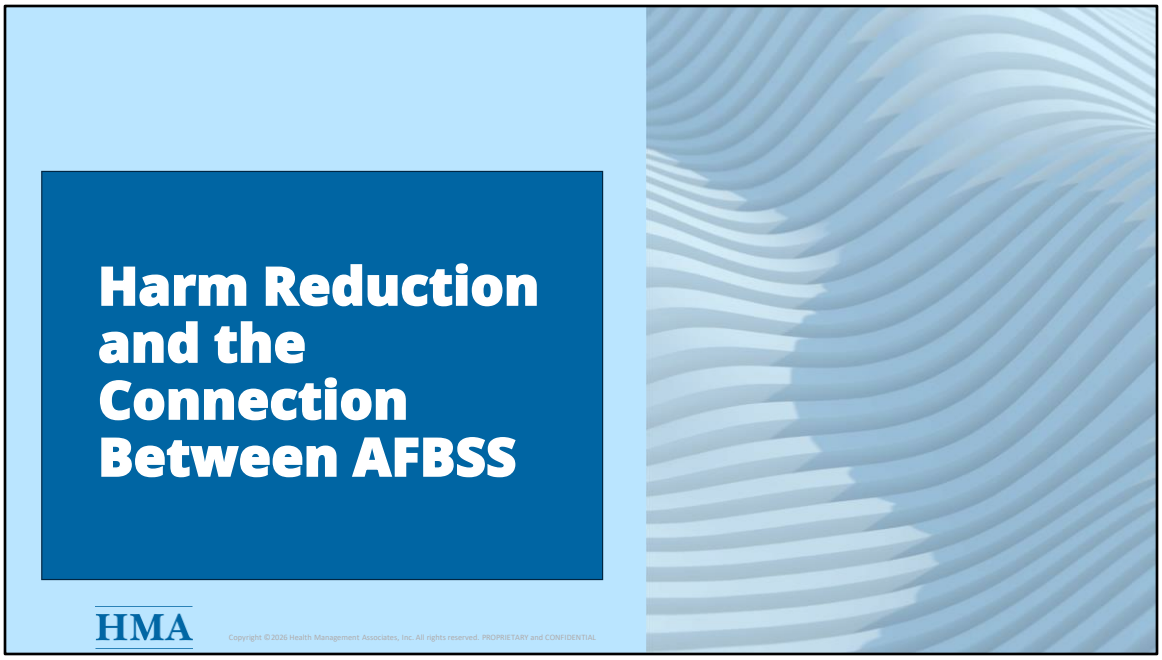
- Harm Reduction and the Connection Between AFBSS
- Determining Needs of People Who Use Drugs
- Introducing Evidence-Based Harm Reduction Strategies
- Evaluating Quality in Harm Reduction Services
- Q&A



[Slide Image Description: This slide shows the learning objectives for this webinar with a light blue background.]

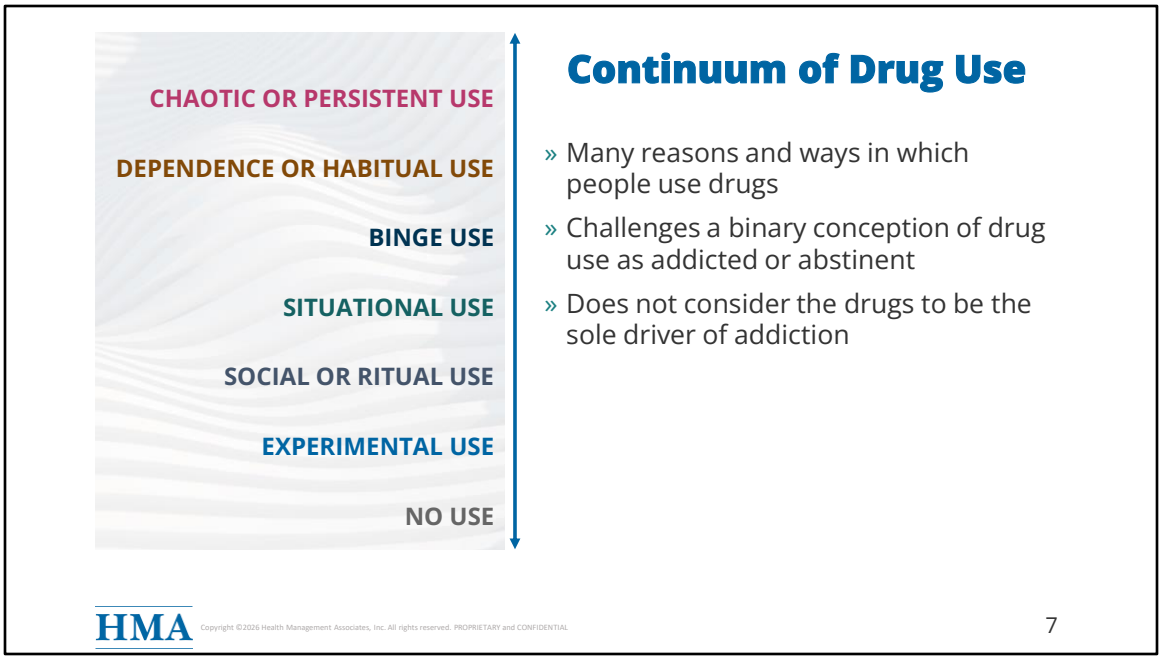
At the end of the session, participants will be able to:

- Identify harm reduction gaps in the continuum of care for people at risk of overdose by accurately and systematically determining community needs.
- Describe at least 2 methods for reaching, engaging, and supporting people at risk of overdose.
- Measure harm reduction effectiveness by naming at least one measurable implementation process outcome and one measurable population health outcome.



[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This first section will cover the basics of harm reduction and the connection between Assertive Field-Based Substance Use Disorder (SUD) Services (AFBSS).

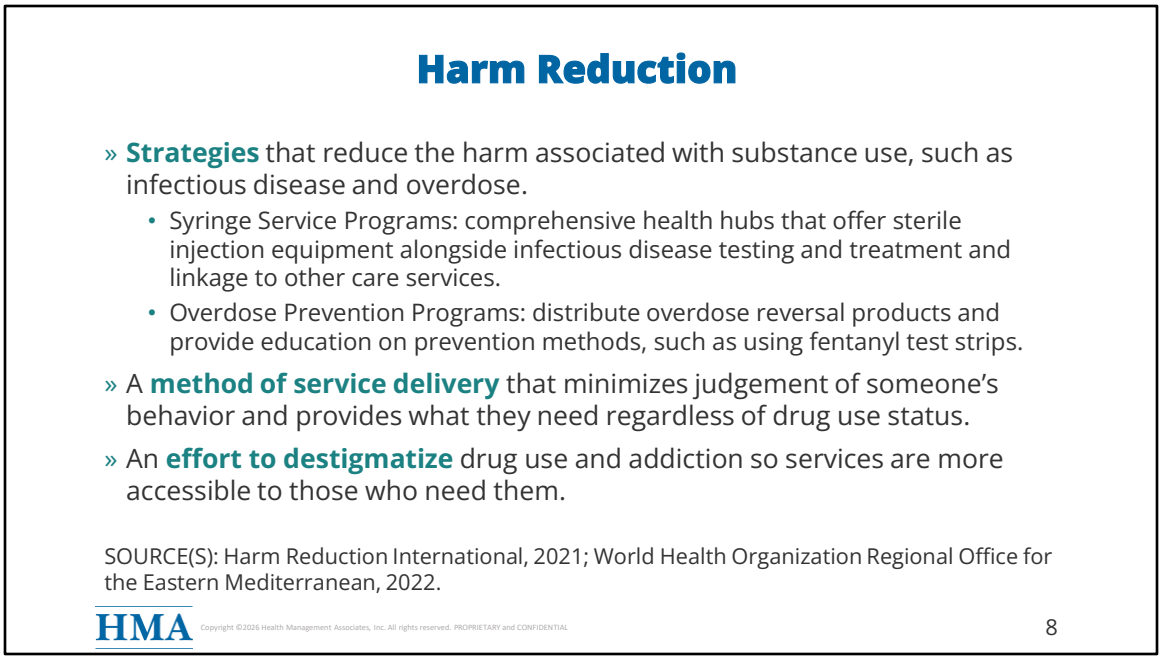


[Slide Image Description: This slide shows a colorful list of the continuum of drug use, with a decorative arrow.]

Not everyone who uses substances will develop an addiction. Substance use occurs along a continuum, and the reasons for and the ways in which people use drugs vary; as do the consequences of that substance use. Whether it be to loosen someone up to feel more comfortable in social situations, or to numb the memories, thoughts, and feelings associated with an experience of trauma, the substance is serving a purpose.

The continuum of drug use is as follows:

- Chaotic or persistent use
- Dependence or habitual use
- Binge use
- Situational use
- Social or ritual use
- Experimental use
- No use

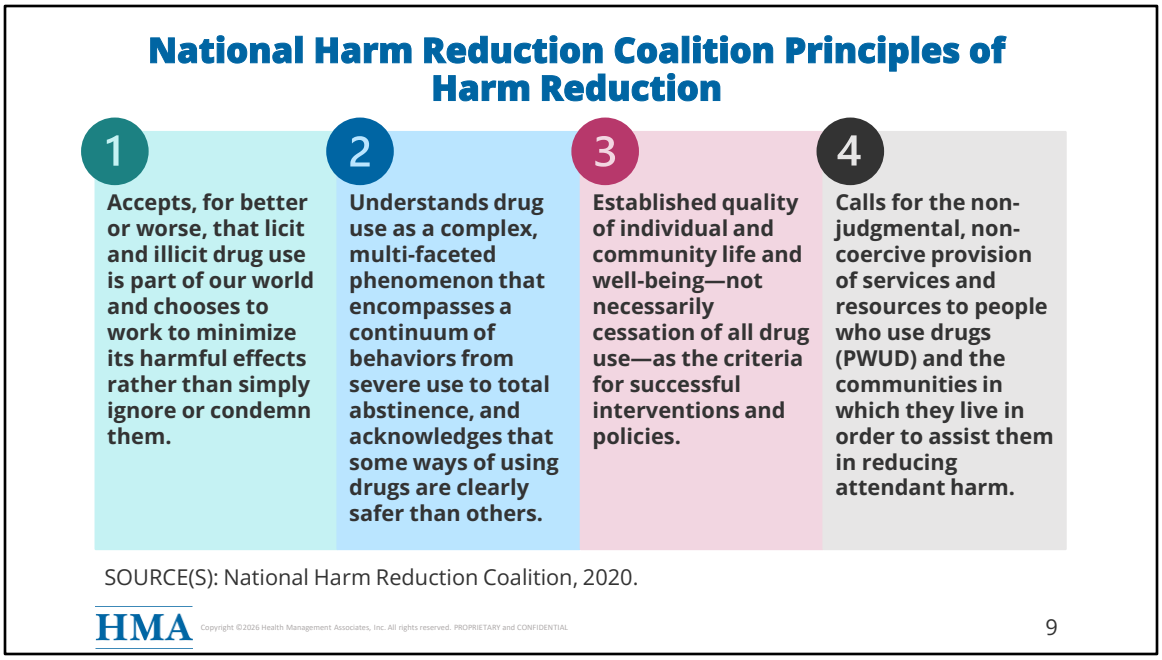


[Slide Image Description: This slide list descriptions of harm reduction.]

Harm reduction is defined in three ways:

- It incorporates a set of strategies designed to reduce the potential harms associated with use of substances, most notably transmission of infectious diseases and overdose and death.
    - Syringe Service Programs: comprehensive health hubs that offer sterile injection equipment alongside infectious disease testing and treatment and linkage to other care services.
    - Overdose Prevention Programs: distribute overdose reversal products and provide education on prevention methods, such as using fentanyl test strips.
- Harm reduction is also an approach, the nonjudgmental provision of services and resources, regardless of drug use status.
- In the larger context, harm reduction is a social justice movement that focuses on destigmatization and decriminalization of drug use, with the goal of increasing access to the services and care for those who use drugs by destigmatizing drug use and addiction.

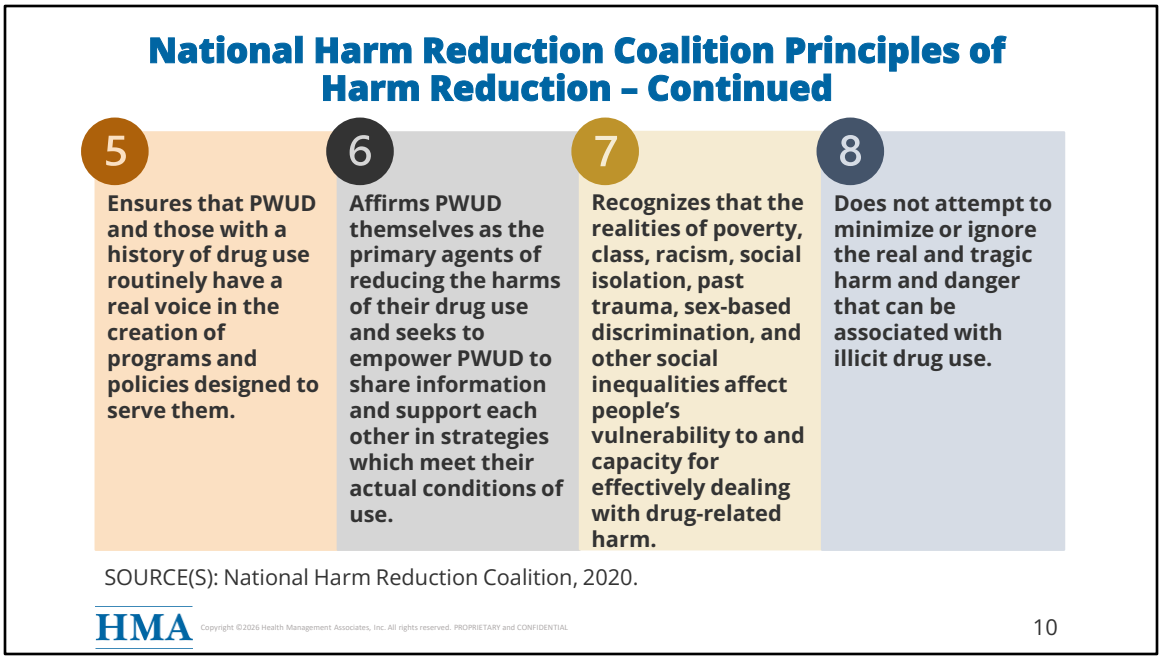
SOURCE(S): Harm Reduction International, 2021; World Health Organization Regional Office for the Eastern Mediterranean, 2022.



[Slide Image Description: This slide shows principles of harm reduction, with four colorful boxes and numbers.]

The National Harm Reduction Coalition has propagated 8 principles of harm reduction. The first four include the following:
1. Accepts, for better or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
2. Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe use to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
3. Established quality of individual and community life and well-being—not necessarily cessation of all drug use—as the criteria for successful interventions and policies.
4. Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs (PWUD) and the communities in which they live in order to assist them in reducing attendant harm.

SOURCE(S): National Harm Reduction Coalition, 2020.



[Slide Image Description: This slide shows principles of harm reduction, with four colorful boxes and numbers.]

The remaining principles of harm reduction include the following:
5. Ensures that PWUD and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them
6. Affirms PWUD themselves as the primary agents of reducing the harms of their drug use and seeks to empower PWUD to share information and support each other in strategies which meet their actual conditions of use.
7. Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect people's vulnerability to and capacity for effectively dealing with drug-related harm.
8. Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with illicit drug use.

SOURCE(S): National Harm Reduction Coalition, 2020.

History of Outreach and Direct Engagement

- Naloxone distribution at community sites significantly reduces opioid overdose.
- Thirty years of research show Syringe Service Programs (SSPs) are safe, effective, and cost-saving.
- People who use harm reduction services are more likely to enter addiction treatment and reduce harmful use behaviors.
  - SSP engagement increases retention in methadone treatment and treatment uptake overall.
  - New users of SSPs are five times more likely to enter drug treatment and almost three times more likely to stop using drugs than persons who do not use SSPs.

SOURCE(S): Fernandes, R. M., et al., 2017; Fischer, L. S., et al., 2025; Hagan, H., et al., 2020.

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[Slide Image Description: This slide lists the history of outreach and direct engagement, with an image of EMS workers.]

Harm reduction has a long history of outreach and direct engagement:

- Harm reduction programs started as outreach programs, and have a long history of developing best practices in this approach. Programs also now have a robust evidence-base.
- Naloxone distribution at community sites significantly reduces opioid overdose.
- Over thirty years of research show Syringe Service Programs (SSPs) are safe, effective, and cost-saving when compared to the treatment of infectious disease. SSP engagement increases retention in methadone treatment and treatment uptake overall.
- People who use harm reduction services are more likely to enter addiction treatment and reduce harmful use behaviors. We see increased retention in methadone programs. This is most likely due to the fact that people enter treatment when they are ready; after engaging a trusted program while they are actively using. Studies show new users of SSPs are five times more likely to enter drug treatment and almost three times more likely to stop using drugs than persons who do not use SSPs.

SOURCE(S): Fernandes, R. M., et al., 2017; Fischer, L. S., et al., 2025; Hagan, H., et al., 2020.

Behavioral Health Services Act

- Counties are required to provide rapid access to all FDA approved medications for addiction treatment (MAT) by strengthening existing and/or standing-up at least one initiative in each of the following three areas that comprise their assertive field-based programs:
  - Data-informed, targeted outreach on an ongoing basis to BHSA-eligible individuals with Substance Use Disorder (SUD) needs to engage them in SUD services, including MAT, if needed
  - Mobile field-based programs
  - Open-access clinics

SOURCE(S): California Department of Health Care Services, 2025.

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[Slide Image Description: This slide lists details from the Behavioral Health Services Act, with an image of the California state capitol building.]

The Behavioral Health Services Fund (BHSA) builds on the Mental Health Services Fund (MHSA) and expands the program to include mental health and substance use disorder (SUD) services. There are specific requirements around engaging the hardest to reach populations through Assertive Field-Based Initiation for SUD Treatment Services (AFBSS). Counties need to prioritize those at highest risk of overdose.

Counties are required to provide rapid access to all Food and Drug Administration (FDA) approved medications for addiction treatment (MAT) by strengthening existing and/or standing-up at least one initiative in each of the following three areas that comprise their assertive field-based programs:

1. Data-informed, targeted outreach on an ongoing basis to BHSA-eligible individuals with SUD needs to engage them in SUD services, including MAT, if needed
2. Mobile field-based programs
3. Open-access clinics

Counties are required to strategically locate assertive field-based outreach and program models in settings where significant numbers of individuals living with SUD are located and/or areas with high rates of overdose reversals, which may include hospital and emergency departments, encampments, SSPs, jails, etc.

Harm reduction and SSPs are mentioned in Policy Manual Section 7.B.6.2 as something BHSS funds can support under outreach and engagement.

SOURCE(S): California Department of Health Care Services, 2025.

Behavioral Health Services Act (Continued)

- Counties are encouraged to promote a person-centered approach in their assertive field-based initiation programs to provide access to life-saving care, prevent overdose, and improve the quality of life for individuals living with SUD. AFBSS programs are encouraged to provide the following activities:
  - Harm Reduction
  - Primary Care
  - Post-Overdose Follow-up Engagement Services
  - Access to Peer Support Specialists
  - Mobile field-based programs
  - Open-access clinics

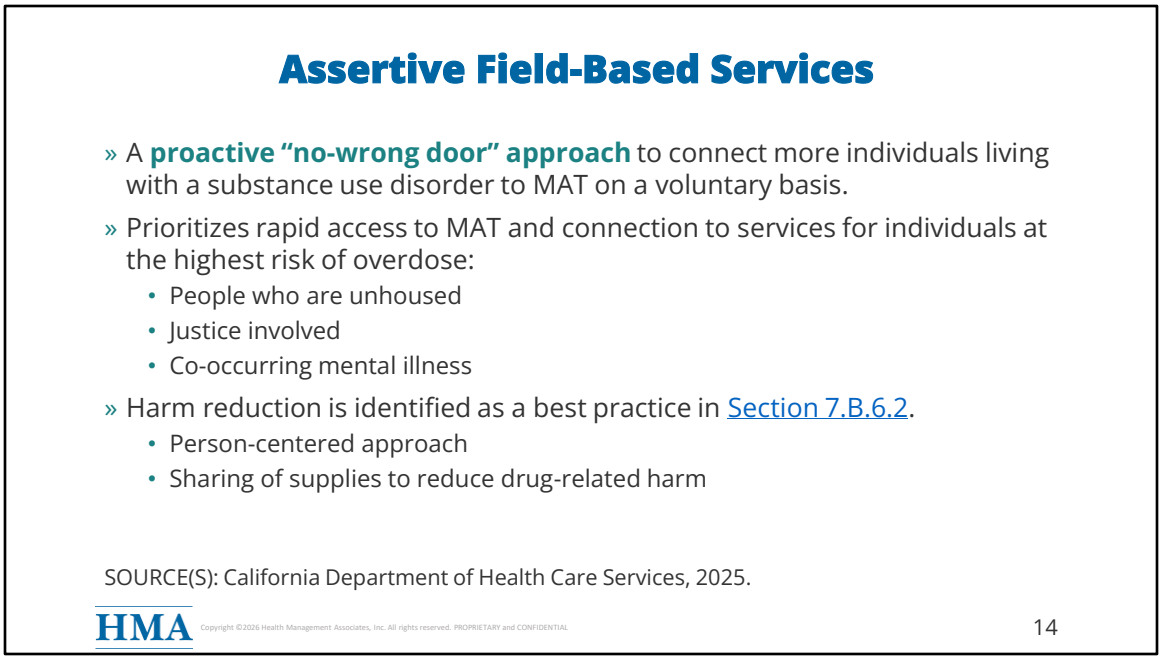
SOURCE(S): California Department of Health Care Services, 2025.

[Slide Image Description: This slide lists details from the Behavioral Health Services Act, with an image of the California state capitol building.]

DHCS highlights some promising and best practices to be used by counties.

- These include harm reduction such as safe use supplies, testing strips and naloxone; primary care (provide individuals with wound care, Hep C and HIV testing and care; engagement in post-overdose follow-up services). This includes developing dedicated communication and coordination channels to alert programs when someone has survived an overdose. Teams should use this to conduct immediate community-based outreach after the known overdose and provide supports, education, and facilitate rapid access to MAT.
- Access to peer support specialists; individuals with lived experience that personally understand the experience of the individuals they serve and help clarify the most effective set of services for each individual's needs.
- Counties can collaborate to establish targeted outreach programs, field-based mobile teams, and open access clinics to maximize efficiencies to expand rapid access to MAT. This can include pooling financial resources to design and support. This might include mobile field-based programs that have an embedded provider, or mobile Opioid Treatment Programs that rotate locations across multiple counties or open access clinics to provider care and accept MAT referrals for individuals residing in partnering counties.

SOURCE(S): California Department of Health Care Services, 2025.



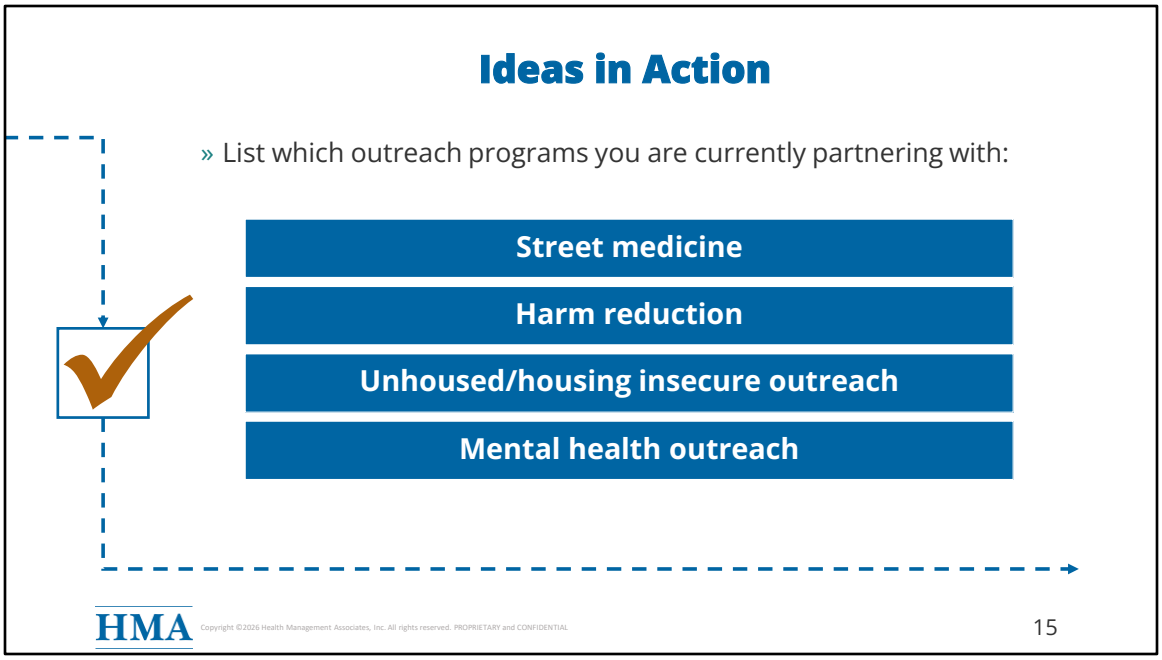
[Slide Image Description: This slide lists details about Assertive Field-Based Services.]

Assertive Field-Based Approach:

- A proactive "no-wrong door" approach to connect more individuals living with a substance use disorder to MAT on a voluntary basis
- Prioritizes rapid access to MAT and connection to services for individuals at the highest risk of overdose:
    - People who are unhoused
    - Justice involved
    - Co-occurring mental illness
- Harm reduction is identified as a best practice in Section 7.B.6.2
    - Person-centered approach
    - Sharing of supplies to reduce drug-related harm

It is also included as a best practice in Section 7.B.6.2, under mobile field-based programs in Section 7.B.6.2.3, and under Open-Access Clinics in Section 7.B.6.2.4. Additionally, it is a program priority to support harm reduction under housing programs in Section 7.C.3, and harm reduction supplies and activities can be included in the 7% of housing intervention funds allowed to be represented by Outreach and Engagement activities (Section C.9.4.4).

SOURCE(S): California Department of Health Care Services, 2025.



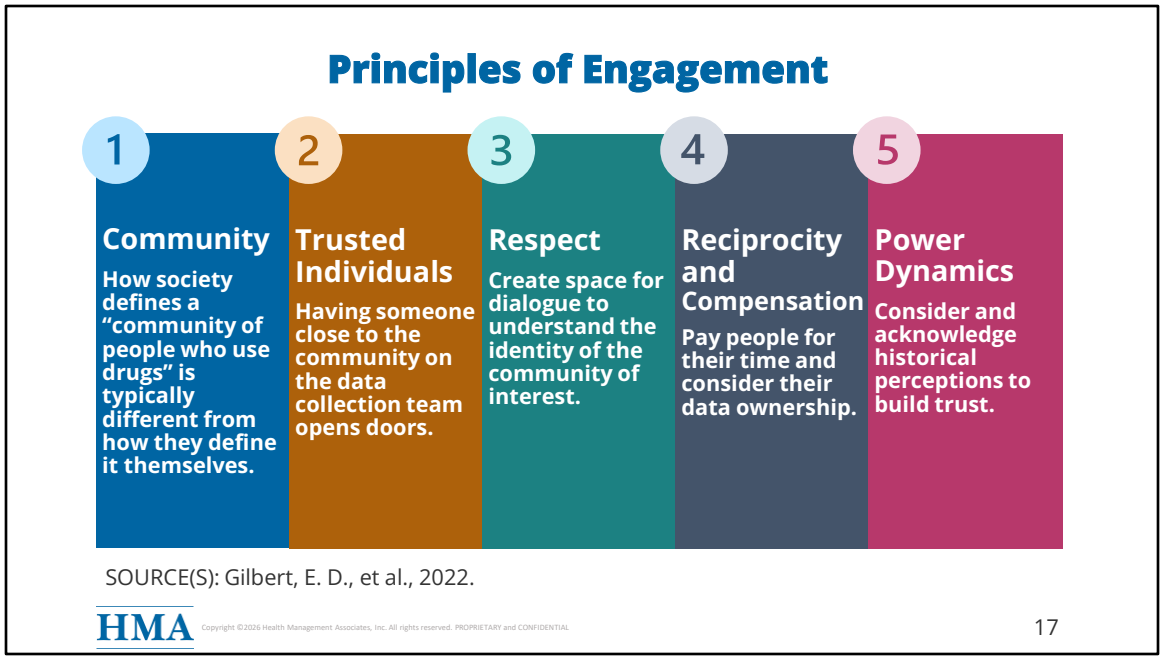
[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow, as well as colorful boxes.]

List which outreach programs you are currently partnering with:

- Street medicine
- Harm reduction
- Unhoused/housing insecure outreach
- Mental health outreach

[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This second section will cover how to identify and address the needs of people who use drugs.



[Slide Image Description: This slide lists principles of engagement.]

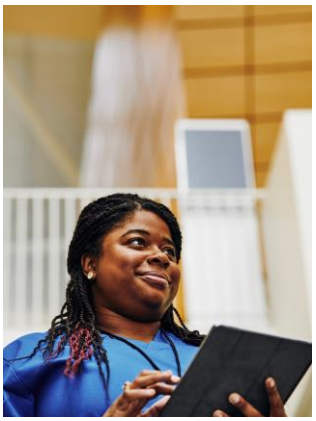
When preparing to partner with individuals and communities, in general, and people who are using drugs specifically, there are suggested principles of engagement.

1. Community: How society defines a "community of people who use drugs" is typically different from how they define it themselves. "Community" is determined and defined by those in the community.
2. Trusted Individuals: Having someone close to the community on the data collection team opens doors. Access and entry to the community is often improved when partnering with a trusted messenger.
3. Respect: Community members should be treated with respect and dignity. Create space for dialogue to understand the identity of the community of interest.
4. Reciprocity and Compensation: Community members should be compensated for their time and have ownership of their data. Findings and conclusions should be communicated back to and confirmed with the community.
5. Power Dynamics: Communities often have long memories. To build trust, county governments need to consider and acknowledge historical perceptions to build trust. "The way a community was treated in the past impacts current collaborations."

SOURCE(S): Gilbert, E. D., et al., 2022.

Community Needs Assessment

- Programs, like AFBSS, intended to reach PWUD and are at high risk of overdose should include impacted people during preparation.
- Questions to consider:
  - What drugs are people using in the community?
  - Where are people using drugs?
  - Who is using drugs?
  - How are they using drugs?
  - What do they need today?
  - How do they procure drugs?
- Community Health Workers can conduct a survey of PWUD.
- People who participate in surveys must be compensated for their time and expertise.



SOURCE(S): Gleason-Comstock, J., et al., 2024; Oguya, F. O., et al., 2021.

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[Slide Image Description: This slide lists information about Community Needs Assessments, with an image of a person holding a tablet.]

Programs, like AFBSS, intended to reach PWUD and are at high risk of overdose should include impacted people during preparation.

To optimize delivery of services for PWUD and are at highest risk of overdose, the community of people at risk should be included in the design of the program.

Questions to ask when assessing community need include:

- What drugs are people using in the community?
- Where are people using drugs?
- Who is using drugs?
- How are they using drugs?
- What do they need today?
- How do they procure drugs?

Using community health workers, peer recovery specialists, or trusted community partners, PWUD can be surveyed with subsequent recruitment driven by participant referral and leads.

Keep in mind survey participants should be compensated for their time.

This is a shift in how behavioral health services have historically been designed and delivered, where the “professionals” decide what people need and then expect them to show up. This model listens to what the people who might receive services need and takes it to the community.

SOURCE(S): Gleason-Comstock, J., et al., 2024; Oguya, F. O., et al., 2021.

Committee or Advisory Participation

- How do you include PWUD in your consultative processes or advisory boards?
  - Hold accommodating meetings to ensure attendance and ask how to make the meeting more inclusive.
  - Prepare new attendees with training and a support person.
    - Engage a trusted harm reduction program.
  - Reimburse for travel and time if possible and appropriate.
  - Be flexible with level of participation.
    - Invite multiple people, not just one, and allow rotating attendance.
  - Acknowledge knowledge gaps with humility, grace, and address discomfort openly and respectfully.

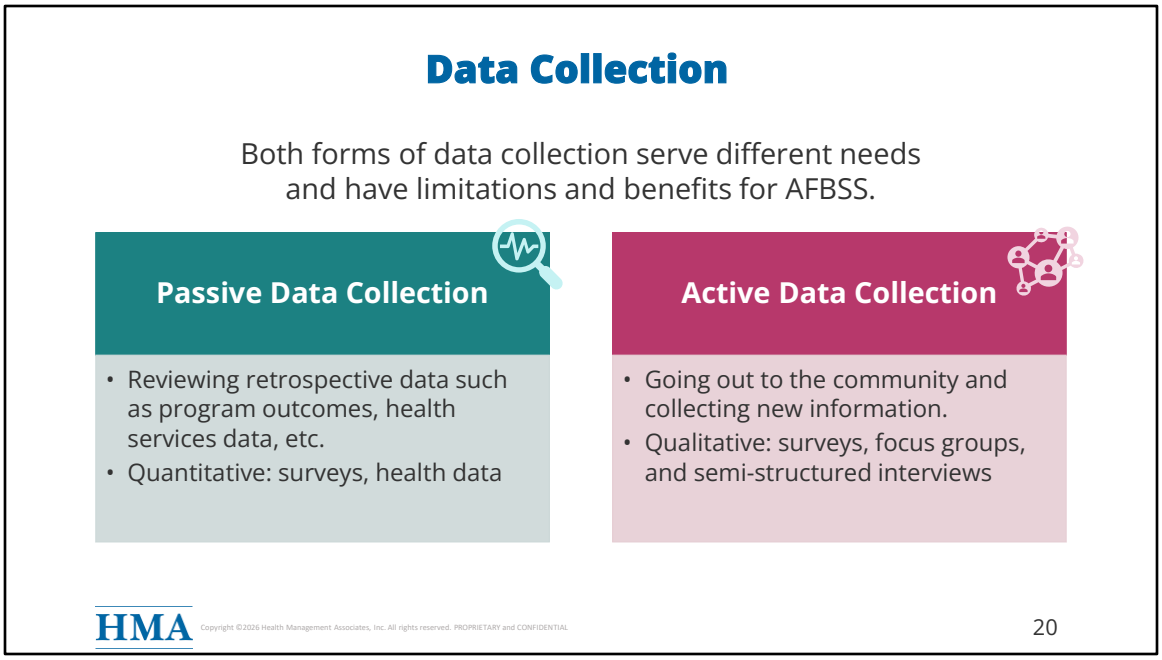
SOURCE(S): AIDS United., 2021.

[Slide Image Description: This slide lists recommendations for committee or advisory participation, with an image of a person writing on a white board.]

How do you include PWUD in your consultative processes or advisory boards?

- Ensure meeting dates and times accommodate the schedules of those you are trying to engage and elicit their ideas on how to make the meetings inclusive.
- Engage a trusted community organization or service provider in recruiting, preparing, and supporting new advisory board attendees.
- When possible and appropriate, compensate board members for their time and travel.
- Be flexible with the expected level of participation; invite multiple people, not just one, and allow rotating attendance.
- Use cultural humility and grace where knowledge gaps may exist and be transparent and respectful.
- It is important to be sure the advisory board is engaged in a meaningful way and not a “rubber stamp” for the leadership’s vision or goals.

SOURCE(S): AIDS United., 2021.



[Slide Image Description: This slide lists two types of data collection.]

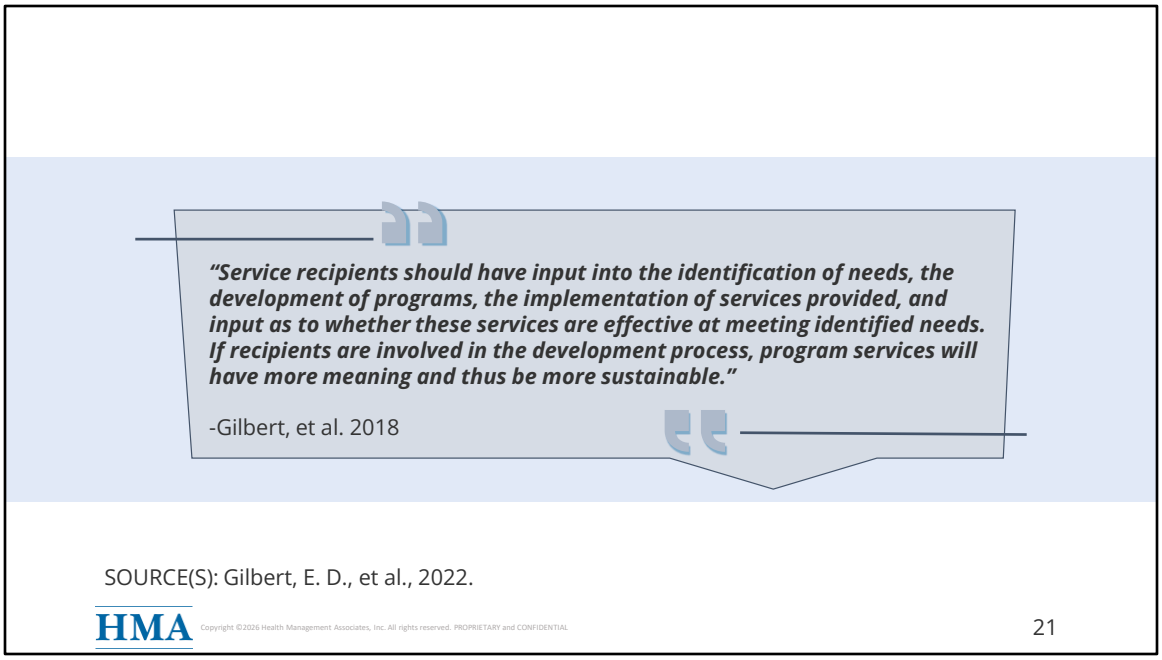
Passive Data Collection:

- Often includes retrospective—previously collected—data review, whether it's epidemiologic data like incidences of overdose events, health services data such as number of individuals served and services provided, or program outcomes metrics.
- This data is typically quantitative, including surveys and health data.

Active Data Collection:

- In contrast, active data collection entails the processes by which new information and data is gathered in the community.
- This data is typically qualitative, including:
    - Surveys with open-ended questions, which allow for a variety of individualized responses.
    - Focus groups, which can generate information at the onset of a line of query or to compliment or verify results from a survey.
    - Individual interviews, which may be more appropriate when querying sensitive topics that may involve self-disclosure.

Both forms of data collection serve different needs and have limitations and benefits for AFBSS.



[Slide Image Description: This slide lists a quote around outreach and support.]

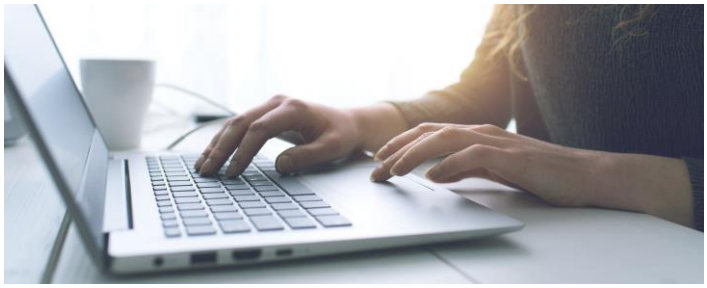
This is an important quote to keep in mind when planning outreach and support.

"Service recipients should have input into the identification of needs, the development of programs, the implementation of services provided, and input as to whether these services are effective at meeting identified needs. If recipients are involved in the development process, program services will have more meaning, and thus be more sustainable."
-Gilbert, et al. 2018

SOURCE(S): Gilbert, E. D., et al., 2022.

Ideas in Action

» List two to three ways you can increase engagement of people who are priority for AFBSS.

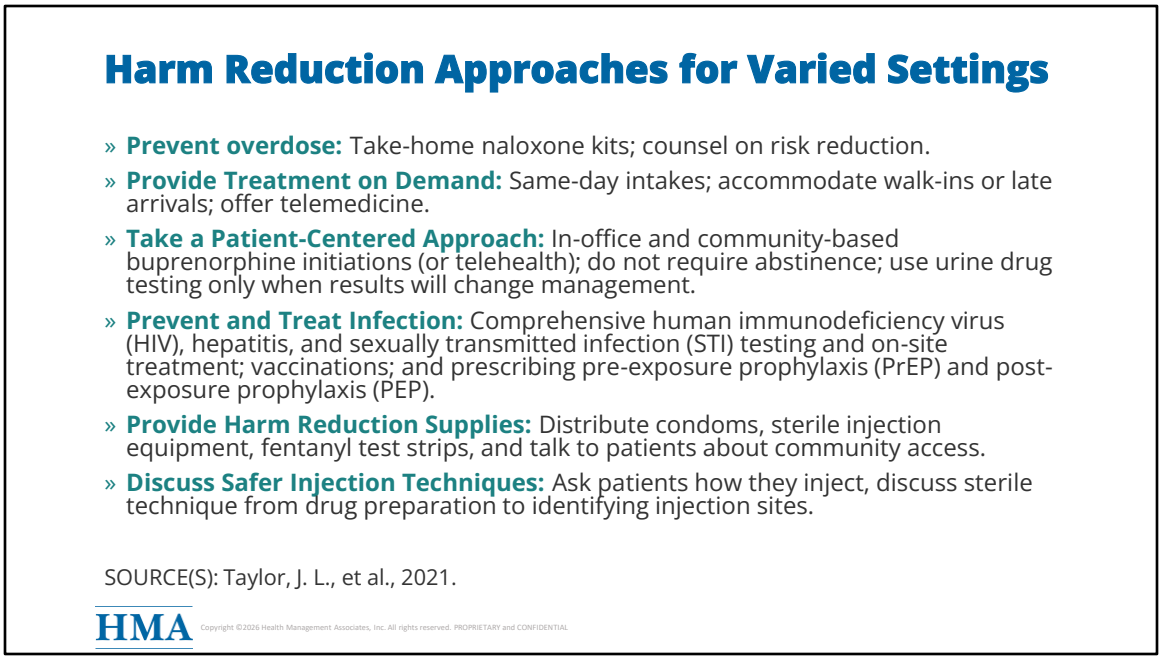


[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow, as well as a person typing on a laptop.]

List two to three ways you can increase engagement of people who are priority for AFBSS.

[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This third section will introduce evidence-based harm reduction strategies.



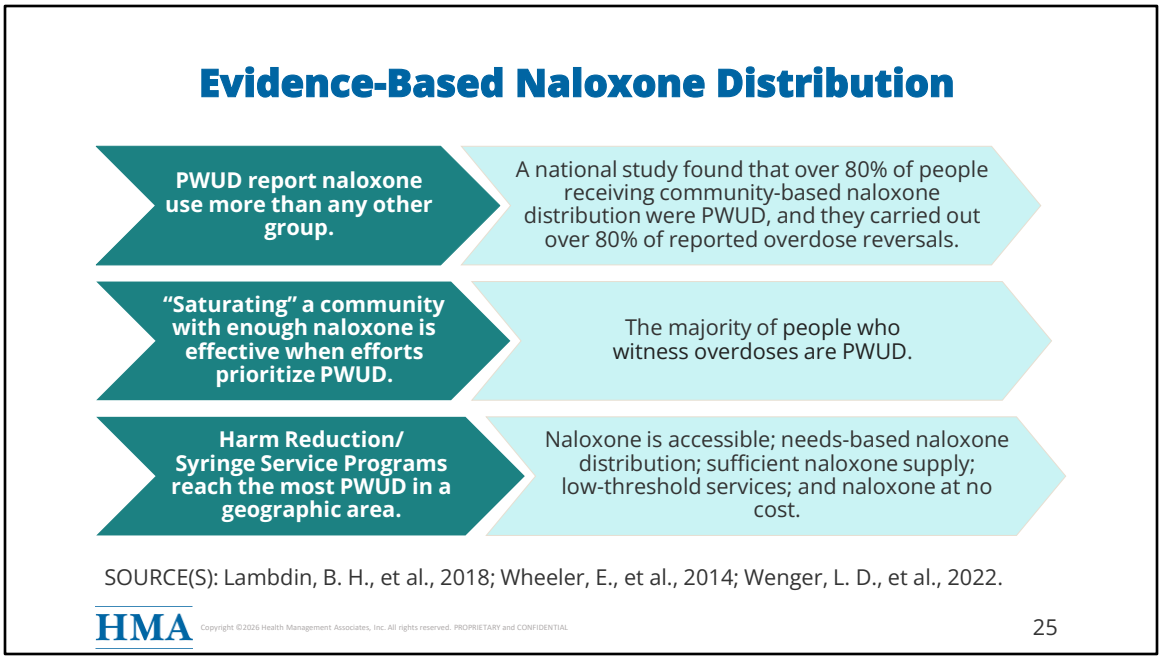
[Slide Image Description: This slide lists harm reduction approaches for varied settings.]

These recommendations are based on research examining how harm reduction can be integrated into clinical treatment, but they are applicable to a variety of settings.

- Prevent Overdose: Prevent overdose by distributing take home naloxone kits and counseling on risk reduction.
- Provide Treatment on Demand: To increase access, treatment should be low-threshold, offering same day intakes, and accommodating appointments and walk ins.
- Take a Patient-Centered Approach: A patient-centered approach allows for patient determined goals. This may look like in-office and community-based buprenorphine initiations (or telehealth); not requiring abstinence; and using urine drug testing only when results will change management.
- Prevent and Treat Infection: This includes comprehensive HIV, hepatitis, and sexually transmitted infection (STI) testing and on-site treatment; vaccinations; and prescribing PrEP and PEP.

- Provide Harm Reduction Supplies: This includes distributing condoms, sterile injection equipment, fentanyl test strips, and talking to patients about community access. This doesn't have to happen only in a syringe service program; supplies can be distributed people need, or people can be referred to a program that does.
- Discuss Safer Injection Techniques: Ask patients how they inject, discuss safer injection techniques from drug preparation to identifying injection sites. This goes beyond infectious disease control to include vein care and protection.

SOURCE(S): Taylor, J. L., et al., 2021.



[Slide Image Description: This slide overviews evidence-based naloxone distribution, with colorful arrows.]

Naloxone distribution is typically directed to people at highest risk of overdose and most likely to witness and respond to an overdose. Following the evidence of community-based naloxone distribution we see why harm reduction programs are prioritized as partners and leaders. They are reaching the most PWUD in a geographic area, including those who are not engaged in treatment nor the criminal justice system.

Keep in mind the following:

- PWUD report naloxone use more than any other group.
    - "Between 1996 and 2014, a national study found that over 80% of laypeople who participated in community-based naloxone distribution were PWUD and over 80% of reported overdose reversals were performed by PWUD," (Lambdin, et al. 2018).
- "Saturating" a community with enough naloxone so it's available for every overdose is effective when efforts prioritize PWUD.
    - "Most people who witness overdoses are other people who use

drugs," (Wheeler, et al. 2015).

- Harm reduction/Syringe Service Programs reach the most PWUD in a geographic area.
    - "The five best practices that were ranked highest by the panel of experts were as follows: (1) naloxone is accessible, (2) needs-based naloxone distribution, (3) sufficient naloxone supply, (4) low threshold services, and (5) naloxone at no cost," (Wegner, et al. 2022).

SOURCES: SOURCE(S): Lambdin, B. H., et al., 2018; Wheeler, E., et al., 2014; Wenger, L. D., et al., 2022.

Risk Reduction Education

PWUD make different decisions when offered information about drug supply.

Behavior change can reduce risk of overdose.

Harm reduction programs are ideal settings for this education.

SOURCE(S): Johns Hopkins Bloomberg School of Public Health and Bloomberg American Health Initiative, 2018; Brunt T., 2017; Wallace, B. van Roode., et al., 2021; Maghsoudi, N., et al., 2020; Karamouzian, M., et al., 2018.

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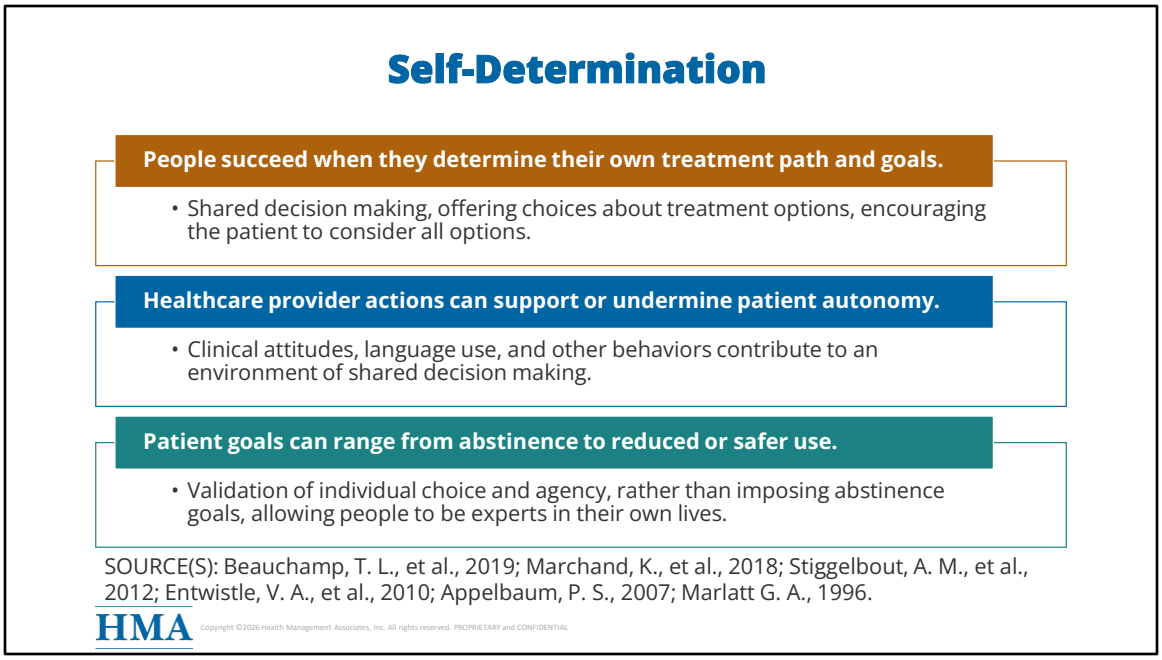
[Slide Image Description: This slide shows risk reduction education, with colorful boxes and an image of a person with glasses and a cast.]

Beyond the distribution of naloxone, many studies show that risk reduction education is effective at changing behavior. It is the behavior change that reduce risk of overdose and infectious disease, not just the intervention.

Keep in mind the following:

- PWUD make different decisions when offered information about drug supply
- Behavior change can reduce risk of overdose
- Harm reduction programs are ideal settings for this education

SOURCE(S): Johns Hopkins Bloomberg School of Public Health and Bloomberg American Health Initiative, 2018; Brunt T., 2017; Wallace, B. van Roode., et al., 2021; Maghsoudi, N., et al., 2020; Karamouzian, M., et al., 2018.



[Slide Image Description: This slide lists principles of self-determination in colorful boxes.]

Self determination is a core ethical practice in healthcare. Behavioral health should be no exception.

Autonomy has a clear role in developing clinical relationships and trust:
- Higher retention in treatment
- Better satisfaction and engagement
- Reduced coercion and stigma
- Improved clinical and quality-of-life outcomes

People succeed when they determine their own treatment path and goals. Shared decision making, offering choices about treatment options, encouraging the patient to consider all options.

Healthcare provider actions can support or undermine patient autonomy. Clinical attitudes, language use, and other behaviors contribute to an environment of shared decision making.

Patient goals can range from abstinence to reduced or safer use. Validation of individual choice and agency, rather than imposing abstinence goals, allows people to be experts in their own lives.

SOURCE(S): Beauchamp, T. L., et al., 2019; Marchand, K., et al., 2018; Stiggelbout, A. M., et al., 2012; Entwistle, V. A., et al., 2010; Appelbaum, P. S., 2007; Marlatt G. A., 1996.

Low-Threshold Medication for Opioid Use Disorder (MOUD)

- MOUD has proven clinically effective to alleviate symptoms of withdrawal, reduce cravings, decrease substance use, and increase treatment engagement.
- Additionally, MOUD has been associated with:
  - Decreased HIV and Hepatitis C transmission
  - Decreased criminal recidivism
  - Increased employment
  - Improved birth outcomes
  - Methadone and buprenorphine reduce overdose by half
- Low-threshold models of buprenorphine delivery include integration in SSPs, mobile units, and street medicine programs.

SOURCE(S): Mattick, R. P., et al., 2009; Mattick, R. P., et al., 2014; Santo, T., et al., 2021; The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, 2020.

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[Slide Image Description: This slide overviews low-threshold medication for opioid use disorder, with an image of a pharmacist checking prescriptions.]

In addition to reduction of substance use and increased treatment retention, medication for opioid use disorder (MOUD) has been associated with a variety of outcomes including reduction in transmission of infectious diseases, improved birth outcomes, and people with opioid use disorder (OUD) treated with buprenorphine or methadone are two to three times less likely to die from overdose than those with OUD not treated with either of these medications.

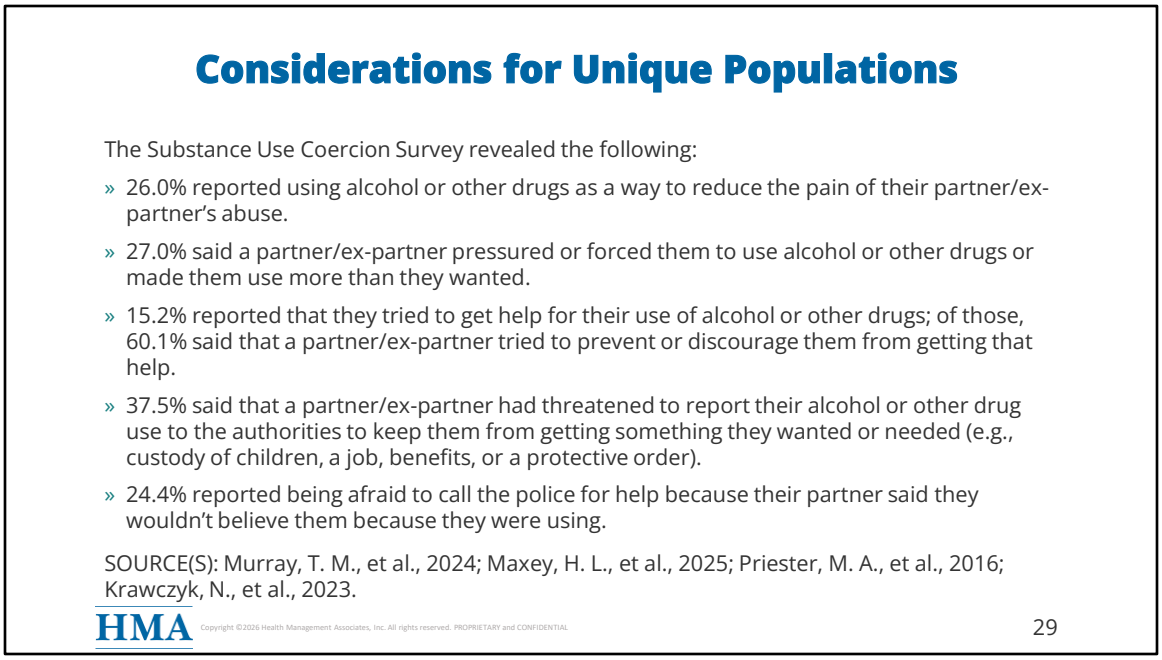
MOUD has proven clinically effective to alleviate symptoms of withdrawal, reduce cravings, decrease substance use, and increase treatment engagement.
Additionally, MOUD has been associated with:

- Decreased HIV and Hepatitis C transmission
- Decreased criminal recidivism
- Increased employment

- Improved birth outcomes
- Methadone and buprenorphine reduce overdose by half

Low-threshold models of buprenorphine delivery include integration in SSPs, mobile units, and street medicine programs. Integration of low-threshold MOUD into non-traditional settings such as mobile clinics, SSPs or street medicine programs has been associated decreased substance use and HIV risk behaviors.

SOURCE(S): Mattick, R. P., et al., 2009; Mattick, R. P., et al., 2014; Santo, T., et al., 2021; The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder, 2020.



[Slide Image Description: This slide lists data for unique populations.]

The Substance Use Coercion Survey (administered to National Domestic Violence Hotline callers who identified as not in immediate crisis), revealed the following:

- 26.0% reported using alcohol or other drugs as a way to reduce the pain of their partner/ex-partner's abuse.
- 27.0% said a partner/ex-partner pressured or forced them to use alcohol or other drugs or made them use more than they wanted.
- 15.2% reported that they tried to get help for their use of alcohol or other drugs; of those, 60.1% said that a partner/ex-partner tried to prevent or discourage them from getting that help.
- 37.5% said that a partner/ex-partner had threatened to report their alcohol or other drug use to the authorities to keep them from getting something they wanted or needed (e.g., custody of children, a job,

benefits, or a protective order).

- 24.4% reported being afraid to call the police for help because their partner said they wouldn't believe them because they were using.

SOURCE(S): Murray, T. M., et al., 2024; Maxey, H. L., et al., 2025; Priester, M. A., et al., 2016; Krawczyk, N., et al., 2023.

Strategies to Support Unique Populations

- **Identify and remove barriers** to care for people with unique situations, i.e., transportation, documentation, insurance status, language, and disability access.
- **Tailor services** to reflect lived cultural experience and community norms of people whose drug use identity intersects with their LGBTQ+ identity, tribal community, or race.
- **Implement best practices** for engaging pregnant PWUD.
- **Consider social complexity** for people who experience different forms of discrimination in systems and make referrals mindfully and with needed supports in place.

SOURCE(S): Murray, T. M., et al., 2024; Maxey, H. L., et al., 2025; Priester, M. A., et al., 2016; Krawczyk, N., et al., 2023.

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[Slide Image Description: This slide overviews strategies to support unique populations, with an image of people holding hands.]

Consider the following strategies to support unique populations:

- Identify and remove barriers to care for people with unique situations, i.e. transportation, documentation, insurance status, language, and disability access.
- Tailor services to reflect lived cultural experience and community norms of people whose drug use identity intersects with their LGBTQ+ identity, tribal community, or race.
- Implement best practices for engaging pregnant PWUD.
- Consider social complexity for people who experience different forms of discrimination in systems and make referrals mindfully and with needed supports in place.

SOURCE(S): Murray, T. M., et al., 2024; Maxey, H. L., et al., 2025; Priester, M. A., et al., 2016; Krawczyk, N., et al., 2023.

Ideas in Action

» List which services are currently available in your county:

- SSPs
- Mobile harm reduction units
- Naloxone
- Test strips
- Education

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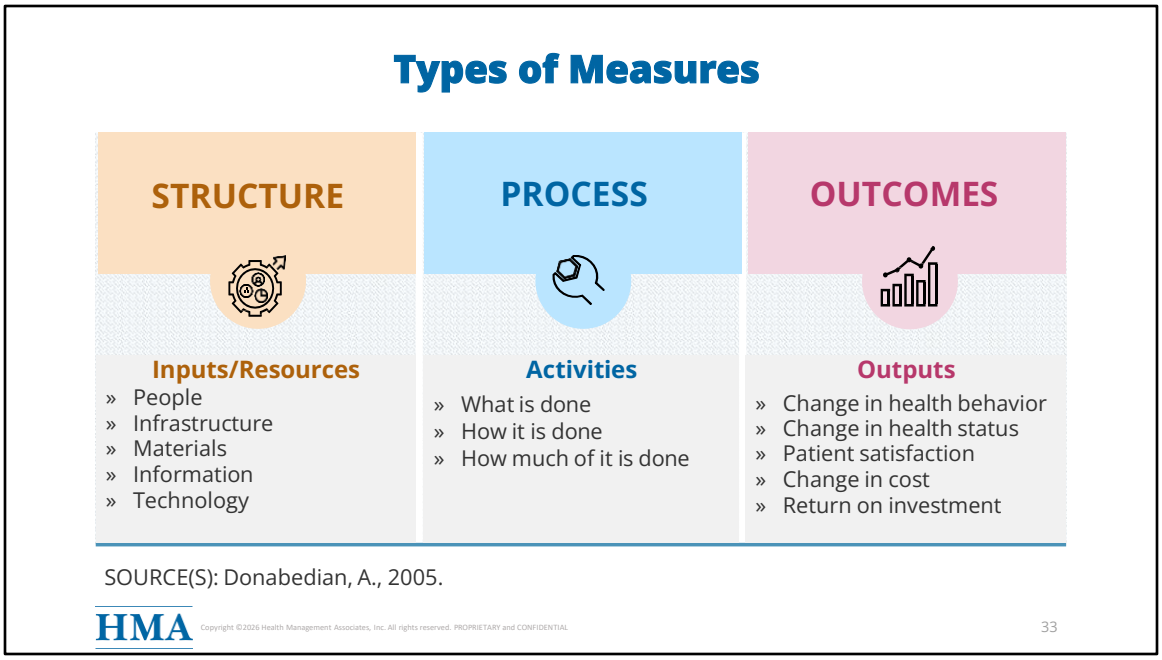
[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow, as well as a checklist.]

List which services are currently available in your county:
- SSPs
- Mobile harm reduction units
- Naloxone
- Test strips
- Education

[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This fourth section will look at evaluating quality in harm reduction services.



[Slide Image Description: This slide lists types of measures, with accompanying graphics including a gear, wrench, and data chart.]

There are three different types of measures: Structure, Process, and Outcomes. All are important, and having targets of each type is necessary to be able to measure impact

Structure are the inputs and resources, including:

- People
- Infrastructure
- Materials
- Information
- Technology

Process includes the activities you perform:

- What is done
- How it is done
- How much of it is done

And then we get to outcomes, which measure the outputs:

- Change in health behavior
- Change in health status
- Patient satisfaction
- Change in cost
- Return on investment

SOURCE(S): Donabedian, A., 2005.

Benefit of Continuous Quality Improvement

Measures	Examples
Structural	• Program availability • Staffing levels and qualifications • Proportion of programs that offer low-threshold services • Funding dedicated to naloxone, safer supplies, etc.
Process	• Number of encounters with people at risk of overdose • Proportion of encounters that include risk reduction education, referrals, or other services • Total referrals to other services, proportion that are completed • Numbers of supplies distributed
Outcome	• Population Level (e.g., rates of nonfatal or fatal overdoses before and after outreach and engagement; increase in uptake of medications for opioid use disorder; and increase in housing beds filled) • Person Level (e.g., self-reported improvements in safety, wellbeing, and quality of life measures)

SOURCE(S): Wiessing, L., et al., 2017; Schaub, M. P., et al., 2013; Ellis, J. D., et al., 2024.

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[Slide Image Description: This slide shows a table, showing a column with measures and a column with examples of those measures.]

Like any evidence-based practice, harm reduction programs benefit from continuous quality improvement. In harm reduction, each of these measures can look like:

- **Structure**: Do we have what we need?
- **Process**: Are we doing it well?
- **Outcome**: Did it make a difference?

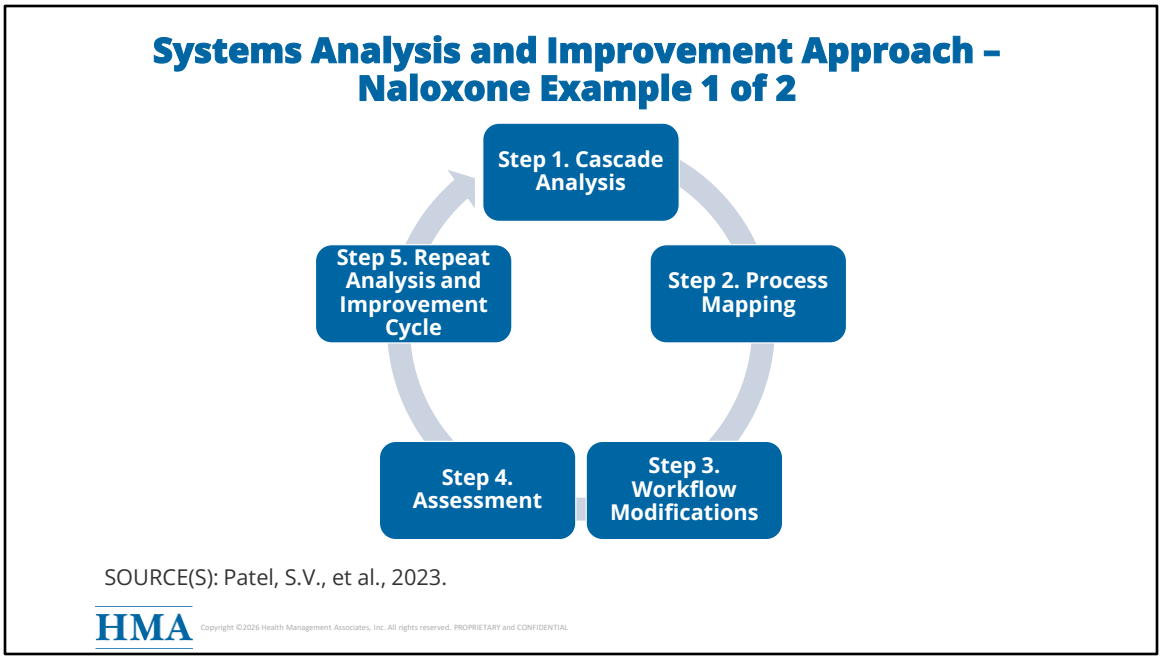
Examples for each of these measures include:

- Structural
    - Program availability
    - Staffing levels and qualifications
    - Proportion of programs that offer low-threshold services
    - Funding dedicated to naloxone, safer supplies, etc.
- Process
    - Number of encounters with people at risk of overdose
    - Proportion of encounters that include risk reduction education,

referrals, or other services
    - Total referrals to other services, proportion that are completed
    - Numbers of supplies distributed
- Outcome
    - Population Level
        - Rates of nonfatal or fatal overdoses before and after outreach and engagement
        - Increase in uptake of medications for opioid use disorder
        - Increase in housing beds filled
    - Person Level
        - Self-reported improvements in safety, wellbeing, quality of life measures

There are a number of studies that provide models for structural evaluation, including not only quantity of programs, but considering their environment and offerings. Performance outcomes need to be understood as primary outcomes that can lead to secondary health impact outcomes—especially when combined with behavior change.

SOURCE(S): Wiessing, L., et al., 2017; Schaub, M. P., et al., 2013; Ellis, J. D., et al., 2024.



[Slide Image Description: This slide shows a graphic representing the Systems Analysis and Improvement Approach.]

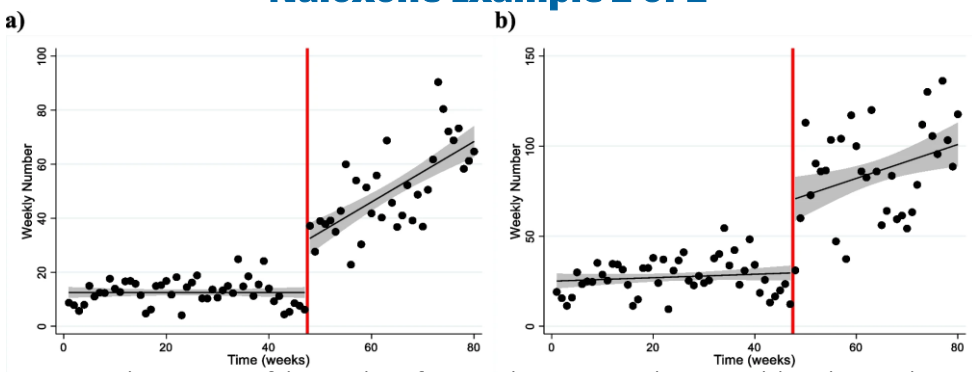
Implementation Science offers a number of quality improvement tools for naloxone distribution and beyond. This is another example of tracking distribution and examining harm reduction methods: The Systems Analysis and Improvement Approach (SAIA).

Two syringe service programs participated in a 6-month pilot of SAIA-Naloxone, which included:

- (1) Analyzing program data to identify gaps in the naloxone delivery cascade,
- (2) Flow mapping to identify causes of attrition and brainstorm programmatic changes for improvement, and
- (3) Conducting continuous quality improvement to test and assess whether modifications improve the cascade.

SOURCE(S): Patel, S.V., et al., 2023.

Systems Analysis and Improvement Approach – Naloxone Example 2 of 2



Interrupted time series of the number of (a) people receiving naloxone and (b) naloxone doses distributed before and after initiating SAIA-Naloxone. The introduction of SAIA-Naloxone is represented by the red vertical line.

SOURCE(S): Patel, S.V., et al., 2023.

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[Slide Image Description: This slide shows a chart detailing outcomes from two syringe service programs.]

The authors subsequently conducted an interrupted time series analysis looking at 52 weeks of data before and 26 weeks of data after initiating SAIA-Naloxone, indicated by the red line. Poisson regression was used to evaluate the association between SAIA-Naloxone and the weekly number of participants receiving naloxone and number of naloxone doses distributed.

The difference? The authors found an average of 105% more naloxone doses distributed per week and 37% more people receiving naloxone. SAIA-Naloxone provided opportunities for syringe service program staff to use data to inform decision making and programmatic modifications.

This was within a harm reduction/SSP context. Even programs established with these principles need to practice continuous quality improvement (CQI) and ensure alignment with best practices. These adjustments were made after process mapping and workflow modifications were implemented, indicated by the red line.

SOURCE(S): Patel, S.V., et al., 2023.

Ideas in Action

- List what you plan to measure from a:
  - Structural Measure
  - Process Measure
  - Outcome Measure
- List what data would you like to have, if resources weren't a problem, to evaluate the services in your county.

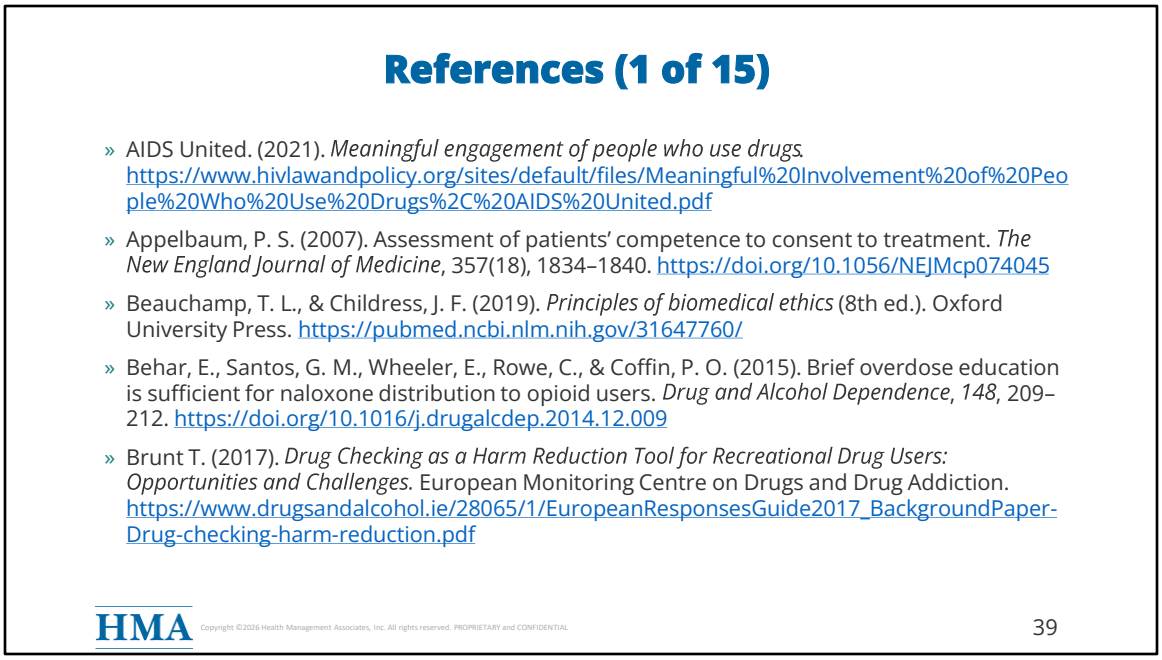
[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow, with people pointing at data on a paper.]

List what you plan to measure from a:
- Structural Measure
- Process Measure
- Outcome Measure

List what data would you like to have, if resources weren't a problem, to evaluate the services in your county.

[Slide Image Description: This slide shows the AFBSS email address.]

We are here to support you and provide you with those opportunities to connect and hear about implementing AFBSS. The website is INSERT and our email address is **info@afbsstraining.org**.



[Slide Image Description: This slide lists webinar references. This is reference slide one of fifteen.]

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[Slide Image Description: This slide lists webinar references. This is reference slide two of fifteen.]

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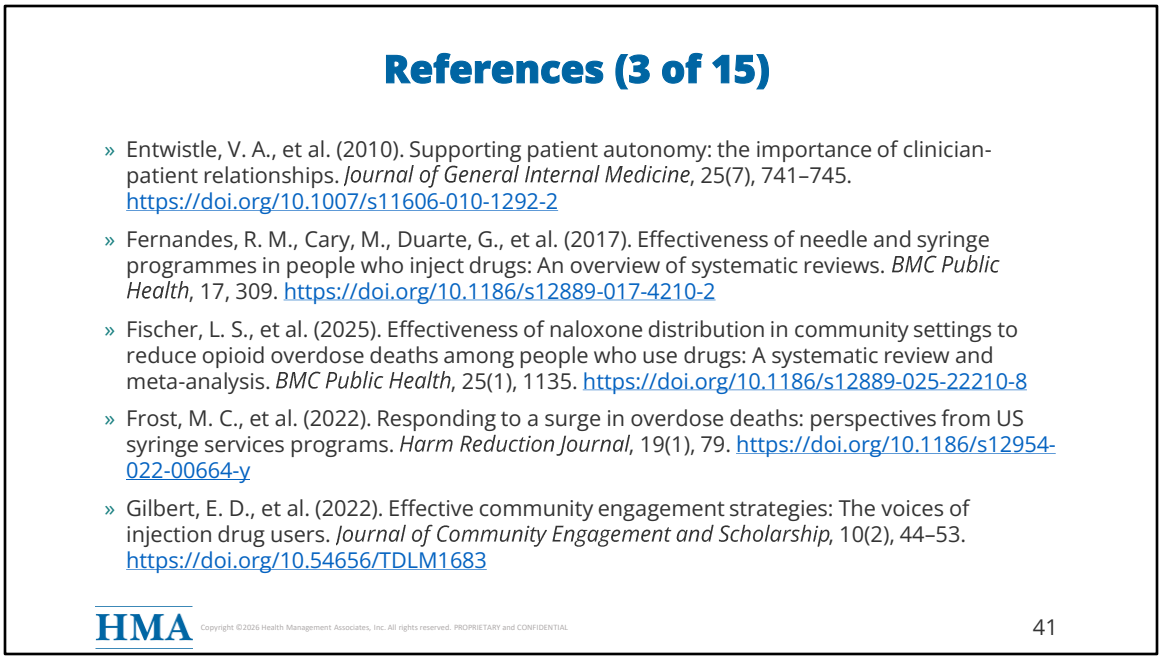

[Slide Image Description: This slide lists webinar references. This is reference slide three of fifteen.]

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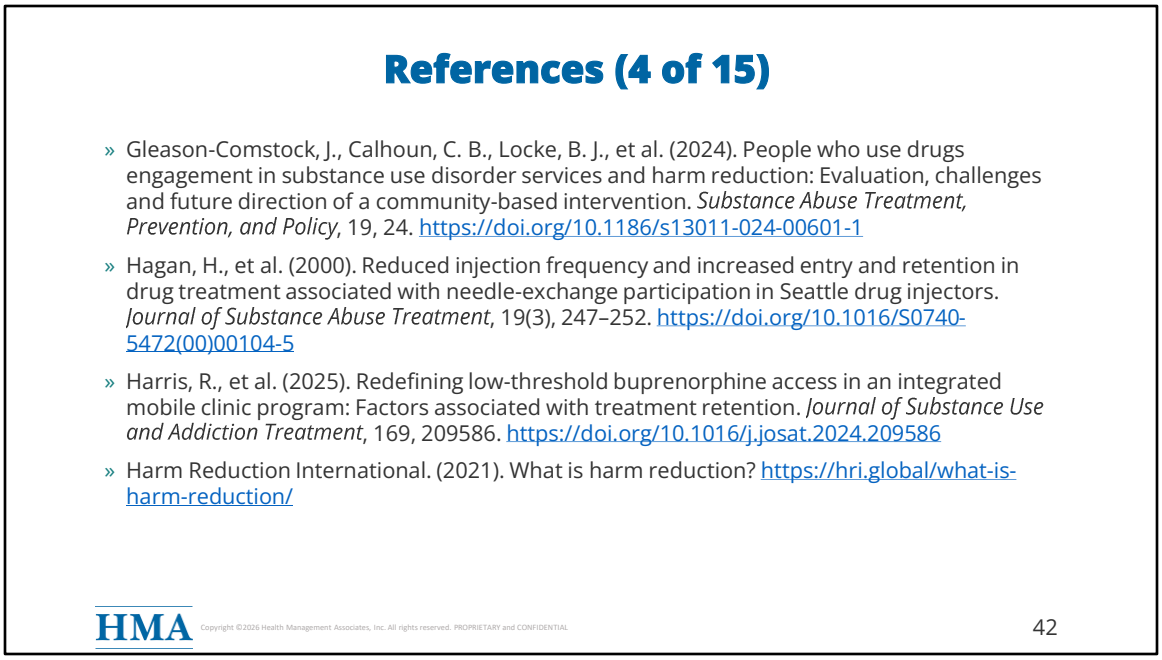

[Slide Image Description: This slide lists webinar references. This is reference slide four of fifteen.]

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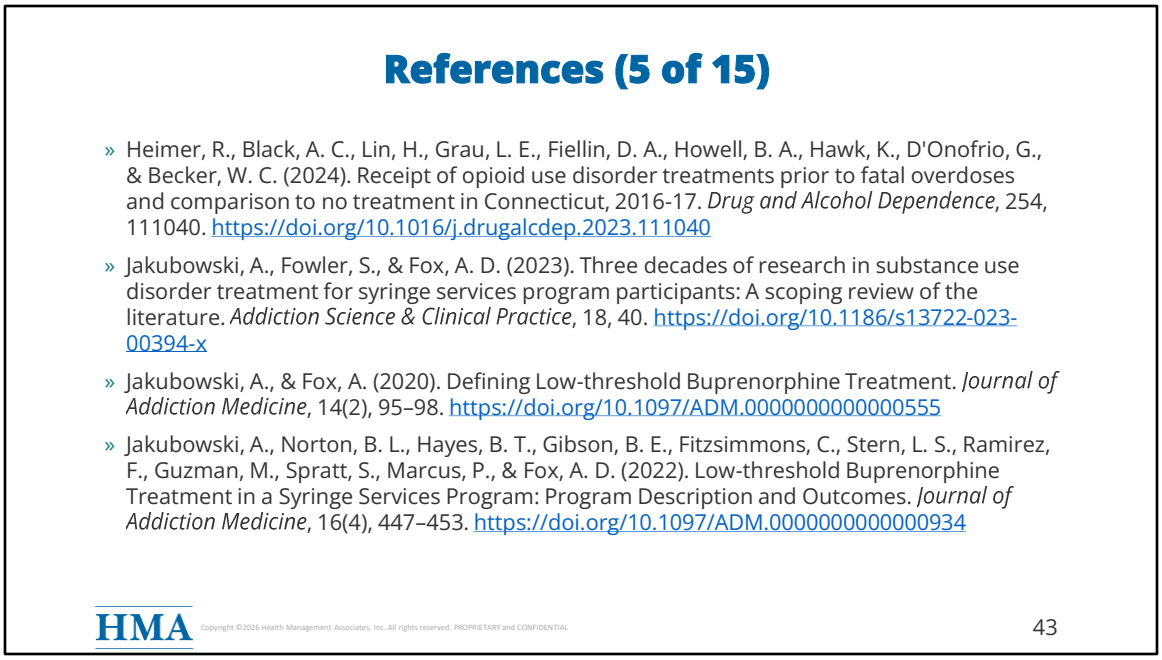

[Slide Image Description: This slide lists webinar references. This is reference slide five of fifteen.]

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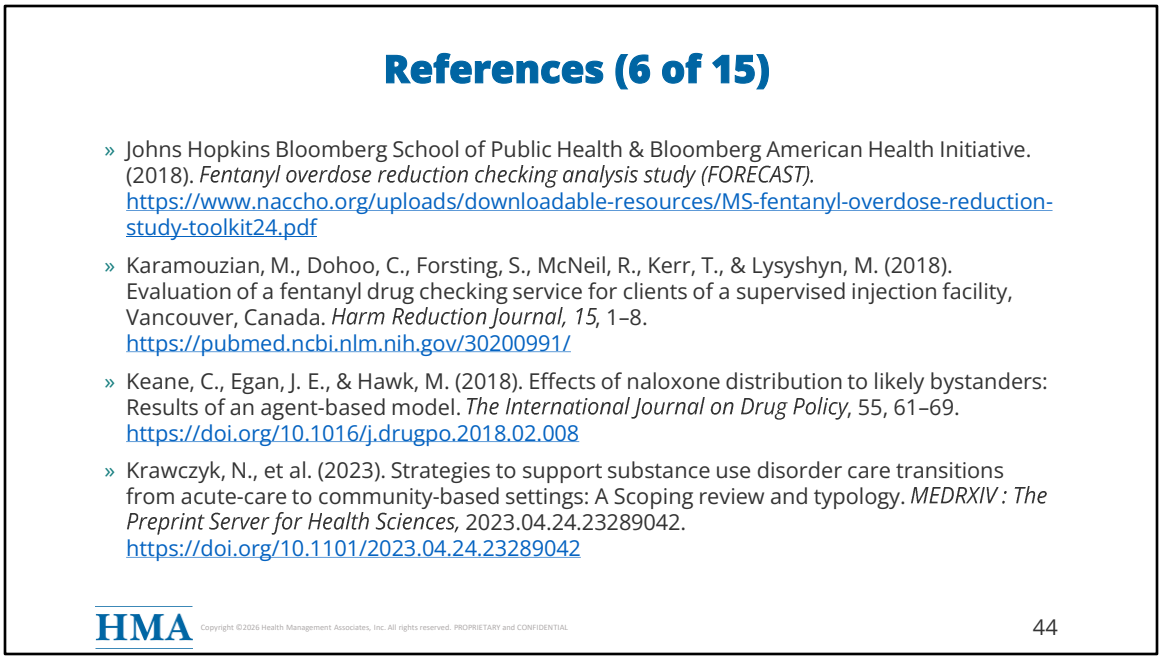

[Slide Image Description: This slide lists webinar references. This is reference slide six of fifteen.]

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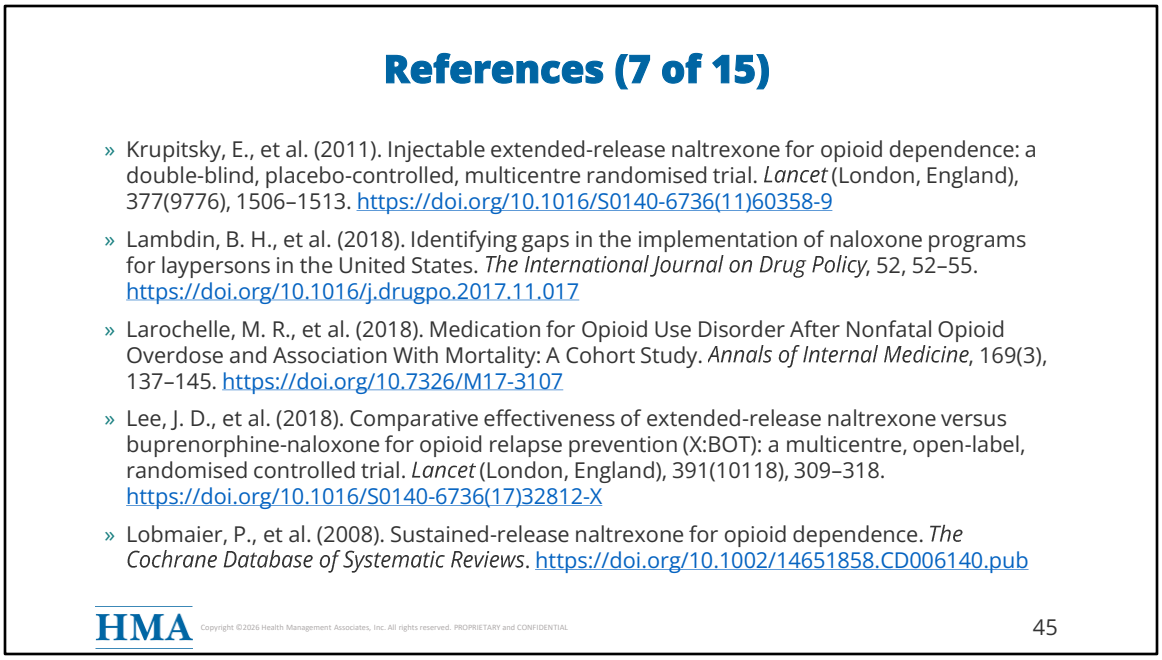

[Slide Image Description: This slide lists webinar references. This is reference slide seven of fifteen.]

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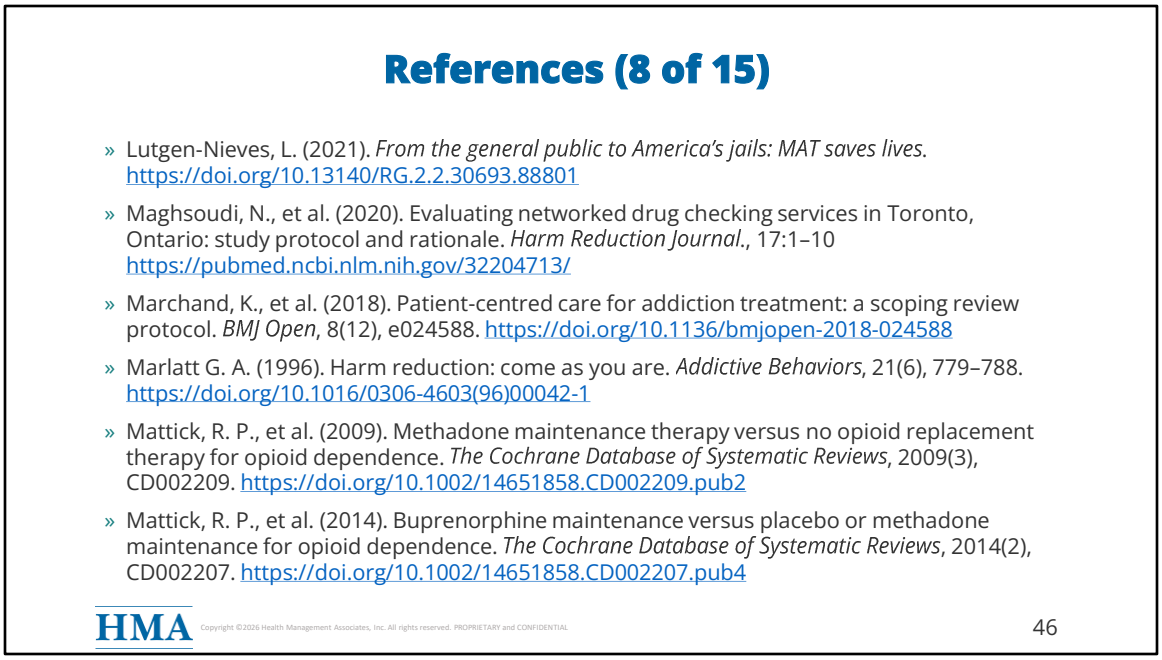

[Slide Image Description: This slide lists webinar references. This is reference slide eight of fifteen.]

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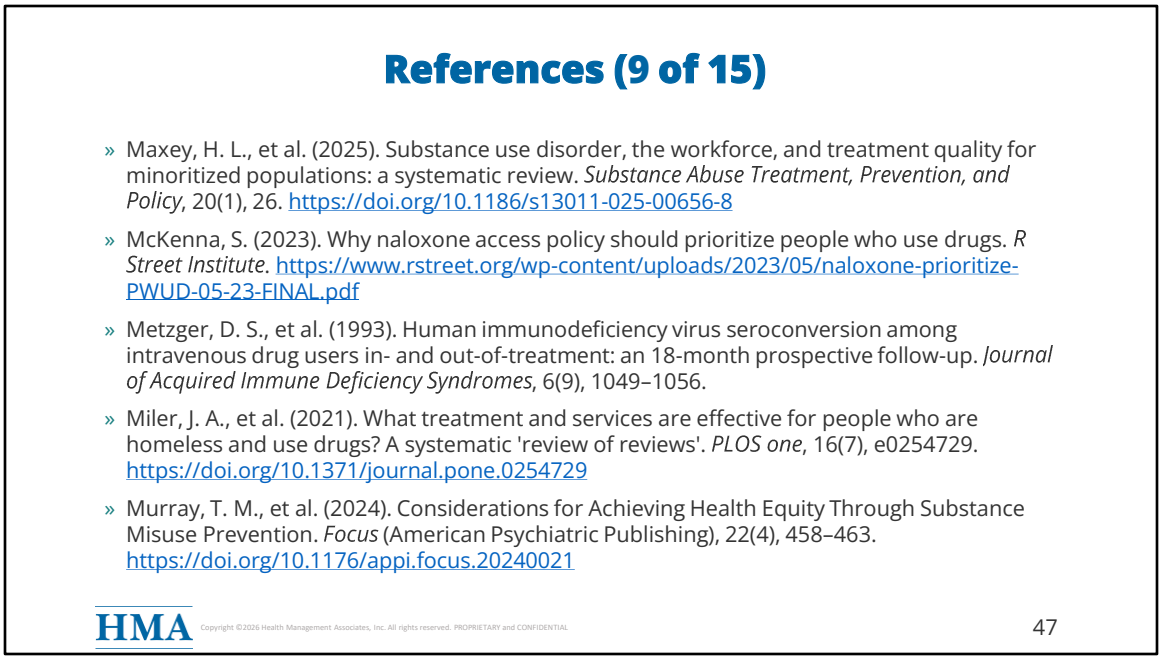

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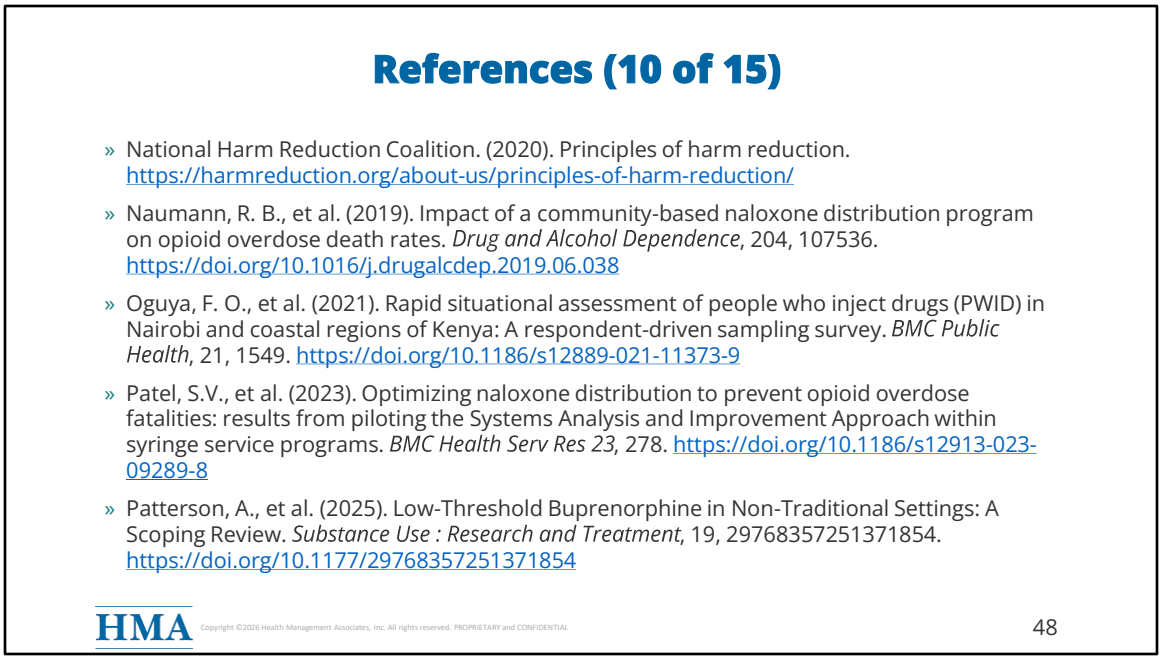

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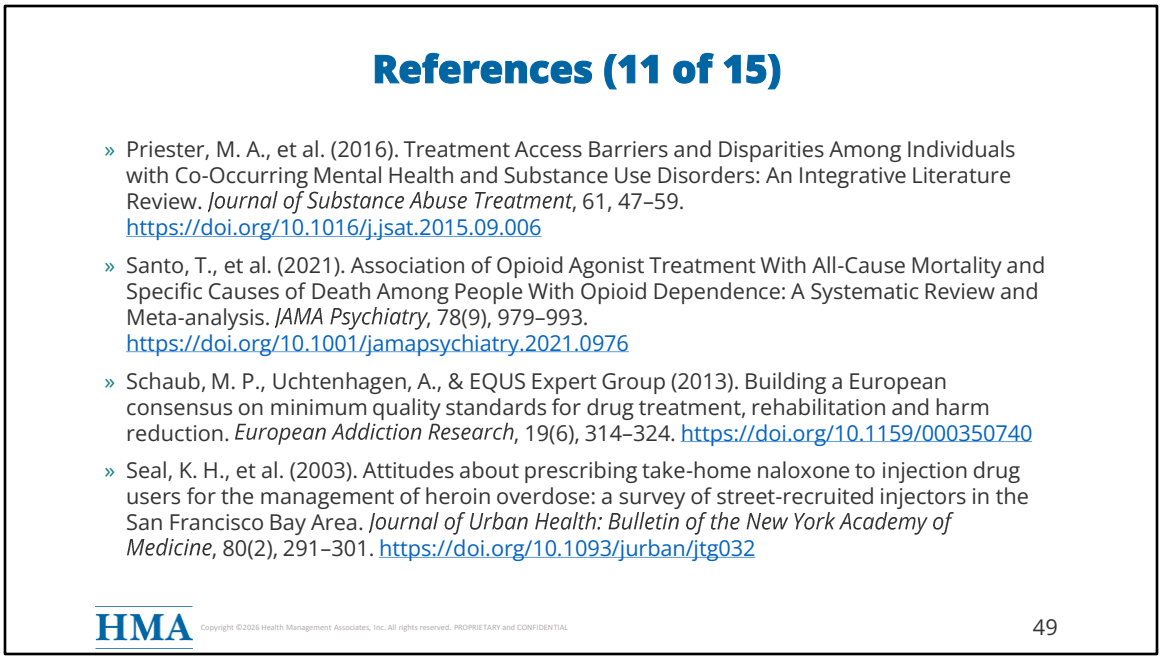

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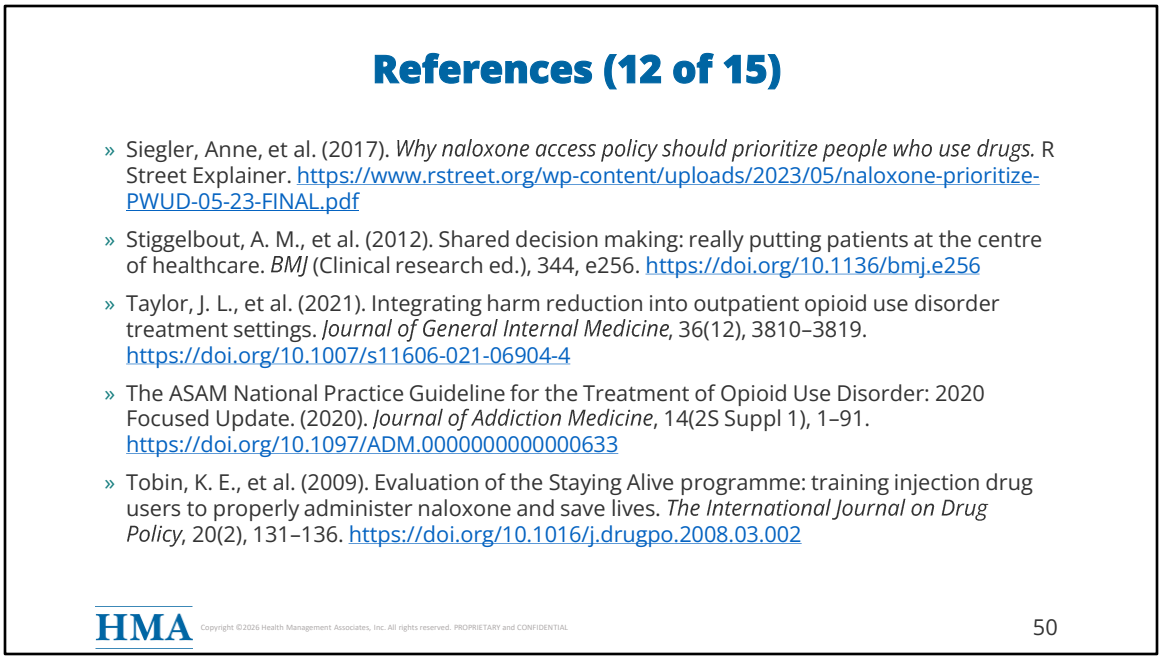

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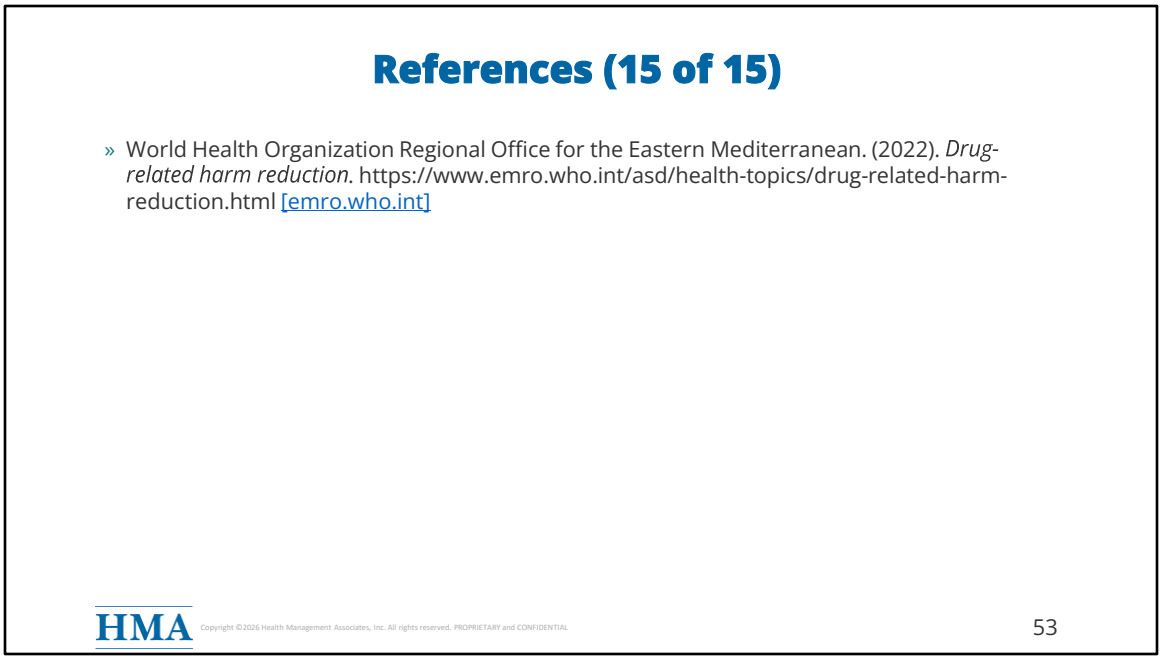

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