North Carolina Safer Syringe Initiative

2017-18 Annual Reporting Summary

State of North Carolina | Department of Health and Human Services
Division of Public Health | Injury and Violence Prevention Branch, Communicable Disease Branch
Spring 2019

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Public Health

Thank you to the NC Division of Public Health's Injury and Violence Prevention Branch and Communicable Disease Branch, and to members of the North Carolina Safe Syringe Initiative workgroup and Advisory Group, for their assistance in the development of this report and their programmatic guidance and leadership.

Please contact the North Carolina Safer Syringe Initiative at SyringeExchangeNC@dhhs.nc.gov for more information.

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Common Acronyms (alphabetical order): **DHHS** – NC Department of Health and Human Services ● **DMH**—NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services ● **DPH** – NC Division of Public Health ● **CD**—Communicable Disease ● **CDB**—NC Communicable Disease Branch ● **ED**—Emergency Department ● **HBV**—Hepatitis B Virus ● **HCV**—Hepatitis C Virus ● **HIV**—Human Immunodeficiency Virus ● **LHD**—Local Health Department ● **IDU**—Injection Drug Use ● IFNC—InjuryFree NC ● **IPRC**—NC Injury Prevention Research Center ● **IVPB**—NC Injury and Violence Prevention Branch ● **MAT** — Medication-Assisted Treatment ● **NCHRC**—NC Harm Reduction Coalition ● **NCSSI**—North Carolina Safer Syringe Initiative ● **OAP**—Opioid Action Plan ● **OPDAAC**—Opioid and Prescription Drug Abuse Advisory Committee ● **PORT**—Post-Overdose Response Team ● **PWID**—People Who Inject Drugs ● **PWUD**—People Who Use Drugs ● **RFA**—Request for Applications ● **SEP**—Syringe Exchange Programs ● **SUD**—Substance Use Disorder ● **UNC**—University of North Carolina at Chapel Hill

2017-2018 Annual Reporting Data Summary

Program Presence and Services

29 Syringe exchange programs participated in 2017-18 annual reporting

39 Syringe exchange programs have registered with the Division of Public Health since July 11, 2016 (state legalization of syringe exchange programs)

8 Syringe exchange programs have ended services or combined with other programs

34 North Carolina counties are actively served by syringe exchange program(s)

69 North Carolina counties have residents served by syringe exchange program(s)

5,352 People received services from a syringe exchange program during the reporting period

3.45 Contacts with a syringe exchange program per participant, average (18,464 total contacts)

34% Increase in program participants from 2016-2017 reporting period

1,587,112 Sterile syringes distributed through syringe exchange programs during the reporting period

37% Increase in syringe distribution from 2016-2017 reporting period

472,409 Used syringes returned to syringe exchange programs for safe disposal (30% return rate). Programs also provide biohazard sharps containers and safe disposal information; data on other methods of safe disposal were not collected.

Naloxone Access and Utilization

19,217 Naloxone kits distributed by syringe exchange programs to people directly impacted by drug use

70% Increase in naloxone distribution from 2016-2017 reporting period

6,195 Referrals to pharmacies, local health departments for naloxone reported by programs

2,660 Overdose reversals reported by participants to syringe exchange programs. Challenges to reporting overdose reversals mean that many reversals occur without documentation.

22% Increase in reported overdose reversals from 2016-2017 reporting period

Treatment and Connections to Care

1,014 Treatment referrals to substance use disorder and mental health services (combined) reported by syringe exchange programs

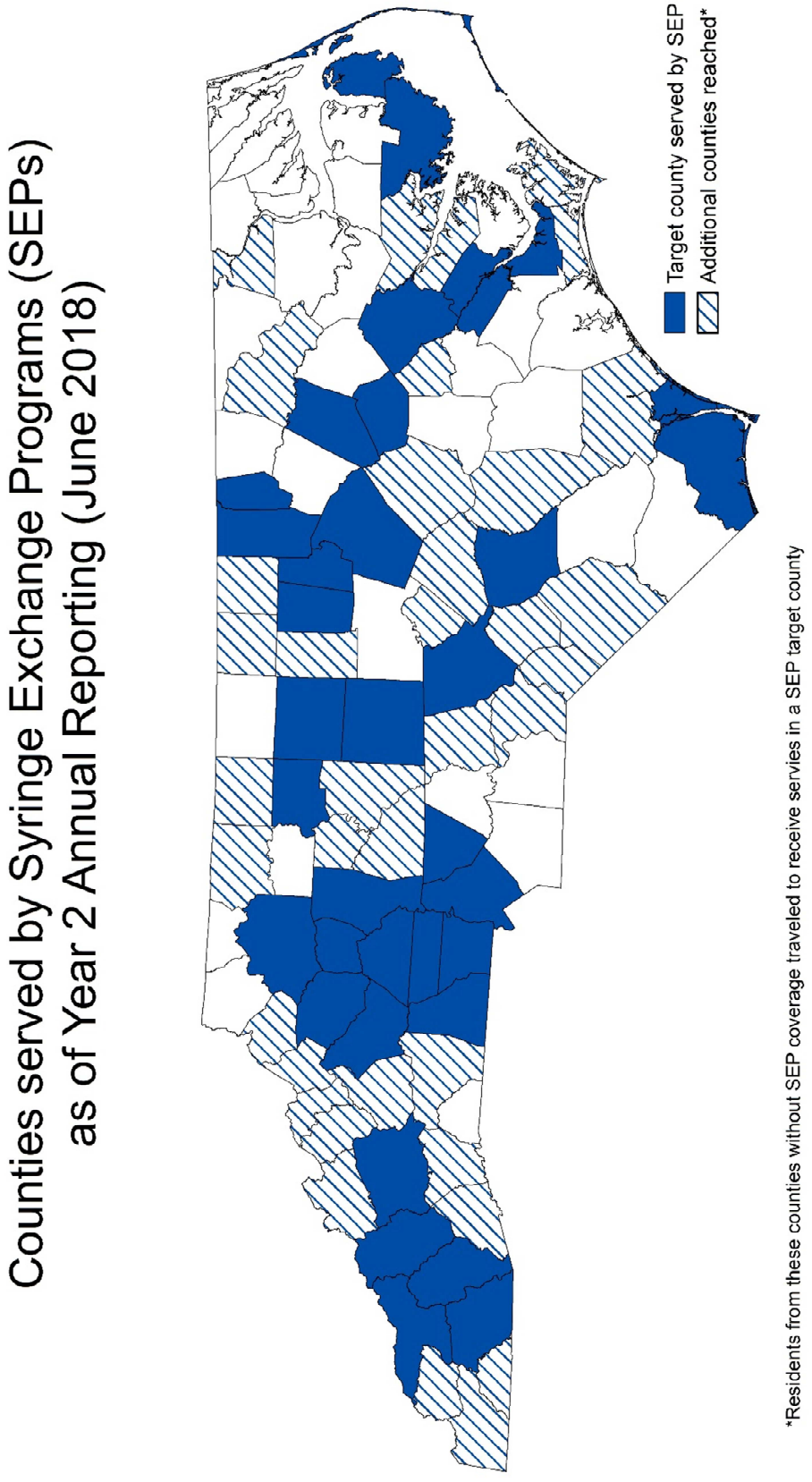
73% Decrease in reported treatment referrals from the last reporting

16 Syringe exchange programs offer HIV and hepatitis C testing. Programs connect participants to confirmatory testing, treatment programs and resources, and share data with the NC Division of Public Health.

3,385 People tested for HIV; 15 people had positive results (0.44% positivity)

1,400 People tested for hepatitis C; 197 people had positive results (14.07% positivity)

Annual Reporting Program Coverage Map



I. Executive Summary

The North Carolina Safer Syringe Initiative (NCSSI), based at the Injury and Violence Prevention Branch (IVPB) of the NC Division of Public Health (DPH), was established to manage program requirements identified in the NC law legalizing syringe exchange programs (SEPs), including registration and annual reporting, and to foster and support best practices for SEPs established and operated in North Carolina.

In North Carolina (NC), as in the United States as a whole, deaths due to medication and drug overdoses have steadily increased since 1999. The vast majority (~90%) of these deaths are unintentional. The overdose crisis is mostly driven by opiates, both prescription and illicit opioids. Since 2012, heroin and synthetic narcotics (including fentanyl and fentanyl analogues) have been increasingly involved in overdose deaths; approximately 80% of unintentional opioid overdose deaths involved illicit opioids in 2017. Movement from opioid medications—which are most likely to be taken orally or snorted nasally—to illicit opioids—which are more likely to be injected—exacerbated the risk of bloodborne disease transmission. In NC, the rates of acute hepatitis B (HBV) and acute hepatitis C (HCV) have increased in the past five years. Newly diagnosed human immunodeficiency virus (HIV) increased between 2015 and 2016 in the state as well.

Increased incidence of injection drug use, driven by the overdose crisis, can lead to sharing and reuse of syringes and injection supplies and the associated spread of bloodborne infections in communities with limited syringe access. Syringe exchange is an evidence-based public health strategy to reduce the spread of infections like HIV and hepatitis C and address health needs of people who inject drugs. SEPs also provide a setting to engage people who use drugs (PWUD) in education and counseling about their health and the health of their communities.

North Carolina legalized SEPs in July 2016 with the enactment of G.S. 90-113.27. The law gives broad guidance for establishing an SEP and outlines core health services SEPs must provide to participants, including: access to syringes and injection supplies at no cost and in quantities sufficient to prevent sharing and reuse (needs-based distribution); secure disposal of syringes and injection supplies; education on overdose prevention, communicable diseases, safer use, and treatment for substance use disorder and mental health conditions; naloxone access (through the SEP or other local source); and referrals to substance use disorder and mental health treatment. The law requires SEPs to register with DPH and submit an annual report that includes data on provided services and impact.

This report summarizes data reported to DPH from registered SEPs actively serving NC communities, DPH data on health conditions associated with injection drug use and the overdose crisis, and recent activities to improve access to and quality of services provided by SEPs in the state.

Updates from 2016-17 Annual Reporting data:

- 8 additional SEPs reported providing services
- 17 more NC counties were served by SEPs
- 3,467 additional contacts between SEPs and participants (18,464 total)
- 432,692 more sterile syringes were distributed in 2017-18
- 70% more naloxone kits were distributed through SEPs
- 17% increase in overdose reversals using naloxone reported to SEPs
- 27% decrease in reported referrals for substance use disorder (SUD) and mental health services[1]

[1] Referrals for SUD and mental health treatment were counted separately in 2016-17 Annual Reporting and may have included duplicates. SEPs reported combined SUD and mental health referrals in 2017-18 Annual Reporting.

NCSSI continued to grow during the second year of implementation of the NC SEP law. During the second year, NCSSI focused on building up and strengthening SEPs and wrap-around infrastructure.

Law Enforcement and Criminal Justice Outreach

Officer awareness of the NC SEP law is critical for building staff and participants' confidence in the law's limited immunity provision, and to ensure that appropriate protections for supply possession are available to program participants, staff, and volunteers.

- Information about SEP legalization and associated protections was included in the 2017-18 NC Justice Academy law enforcement training curriculum, led by the NC Department of Justice.
- The NC Conference of District Attorneys invited NCSSI to contribute an article to their quarterly newsletter, which was published in Spring 2018.
- In October 2018, DPH participated in a statewide forum hosted by the NC Attorney General's office on pre-arrest diversion programs and their integration with related programs, including SEPs.

Faith-Based Outreach

Faith-based SEPs operate in NC and offer unique and culturally relevant perspectives on overdose crisis response efforts and community engagement.

- NCSSI connected with NC Council of Churches staff working on the overdose crisis and participated in a presentation to Council leadership on harm reduction and health services for people who use drugs (PWUD), organized by the Harm Reduction Coalition.
- NCSSI and partners participated in the planning of a conference for faith leaders on responses to the overdose crisis, including SEPs and other harm reduction-based approaches.

SEPs in NC Opioid Action Plan

- Expanding state SEP access was included as a priority in the *NC Opioid Action Plan*, released in June 2017.
- The *NC Opioid Action Plan* calls for the convening of a "group of current and former users and others in recovery to guide Plan components and implementation of strategic actions."
- The Advisory Group was established in 2018 and met five times during the year.
- The first grant funding to include SEP-related funds was released in 2018. NC DHHS granted $1.5 million to twelve projects, including at least two SEPs, under the Opioid Action Plan Implementation Initiative RFA. Funds could not be used to purchase injection supplies but were allowed for other program services and supplies.
- The Division of Mental Health, Development Disabilities, and Substance Abuse Services (DMH/DD/SAS) within NC DHHS purchased 9,864 naloxone kits in 2018, with 3,444 kits distributed to SEPs.

Training and Technical Assistance

A cycle of the *InjuryFree NC Academy* on establishing SEPs and naloxone distribution programs began in October 2017. A total of three trainings were held in Chapel Hill, NC between October 2017 and June 2018. Eight teams, representing eleven counties, participated; two teams began SEP services during the cycle and others have programs in development.

Policy Change

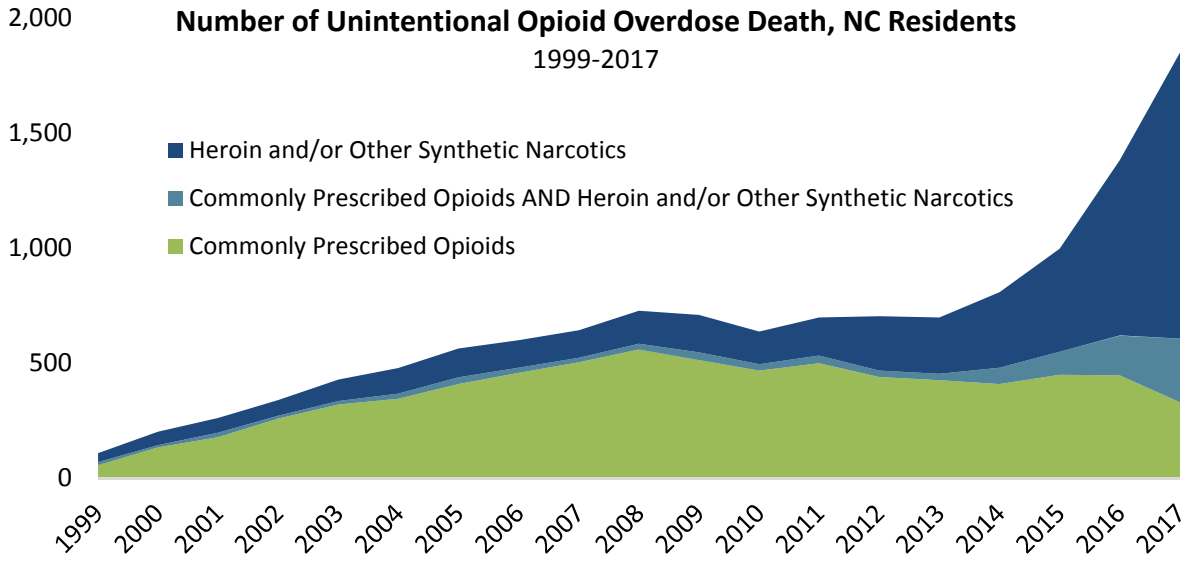
The *STOP* (Strengthen Opioid Misuse Prevention) *Act* of 2017 changed the SEP law's funding language from a prohibition on the use of *all public funds* to a prohibition on the use of *state funds* for the purchase of syringes and injection supplies. SEP leaders report the law change has helped some local communities support SEP services, but regularly express interest in seeing remaining funding barriers lifted to allow partners greater flexibility in supporting and sustaining this important work.

II. Burden of the Overdose Crisis in North Carolina

Prepared by the Injury and Violence Prevention Branch, NC DPH[2]

In NC, as in the United States as a whole, deaths due to medication and drug overdoses have been steadily increasing since 1999, and the vast majority (~90%) of these are unintentional. The epidemic of medication and drug overdose is mostly driven by opiates, both prescription opioids and illicit opioids. Historically, prescription opioids (drugs like hydrocodone, oxycodone, morphine) have contributed to the majority of medication/drug overdose deaths. More recently, other synthetic narcotics (heroin, fentanyl and fentanyl analogues) are resulting in increased deaths. Deaths involving cocaine, benzodiazepines, psychostimulants, alcohol and other drugs are also on the rise.

In 2017, an average of five residents a day died from unintentional opioid overdose in NC Unintentional opioid deaths have increased from just over 100 deaths in 1999 to over 1,880 in 2017. These numbers include deaths from both prescription and illicit opioids.



The statewide outpatient opioid dispensing rate for 2017 was 51 pills per resident. Previous analyses in NC have shown that opioid overdose deaths are more common in counties where more opioids are dispensed.[3] Deaths involving illicit opioids are continuing to increase and are accounting for a larger proportion of the total opioid deaths; in 2017 approximately 80% of opioid overdose deaths involved heroin, fentanyl, and/or a fentanyl analogue.

The number of hospitalizations and emergency department (ED) visits related to opioid overdose also continue to rise. In 2017, there were over 3,300 opioid poisoning hospitalizations and over 7,400 opioid poisoning ED visits; for every one opioid overdose death there were just under two hospitalizations and nearly four ED visits due to opioid overdose.

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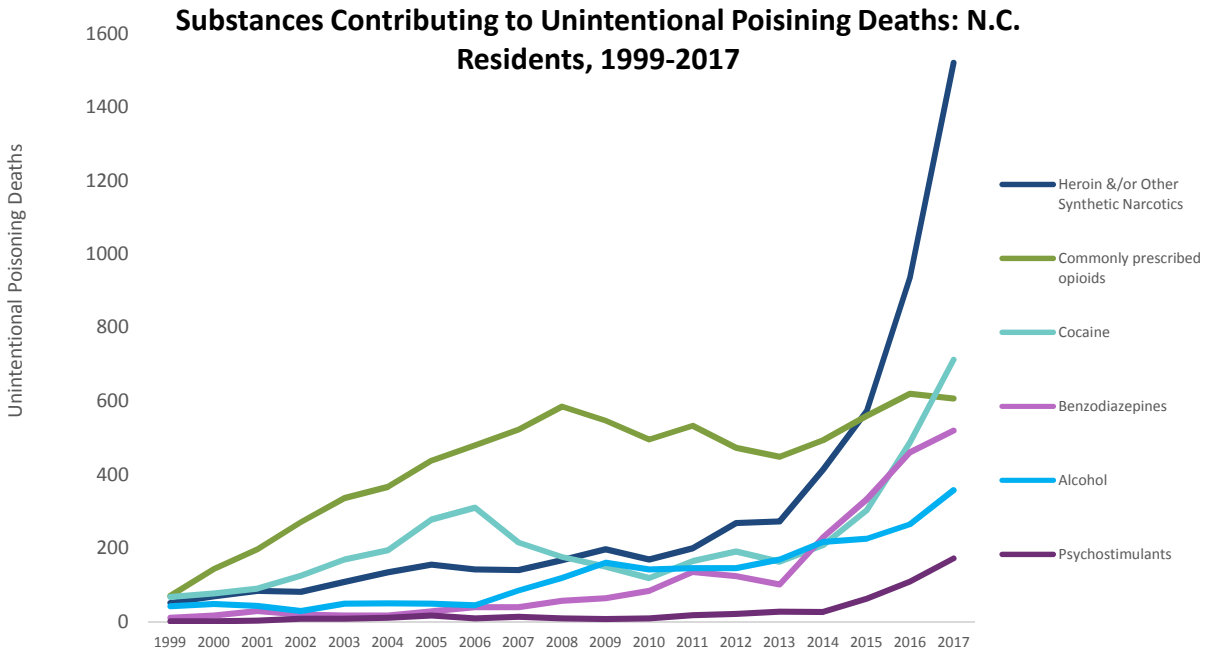
[2] Data collected through the NC State Center for Health Statistics, NC Violent Death Reporting System, Controlled Substances Reporting System, and NC Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT).

[3] Proescholdbell, S. K., Cox, M. E., & Asbun, A. (2017). Death Rates from Unintentional and Undetermined Prescription Opioid Overdoses and Dispensing Rates of Controlled Prescription Opioid Analgesics – 2011-2015. *North Carolina Medical Journal, 78*(2), 142-143. doi:10.18043/ncm.78.2.142

In 2018, NC DHHS launched the Opioid Action Plan Data Dashboard, an integrated tool to track and monitor the epidemic. The dashboard shares aggregate data and statistical analyses of current trends at state, regional, and county levels. In 2019, IVPB will continue with regular data monitoring of opioid-related deaths, hospitalizations, ED visits, and other key metrics. Continued efforts will be made to update and expand the opioid data dashboard, as well as to develop other critical tools for partners at the state and local level.



III. Annual Report Disease Summary

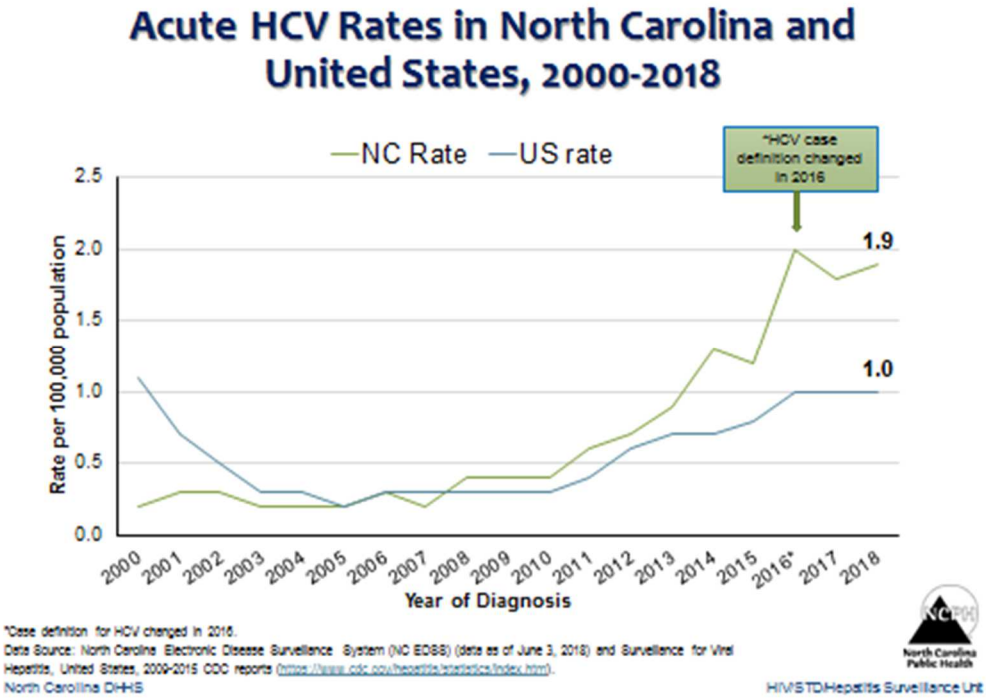
Prepared by the Communicable Disease Branch, NC DPH[4]

In North Carolina, the rates of acute hepatitis B (HBV) and acute hepatitis C (HCV) have increased in the past five years. Newly diagnosed human immunodeficiency virus (HIV) increased between 2015 and 2016 in North Carolina as well. As transmission of these diseases can occur through injection drug use (IDU) practices, it is important to understand the epidemiology of these diseases in the state.

The number of acute HBV cases diagnosed in North Carolina in 2017 was 185, a rate of 1.8 cases per 100,000 population, compared to 94 cases in 2013 (1.4 per 100,000). The highest rates of newly diagnosed acute HBV occurred among the 35 to 44-year-old age group. This age group comprised 35% of the total acute HBV cases. In 2017, acute HBV diagnoses among White/Caucasian men and women comprised 70% of the total acute HBV, at rates of 2.4 and 1.6 per 100,000, respectively. The highest rates of acute HBV in 2016 were among American Indian/Alaska Native women, a rate of 1.6 per 100,000. In 2017, the use of injecting drugs is reported by 33% of people with acute HBV; it is likely underreported. Acute HBV exposure through IDU has also been increasing since 2014 (14% in 2013 to 33% in 2017). The highest rates of acute HBV were among residents living in the western part of NC.

[4] North Carolina HIV/STD/Hepatitis Surveillance Unit. (2018). 2017 North Carolina HIV/STD/Hepatitis Surveillance Report. North Carolina Department of Health and Human Services, Division of Public Health, Communicable Disease Branch. Raleigh, North Carolina.

The number of acute HCV cases diagnosed in North Carolina in 2017 was 186 at a rate of 1.8 cases per 100,000 population, compared to 87 cases in 2013 (0.9 per 100,000). The highest rates of newly diagnosed acute HCV occurred among the 20 to 39-year-old age group. This age group comprised 52% of the total acute HCV cases. In 2017, acute HCV diagnoses among White/Caucasian men and women comprised 79% of the total acute HCV, at rates of 2.3 and 2.2 per 100,000, respectively. The highest rates of acute HCV in 2017 were among American Indian/Alaska Native men and women, a rate of 7.3 per 100,000. In 2017, the use of injecting drugs is reported by 47% of people with acute HCV; it is likely underreported. Acute HCV exposure through IDU has also been increasing since 2013 (34% in 2014 to 47% in 2017). The highest rates of acute HCV were among residents living in the western part of NC.



There were 1,310 new diagnoses of HIV reported among the adult and adolescent (over 13 years old) population, at a rate of 15.9 cases per 100,000 population. This rate is a slight decrease from 2016, where 1,399 persons were newly diagnosed with HIV at a rate of 16.4 per 100,000 population. Men made up the highest proportion of newly diagnosed HIV (N=1,057; 81%) compared to women (N=253;19%). People between 20 and 29 years old had the highest rates of newly diagnosed HIV in 2017, comprising 41% (N=537) of the newly diagnosed population. Black/African Americans represented 65% (N=849) of new diagnoses, with a rate of 45.5 per 100,000. For adults and adolescents newly diagnosed with HIV in 2017, men who report sex with men (MSM), indicated in 64.5% of all cases; heterosexual transmission risk in 29.8%; injection drug use (IDU) in 3.4%, and MSM/IDU in 2.4%. The highest rates of HIV were among residents living in the central part of the state.

Syphilis and gonorrhea rates in NC have also increased since 2014. While these diseases are not generally transmitted through injecting drug use, co-infection with HIV is increasing, and they may spread among people having sex while using drugs. SEPs can be an essential source of condoms, other safer sex supplies, and education and support for harm reduction measures related to sexual activity as well as injecting practices.

In 2018, the Communicable Disease Branch will begin monitoring HBV, HCV, and HIV diagnoses in hospital discharge and emergency department data. Staff will assess endocarditis and sepsis diagnoses in these patients, as these diagnoses are common among injection drug users. The Communicable Disease

Branch will continue with routine data monitoring, including demographics and geographic locations, at the county and state level for these diseases.

IV. NCSSI Priorities: Year Two

By the time of legalization in 2016, SEPs had operated in NC for over a decade. Directly impacted people established early exchanges in response to unmet community needs. DPH collaborates with formerly underground SEPs to benefit from their knowledge, experience, and infrastructure. Long-running exchanges, experienced in serving participants and accustomed to operating without governmental support or oversight, readily offered advice and informed state priorities following legalization. This dynamic—unique among states that have recently legalized SEP—requires regular communication, transparency, and clearly defined goals.

Year two of the NC Safe Syringe Initiative has seen growth and expansion of SEPs. Concurrent and environmental changes have facilitated program adoption and progress. The statewide *Opioid Action Plan* (OAP), adopted in 2017 through 2021, includes SEPs as a local response strategy to increase access to naloxone and other preventative health services. SEP operation also supports other areas of the plan—including health system care linkages, post-overdose reversal response, tailored services for pregnant women and justice-involved people, Law Enforcement-Assisted Diversion (LEAD, and other pre-arrest diversion [PAD] programs), and SUD treatment access and community-based recovery support—by expanding harm reduction infrastructure and encouraging critical relationships between medical and social service providers.

Legalization has also required increased group knowledge of drug user health and behaviors, informing response to the overdose crisis. Progression of the overdose crisis and changes in drug type and route of administration highlighted the need for subject matter expertise in and general familiarity with drug administration practices, health behaviors, and care-seeking and service navigation among PWUD. SEP legalization helped facilitate the greater and more consistent participation of SEP leaders in state-convened work; changes in NC drug use and overdose trends positioned them as sources of vital knowledge and representatives of people in active use. SEP leaders and staff participate regularly in OPDAAC and OPDAAC Coordinating meetings. Seeing the state's new responsibilities under legalization, program staff also recognized the value in self-representation and direct participation.

DPH anticipated that, after an initial rush of new programs following legalization, future programs would emerge more gradually and potentially require more comprehensive technical assistance. This prompted two areas of work during the second year of legalization: building up and strengthening early, existing programs, and expanding technical assistance and program development support.

Building Up Existing Programs

For exchanges operating before July 2016 and those established immediately following legalization, funding and resources to sustainably expand services are more urgent needs than foundational technical assistance. Service demand increases as the scope of the overdose crisis grows. Legalization also brought underground exchanges "into the light," increasing visibility and participant comfort accessing services. This also drives demand, and formerly underground exchanges—particularly grassroots programs—require their own support and partnership to weather these changes. Because of the variation and experience among well-established programs, supports and interventions that programs can tailor or draw from as needed, rather than prescriptive program development, are most promising. Funding opportunities available through or supported by DPH have aimed to give SEPs flexibility in funds use. Given NC's unique program diversity, experience, and reach, DPH should encourage creative channels and settings

for engaging with PWUD. This is also advantageous for newer programs, by helping them to develop unique partnerships in their communities to support program growth and sustainability over time.

The NC Opioid Action Plan Implementation Initiative RFA allowed local communities, public and private organizations, and health systems to propose projects to support implementation of the OAP. The Action Plan's broad scope prompted a wide variety of project proposals. Of the 18 applicants awarded funding, at least two pursued SEP-based projects, and others proposed related or wrap-around services like PORTs. The period for this funding is Spring 2018 through Summer 2019.

When available, grant spend-downs and stand-alone funds have been used to purchase naloxone kits for distribution through SEPs. DMH/DD/SAS purchased 9,864 naloxone kits in 2018, with 3,444 earmarked for SEPs. Even kits not earmarked for SEPs can alleviate demand from partner agencies and the broader community, ensuring that SEP-specific kits are available for people most likely to be able to respond in the event of an opioid overdose—fellow drug users.

In addition to disease prevention functions, SEPs offer an uncommonly direct channel for connecting with people in active use who may not otherwise be reached by hospitals, health systems, and SUD treatment providers. Building up existing programs promotes program sustainability and further dedicates space for connecting with underserved populations. As the scope of the crisis evolves, focusing on social determinants of health—the overarching social systems that dictate which groups are most at risk of infection and overdose—rather than introducing interventions for each new trend, is a promising approach. By developing relationships with participants; proactively shaping and adapting programs; and advocating for healthcare in addition to social supports, housing access, and employment opportunities for PWUD, SEPs are critical partners in identifying potential social determinants-focused areas of work and ensuring that these opportunities are available and accessible to people in active use. Timely funding of SEPs supports short-term priority areas and long-term prevention efforts.

Tailoring Technical Assistance

Following legalization, DPH needed to provide broad education, awareness, and preliminary program guidance. NCSSI also had to establish program roles, expectations, and internal protocols to manage and direct SEP-related work. Developing technical assistance to best respond to programs' needs and assets is and will remain an ongoing priority.

> *InjuryFree NC Prescription Drug Overdose Academy: Establishing Syringe Exchange and Naloxone Distribution Programs (2017-18)*

The InjuryFree NC Academy is a workforce development training model developed by IVPB and the Injury Prevention Research Center (IPRC) at UNC. Previous cycles of the Academy addressed priority areas of work within the injury and violence prevention field, including suicide prevention, community violence prevention, and adoption of shared risk and protective factor frameworks. The 2017-18 Academy on establishing syringe exchange and naloxone distribution programs consisted of three training sessions, held in October 2017 (two days), February 2018 (two days), and June 2018 (one day). Eight teams participated, representing a total of eleven counties. A local health department staff member helmed each team, and all were required to include at least one member of a local law enforcement agency. This set-up was intended to ensure that public health and law enforcement agencies would be following each program's development concurrently and preparing for its implementation and operation.

The Academy curriculum included presentations on the history of harm reduction and harm reduction-based health services; the current overdose crisis and its health impacts, including surveillance tools and data access; exchange program models and best practices; NC perspectives on response efforts and

program operation, including requirements set out in the SEP law; and cultural humility, outreach practices, motivational interviewing, and other skills critical for positively and proactively connecting with PWUD. The Academy also included panels and guest speakers, including staff of actively operating SEPs; people with lived experience of drug use, incarceration, homelessness, and sex work; leadership and staff from related medical and social service agencies, including LHDs, health systems and SUD treatment providers, faith community, and first responders; policy experts; and epidemiologists and researchers. Information was presented lecture-style and through activities and skills-based practice. Between Academy sessions, teams identified action steps and completed preparatory work, and had access to coaches and subject matter experts.

Two teams' SEPs began operating during the Academy cycle. Others are in development or have channeled their Academy work into supporting other health services for PWUD in their counties. Teams have also benefitted from OAP Implementation Initiative and IVPB-directed funding.

NC SEP Establishment and Operations Toolkit

The curriculum and resources developed for the SEP Academy covers history and context, community assessment for priority services, budget and supply management tools, staff skills, and operations and sustainability guidance. Following the Academy, NCSSI and IVPB staff began reorganizing Academy materials to be developed into a toolkit-style resource on SEP establishment and operations in NC Among states that have recently legalized SEP, releasing a state toolkit or comprehensive guidance document to introduce the law, any associated legal protections, program requirements and restrictions, and other associated policies and resources is common. NC accomplishes many of these goals through community education, strategic partnerships, program reports (like the annual reporting summary), and dedicated technical assistance. However, the nature of the NC SEP law—allowing for the establishment of SEPs through a variety of public and private agencies and organizations—means that new programs typically seek both general knowledge and tailored guidance during their development. This differs from other states, where a limited set of program protocols—guidance for introducing syringe access through solely LHDs, or through AIDS service organizations—might sufficiently allow for SEP implementation. Creation of a toolkit specific to NC is therefore most important for providing a general introduction to SEP history, evidence base, and best practices for establishment, operations, and sustainability. NCSSI staff time can then be most efficiently and effectively used to provide one-on-one technical assistance on specific topics or regarding circumstances unique to each program.

NCSSI conducted interviews with SEP Academy participants following the final session on their experiences with the Academy materials and recommendations for toolkit components. Academy participants represented a sample of typical staff involved with establishing health department-involved SEPs, and provided helpful perspectives on introduction to and navigation through the SEP establishment process and orientation to provision of PWUD health services. NCSSI also interviewed leaders and staff of active SEPs and key partners within DHHS to collect their recommendations and guidance. The first draft of the toolkit was completed in summer 2018 and presented to members of the NCSSI workgroup. The completed resource is expected in 2019 or early 2020.

New Projects, Engagement, and Partnerships

New partnerships continue to emerge between NCSSI and allied organizations within NC and in other states and jurisdictions. By pursuing opportunities for collaboration, NCSSI seeks to elevate issues important and relevant to SEP participants and staff, facilitate connections to support SEP operation and sustainability, and share promising strategies and guidance recommendations gained through NC's experience.

NCSSI was able to support the DPH Communicable Disease Branch's (CDB) efforts responding to hepatitis A (HAV) cases in central NC during 2018. Populations at risk of HAV infection included people using drugs, people experiencing homelessness, and men who have sex with men. NCSSI contributed input on response strategies, reaching PWUD and people experiencing homelessness, and co-located services. NCSSI notified regional SEPs of the outbreak, helped to distribute guidance and resource information, and was able to work with a local SEP to guide work. Participating in CDB's response team offered an opportunity to learn from DPH partners and connect with related agencies, including the NC Coalition to End Homelessness and state Veterans Health Administration facilities.

Analysis of state death data revealed that unintentional overdose death rates among American Indians are as high or higher than those among all other races/ethnicities for almost all drug types, including commonly prescribed opioids, synthetic narcotics including fentanyl, and cocaine. Trends in NC from 2000 through 2016 also show that unintentional overdose deaths from all types of drugs dramatically increased among American Indians. As the IVPB Epidemiology Unit collected and analyzed data, NCSSI offered support to efforts by the Eastern Band of Cherokee Indians to establish a SEP through the Tsalagi Public Health system. The Tsalagi Public Health SEP began operating in Winter 2018, serving residents of the Qualla boundary and surrounding counties. IVPB worked with the Communicable Disease Branch to present data on overdose and acute hepatitis infection among American Indians, representing two primary health issues associated with unsafe use practices. In preparing its analyses for publication, authors also worked with Tsalagi staff to prepare a summary of their work to include as an example of community-driven response to the overdose crisis. The North Carolina Medical Journal accepted that article, Overdose Deaths and Acute Hepatitis Infections among American Indians in North Carolina, for publication in 2019.

The 2017 Opioid Action Plan includes as a key strategy creation of an advisory group representing people with lived experience of drug use and SUD. This group is intended to inform work conducted through OPDAAC and other state-led partnerships and to provide feedback on projects and strategies informed by both personal and professional experience. Planning meetings for this group began in June 2018 and have continued monthly. The current form consists primarily of SEP leaders and staff, typically those with lived experience; IVPB staff and colleagues from DMH/DD/SAS; and key community partners. The group is providing guidance on ongoing NCSSI work, including identifying activities under the Crisis NOFO and guiding execution of funded projects, while refining its form and function.

NCSSI submitted an abstract to the 2018 Harm Reduction Conference, which was accepted for presentation in New Orleans in October 2018. The presentation, "Syringe Exchange Legalization and Harm Reduction Partnership in North Carolina: Experiences and Best Practices," provided an opportunity to connect with colleagues in states exploring SEP legalization and those interested in learning from NC's experience. NCSSI was invited to participate in an educational event at the Iowa state legislature, organized by the Iowa Harm Reduction Coalition. Staff will also participate in a panel at the Southern Regional SSP (Syringe Services Program) and Drug User Health Institute, organized by NASTAD (National Association of State and Territorial AIDS Directors). The lessons learned through implementation of the NC SEP law can be instructive to organizations and agencies within NC and to other states and jurisdictions. NC in turn is informed by others' approaches and experiences in this evolving and expanding field. Notably among peer states, however, NC is unusually constrained: it is the only state to legalize SEPs with a prohibition on the use of state funds for program supplies in place.

CD Program Updates

Prepared by the Communicable Disease Branch, NC DPH

The following updates were prepared and contributed by the Viral Hepatitis Program at the Communicable Disease Branch. For more information on Communicable Disease's programs and

services to protect the health of people who inject drugs and others at risk of infection, please contact program manager Christie Caputo at christina.caputo@dhhs.nc.gov.

- Beginning 2017, all health departments in NC are able to offer risk-based, no-cost HCV testing to uninsured individuals through the State Laboratory of Public Health (SLPH). In 2017, 21,437 (21% positivity) hepatitis C RNA tests were completed at SLPH.
- As of September 2017, SLPH will be offering risk based HBV screening to uninsured individuals in NCALHD regions 1-3 and 8.
- Beginning in December 2017, a pilot project supports pre-treatment labs as a resource in select counties. Please contact the Program for more information on this funding.
- Beginning November 1, 2017, there is *no longer a fibrosis requirement to receive HCV treatment coverage through Medicaid*. This is a welcome change from the previous treatment coverage requirement of a liver fibrosis score of F2 or greater.
- October 3-5, 2017, NC Hepatitis Program hosted a multistate hepatitis C summit to discuss common barriers, and share best practices.
- Rapid HCV testing and training is available through the HIV Prevention Program. To find out more information and to enroll please contact Marti Eisenberg, Integrated Targeted Testing Services Coordinator, at marti.eisenberg@dhhs.nc.gov.
- The North Carolina Hepatitis Program now distributes harm reduction kits to those in need. Since the beginning of 2018, over 1,500 harm reduction kits and additional supplies were distributed.
- The North Carolina Hepatitis Program is currently working in collaboration with the hepatitis A team to address the growing outbreak of hepatitis A in North Carolina. This team is working closely with IVPB and NCSSI to guide community based organizations and other groups working with PWUD in methods of hepatitis A prevention.

Hepatitis Program Updates

- Three Hepatitis C Bridge Counselors established in NCALHD regions 1, 2 and 8 (home counties for bridge counselors are Jackson, Buncombe, and New Hanover).
- One State Hepatitis Bridge Counselor established for Jail and Prison Linkage to Care Pilot Projects
- The North Carolina Hepatitis Academic Mentorship Program (CHAMP): This academic mentorship program is a partnership between CDB, UNC, and Duke University to help train primary care providers to treat for hepatitis C. CHAMP enrollees must commit to attending one all day intensive boot camp, and twice monthly calls for one year. Providers are able to start treating patients as soon as they feel comfortable and their clinic is set up to receive patients.
- Since its start in October 2016, four boot camps and call cohorts have been completed. Over 85 providers have completed boot camp, ranging as far west as Cherokee County to as far east as Dare County. In addition, two hepatitis C clinic capacity-building workshops, held by Dr. Richard Moore III, were completed in 2018 to help support and guide new providers in building the infrastructure to maintain a hepatitis C clinic in their practice.
- Preliminarily, within the first year of the first cohort of CHAMP providers: 7,500 patients were screened for hepatitis C; 552 patients were identified as hepatitis C positive; 350 were linked to treatment; and 112 patients achieved cure. CDB anticipates these numbers to grow as the program continues.

V. 2017-18 Annual Reporting Process and Data

The NC SEP law requires active programs to participate in annual reporting of program information and data to DPH. For more information about annual reporting, please see the 2016-17 Annual Reporting Summary.

Prior to the first year of reporting, NCSSI's approach was to keep the process and information collected as basic as possible. The process remained largely the same for the 2017-18 reporting period, with the addition of two key questions. Again there was good participation and few complications.

Manually exporting data from completed 2017 annual reporting forms delayed synthesis and analysis. In advance of the 2018 reporting period, NCSSI redeveloped the reporting form to enable automated data extraction following form submission. During form redevelopment, questions were reexamined and, based on how the question was interpreted and what information was provided in 2017-18, reworded or adjusted as needed. The first year, NSSI asked programs to report in which counties their programs were active. Some programs collect information on participant county of residence and responded with this information in addition to the counties where the program itself maintains a service presence. To best capture this information, the second version of the annual reporting form included response options for "county of operation" and "counties with residents served." This allows the programs to demonstrate program reach and travel distances for services and to identify counties or regions markedly underserved by syringe access services.

The second version of the form also includes expanded responses about types of distributed safer use and health supplies. Following the 2016-17 reporting period, NC was asked to participate in a CDC Morbidity and Mortality Weekly Report (MMWR). The report, Access to Syringe Services Programs — Kentucky, North Carolina, and West Virginia, 2013–2017, collects and compares SEP reporting data from three states. North Carolina was the only participating state not to formally collect information about supply distribution and demand. The SEP law specifies that DPH must collect data on the number of "injection supplies" distributed by and returned for disposal to SEPs. NCSSI adhered to the language in the law for the first reporting form. However, this produced combined figures that could not be well analyzed or interpreted. To better evaluate NC programs and impact, NCSSI restructured questions about distributed supplies. Typical program supplies are included in the table below; fill-in responses are included in the open-text section.

Both of the substantially reformatted questions—counties served and supplies distributed—were reviewed by SEP staff for availability of information, wording, and ease of instruction prior to inclusion in the annual reporting form. Programs are not required to collect county of residence information or itemized supply counts.

Finally, the revised form includes an expanded introduction to provide background on the SEP law, the annual reporting process, and navigating the reporting form. It also contains program operations guidance that was distributed by email in 2017, making this information—about security plan updates and redistribution and law enforcement awareness of the SEP law—regularly accessible through the form in addition to email reminders.

2017-18 Annual Reporting Process

NCSSI began notifying active SEPs about the upcoming annual reporting process in June 2017. There were some clarification questions leading up to the July 31 deadline, but distributed information and experience from the previous year seem to have been effective in preparing the programs. Again a minority of programs required direct follow-up at the deadline or subjected their forms late. Upon follow-

up, one program indicated that they were no longer active, and thus would not be submitting a form. NCSSI was unable to reach identified contacts from a second program in July and August and, assuming that the program was no longer operating, removed it from the list of active programs.

2017-18 Annual Reporting Data and Figures

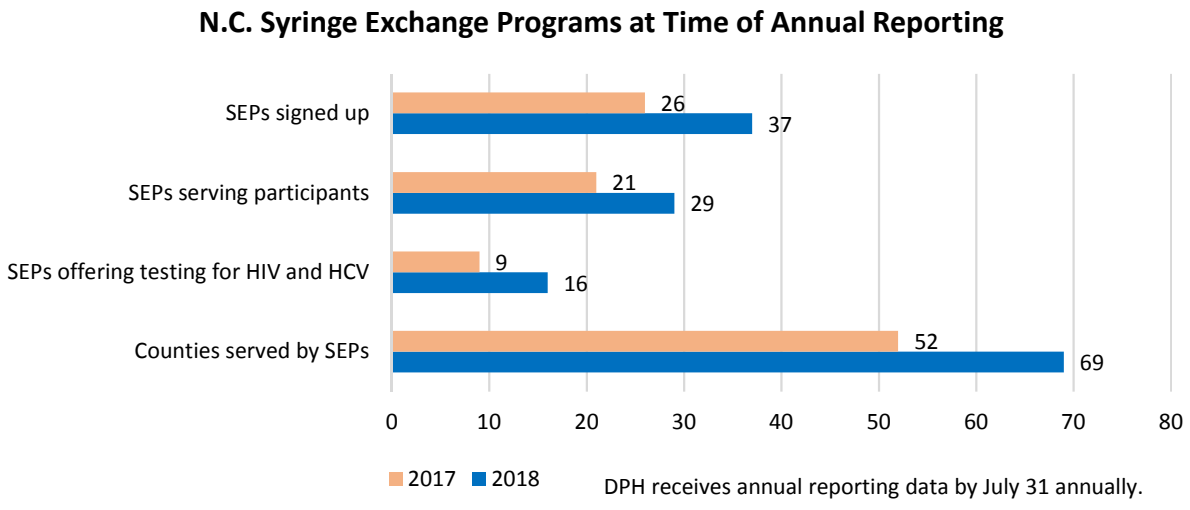
Active programs	29
Connections	
Unique participants	5,352
Total contacts	18,464
Syringes and Safer Use Supplies	
Syringes distributed	1,587,112
Syringes collected for disposal	472,409
Cookers	118,131
Cottons, filters	925,095
Tourniquets	58,536
Sterile water	24,372
Sharps containers	8,257
Acidifiers (breakdown)	634
Fentanyl test strips	5,000
Alcohol wipes or swabs	312,273
Other wound care (bandages, gauze)	12,947
External (male) condoms	34,194
Internal (female) condoms	185
Lubricant	3,472
Menstrual hygiene supplies	15
General hygiene supplies	2,061
Supplies collected for disposal	16,289
Naloxone	
Naloxone kits distributed	19,217
Referrals to other sources for naloxone kits	6,195
Overdose reversals reported	2,660
Testing and Referrals	
SUD and mental health treatment referrals	1,014
SEPs with HIV testing capacity	16
Individuals tested for HIV	~3,385
Positive HIV tests	15 (0.44% positive)
SEPs with HCV testing capacity	16
Individuals tested for HCV	~1,400
Positive HCV tests	197 (14.07% positive)

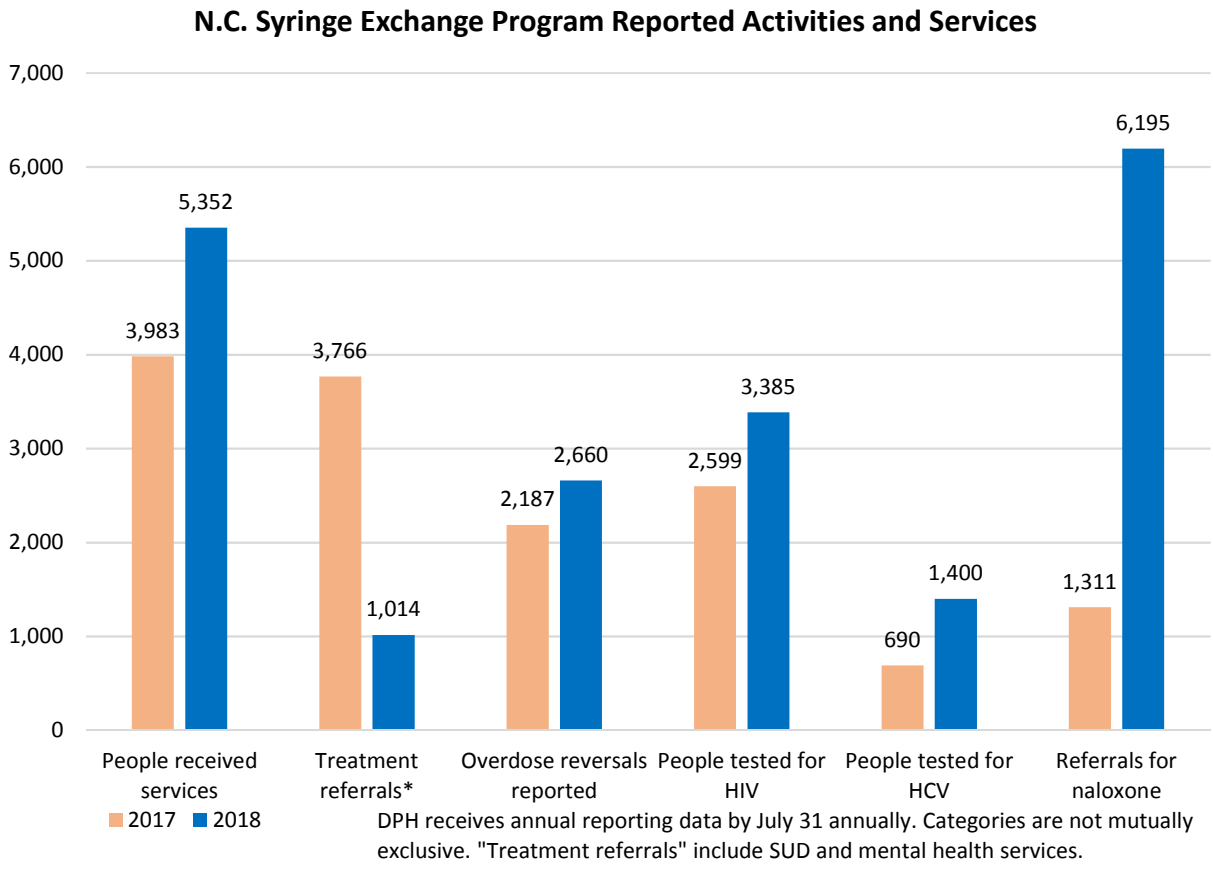
The annual reporting form also includes an open-text section for sharing additional information about program operations, including feedback from participants and staff, community relations, and requests for technical assistance. Open-text responses addressed the following areas:

- Program start dates, time range of reported, data stages of development, participant reach
- Relationships and dynamics (positive and negative) with community agencies and organizations, including law enforcement, local health departments, and district attorney's offices
- Challenges of tracking and reporting returned supplies

- Requests for technical assistance to implement program evaluation tools
- Challenges of limited program availability and limited funding channels
- Details and clarifications about supply reporting
- Program successes, including finding a MAT program for a pregnant participant so she could receive prenatal care; support group and care navigation for people living with hepatitis C; adaptive services and expanded supply provision; recovery support; distribution and collection of sharps containers for officers' patrol cars; development of a sex worker organizing program and drug user advocacy;
- Reports of law enforcement officers taking, ripping up, or otherwise invalidating participants' ID cards or written verification
- Support and guidance received from community partners and other harm reduction organizations
- Participation of directly impacted people in program development
- Services provided by the SEP to the community at large
- Program access to HIV and HCV testing materials, referral networks for connections to confirmatory testing and care
- Barriers to returning used syringes to the SEP for secure disposal, including lack of transportation, fear of law enforcement encounters, and lack of confidence in the limited immunity provision
- Recommendation for installation of community-based syringe collection kiosks or drop boxes to increase access to safe disposal services
- Concerns about research being conducted in the SEP's area of service involve program participants without the SEP's knowledge
- Plan for redistributing security plan (required annually)
- Other distributed supplies reported by SEPs: hand sanitizer, safer sex supplies, aloe cream, latex gloves, antibacterial ointment, storage bags, paper bags, lip balm, educational materials

Following the 2016-17 and 2017-18 annual reporting periods, NCSSI sent emails to LHD directors with information about SEPs active in their counties and/or serving county residents, if that information was available. This outreach has been useful for encouraging program awareness, supporting referrals to SEP services, notifying local jurisdictions of SEP presence, and asking for support from LHDs in educating partner agencies about these programs.





VI. NCSSI Trajectory

The second year of SEP legalization brought additional programs, added services, and new partnerships and projects. Though barriers to program implementation and uptake remain (and will likely continue), NC's experience shows early progress. A critical feature has been active programs developing and defining their own interests, parameters, and partnerships. Expanding SEP services to meet NC's demand will require creativity, innovation, and collaboration. SEPs' flexibility and agility make them strong partners for trying new approaches and adapting and refining services. By empowering experienced SEPs, DPH can support urgently needed services and learn from their experiences, in turn sharing that guidance with new programs, partner agencies, and other states and jurisdictions. A bill proposed during the NC 2018-19 legislative session allows for the use of state funding to purchase syringes and injection supplies, which would allow SEPs to pursue additional funding streams and improve sustainability. A promising strategy for accessing these state funds would be to allow local management entity-managed care organizations (LME-MCOs) to support SEPs, incorporating syringe access into other services for people with mental health and SUD treatment needs and facilitating care referrals. As this and other opportunities arise, it will be necessary for NCSSI to balance its core role and services with participation in and support of new projects and opportunities, particularly as related funding comes available. Continuing early, rapid steps to fold SEP education and technical assistance into DPH's body of work, DPH and NCSSI must also focus on internal and external sustainability, including strengthening relationships.

Program Sustainability and Support

Financial support is vital, and program funding has material impact for programs and participants and encourages program buy-in. In the absence of dedicated, sustainable program funding, NCSSI seeks to alleviate barriers to syringe access and facilitate programs' work through other types of support, including assisting programs in navigating state systems. Legalization allowed for the development of SEP and harm reduction infrastructure within DPH. Flexibility and prioritization of relationship-building and effective partnership are critical for both SEP service provision and DPH capacity-building. Personal relationships are invaluable, and the ability to regularly spend time and work with SEP leaders and staff has facilitated program growth and interconnection. As communities establish more programs, the ability for DPH to connect with staff and participants is paramount.

To effectively sustain and support SEPs, DPH and partner agencies should understand the necessity and value of providing health services to PWUD and working with people with lived experience in the development and provision of those services. Building that awareness, buy-in, and infrastructure to allow collaboration is an enduring priority. This includes ongoing law enforcement education and outreach and improvement to the limited immunity provision to encourage syringe disposal through SEPs. The OPDAAC-affiliated Advisory Group will be a dedicated setting for PWUD to become involved with state-led overdose response work. Regional organizing of SEPs; encouraging IFNC SEP Academy participants to visit and learn from local programs before starting their own; sequencing future funding opportunities with technical assistance and workforce development events: these are all efforts with short-term goals intended to support program sustainability and coordination in the long term.

InjuryFree NC Academy: Establishing Syringe Exchange Programs (2019)

Following review of the Academy cycle and feedback from participants and partners, the second cycle was restructured to consist of two, three-day regional Academies on Establishing SEPs. Sessions will be held in Greenville (Eastern NC) in February 2019 and in Wilkesboro (Western NC) in April 2019, with teams primarily drawn from each region. IVPB and IPRC are exploring the "boot camp" structure as a way to provide broad, foundational information and guidance to teams, regardless of their previous experience or current stage of development. Technical assistance during and following the Academy sessions will allow tailoring of discussions, program characteristics, and action planning as participants share their work and experience with their home communities.

Unexpectedly, some active SEPs have elected to participate, using the Academy as orientation and workforce development for new and current staff. Though not identified as likely participants during Academy planning, the collaborative environment of the Academies and focus on learning from the experiences and expertise of operational SEPs and experienced harm reductionists makes them welcome participants. Their interest additionally suggests that further adapting the InjuryFree NC model to provide workforce development for staff of operational SEPs.

Data Collection, Surveillance, and Research Projects

DPH conducts regular data analysis and research on the overdose crisis, and there is growing interest in working with SEPs to both identify pressing research questions and collect information and insight. Data collection projects include annual reporting—how can DPH assist in program monitoring and data collection to reduce burden on programs—and other areas of interest related to drug use and SUD to better inform DPH and state partners. With new and growing interest in drug user health and the experiences of PWUD, research partnerships and projects can be used to inform program development, showcase work, and educate partners, but should not occur at the expense of service provision or benefits of program participation. DPH may be able to assist in engaging partners in research planning to avoid duplication or overburdening programs.

These three primary priorities will carry NCSSI into the 2018-19 cycle. The body of DPH SEP data grows with each annual reporting period, and some evaluation and analysis will be possible. Possible topics include evaluating awareness of and experience with the limited immunity prohibition; variation in return rates and visit frequency; and care access and navigation for SEP participants.

SEPs are unique and effective channels for connecting with people in active use and those seeking medical and social services, including SUD treatment. The configuration and delivery of services allows for unique uptake and dissemination: people enter exchange programs as passive recipients and through connection, education, and advocacy become active service providers in their own communities, demonstrating safer use techniques to peers, encouraging naloxone use, and distributing sterile supplies to people without access. In implementing SEP legalization and building a sustainable system, we must strive to preserve programs' spirit and function while encouraging collaboration and accountability.

North Carolina Safer Syringe Initiative

Annual Reporting Form

To be completed by July 31st annually

Please send completed forms, any additional materials, and other inquiries to SyringeExchangeNC@dhhs.nc.gov.

Thank you!

As of July 11, 2016, North Carolina (G.S. 90-113.27) allows for the legal establishment of hypodermic syringe and needle exchange programs. Any governmental or nongovernmental organization "that promotes scientifically proven ways of mitigating health risks associated with drug use and other high risk behaviors" can start a syringe exchange program.

Syringe exchange programs in North Carolina are required to provide the following services:

- Syringe disposal
- Distribution of sterile syringes and new injection supplies at no cost and in sufficient quantities to prevent sharing or reusing
- Education materials concerning:
    - Prevention of disease transmission, overdose, and substance use disorder
    - Treatment options, including medication-assisted therapy and referrals
- Naloxone distribution and training, or referrals to these services
- Consultations/referrals to mental health or substance use disorder treatment
- Security plans addressing site, personnel and equipment security distributed to police and/or sheriff's departments with jurisdiction over syringe exchange locations

The Division of Public Health (DPH) is responsible for collecting data annually on program reach and provided services. The annual reporting period closes July 31st and covers the previous year of operations (or, for programs that have been operating for less than a full year at the time of annual reporting, operations to date). DPH recommends reviewing the annual reporting form before starting services to ensure that internal data-collection and program monitoring will collect the required information.

Programs are required to submit security plans to the local law enforcement agencies with jurisdiction over locations of operation. This helps ensure that local law enforcement are aware of the program and are familiar with the limited immunity provision. Exchanges are considered "active" in a given county once the security plan is distributed to appropriate law enforcement agencies. Programs should review security plans, make any needed changes, and redistribute plans annually to local law enforcement. If programs are serving a high number of people from a different region or jurisdiction, programs can share security plans and program information with additional agencies to promote awareness and familiarity.

Annual reporting allows DPH to monitor program development and service coverage. Programs are encouraged to contact DPH as needed to share questions, concerns, and program priorities. The annual reporting process provides a formal opportunity for syringe exchange programs to share this information and other feedback.

Information collected during annual reporting is shared in the NC Safer Syringe Initiative Annual Reporting Summary.

Please **complete this form electronically** if possible. Send completed forms (including scanned forms) and any additional information as email attachments to SyringeExchangeNC@dhhs.nc.gov.

Please contact the NC Safer Syringe Initiative at SyringeExchangeNC@dhhs.nc.gov with any questions or additional materials.

Program Information

1. Name of the **organization or agency** operating the syringe exchange program:

_____

1a. Name of the **syringe exchange program**, if different from above:

_____

2. Contact Information

	Primary Contact		Secondary Contact
Name	_____	Name	_____
Phone	_____	Phone	_____
Email	_____	Email	_____

3. Syringe exchange **program model** (check all that apply):

- ☐ **Fixed site**: exchange runs from a permanent, fixed location (including regular shared-space locations)
- ☐ **Mobile**: exchange run from a mobile vehicle, operating in one or more locations
- ☐ **Peer-based**: exchange run through peer networks distributing in a community
- ☐ **Integrated**: exchange services through an existing agency, including health department or treatment program

4. Physical address(es) of the syringe exchange program (if applicable):

Location 1: Street Address _____

City/Town _____ Zip Code _____

Location 2: Street Address _____

City/Town _____ Zip Code _____

If you have more than two program locations, please provide additional addresses in an email to SyringeExchangeNC@dhhs.nc.gov.

5. Regions Served

Please use the **first red-lined box** to select counties where the syringe exchange operates (including fixed and mobile locations and regular outreach sites). If the program records counties in which participants reside, please use the **second blue-lined box** to select counties and neighboring states with residents being served by the program.

> **Example**: My exchange has a fixed location in Durham and does regular mobile outreach in Person County. Participants come from Durham, Person, Caswell, and Vance counties and from Virginia. I select the first red-lined box for Durham and Person, and the second blue-lined box for Durham, Person, Caswell, Vance, and Virginia.

Alamance	☐	☐	Alexander	☐	☐	Alleghany	☐	☐	Anson	☐	☐
Ashe	☐	☐	Avery	☐	☐	Beaufort	☐	☐	Bertie	☐	☐
Bladen	☐	☐	Brunswick	☐	☐	Buncombe	☐	☐	Burke	☐	☐
Cabarrus	☐	☐	Caldwell	☐	☐	Camden	☐	☐	Carteret	☐	☐
Caswell	☐	☐	Catawba	☐	☐	Chatham	☐	☐	Cherokee	☐	☐
Chowan	☐	☐	Clay	☐	☐	Cleveland	☐	☐	Columbus	☐	☐
Craven	☐	☐	Cumberland	☐	☐	Currituck	☐	☐	Dare	☐	☐
Davidson	☐	☐	Davie	☐	☐	Duplin	☐	☐	Durham	☐	☐
Edgecombe	☐	☐	Forsyth	☐	☐	Franklin	☐	☐	Gaston	☐	☐
Gates	☐	☐	Graham	☐	☐	Granville	☐	☐	Green	☐	☐

Guilford	☐ ☐	Halifax	☐ ☐	Harnett	☐ ☐	Haywood	☐ ☐
Henderson	☐ ☐	Hertford	☐ ☐	Hoke	☐ ☐	Hyde	☐ ☐
Iredell	☐ ☐	Jackson	☐ ☐	Johnston	☐ ☐	Jones	☐ ☐
Lee	☐ ☐	Lenoir	☐ ☐	Lincoln	☐ ☐	McDowell	☐ ☐
Macon	☐ ☐	Madison	☐ ☐	Martin	☐ ☐	Mecklenburg	☐ ☐
Mitchell	☐ ☐	Montgomery	☐ ☐	Moore	☐ ☐	Nash	☐ ☐
New Hanover	☐ ☐	Northampton	☐ ☐	Onslow	☐ ☐	Orange	☐ ☐
Pamlico	☐ ☐	Pasquotank	☐ ☐	Pender	☐ ☐	Perquimans	☐ ☐
Person	☐ ☐	Pitt	☐ ☐	Polk	☐ ☐	Randolph	☐ ☐
Richmond	☐ ☐	Robeson	☐ ☐	Rockingham	☐ ☐	Rowan	☐ ☐
Rutherford	☐ ☐	Sampson	☐ ☐	Scotland	☐ ☐	Stanly	☐ ☐
Stokes	☐ ☐	Surry	☐ ☐	Swain	☐ ☐	Transylvania	☐ ☐
Tyrell	☐ ☐	Union	☐ ☐	Vance	☐ ☐	Wake	☐ ☐
Warren	☐ ☐	Washington	☐ ☐	Watauga	☐ ☐	Wayne	☐ ☐
Wilkes	☐ ☐	Wilson	☐ ☐	Yadkin	☐ ☐	Yancey	☐ ☐
Eastern Band of the Cherokee Nation			☐ ☐	Georgia	☐	South Carolina	☐
Tennessee	☐	Virginia	☐	Other: _____			☐ ☐

6. Populations served by the syringe exchange program (check all that apply):

- ☐ Injection drug users (people who inject or otherwise use illicit drugs or drugs not as prescribed)
- ☐ Sex hormone/hormonal therapy injection users
- ☐ HGH, steroid users
- ☐ Diabetic insulin users
- ☐ People who inject other prescribed medication (including interferon to treat hepatitis)
- ☐ Other: _____

7. How does the program **dispose of used syringes**, needles, and injection supplies (check all that apply)?

- ☐ Biohazard company (please list): _____
- ☐ Clinic or hospital partnership (please list): _____
- ☐ Local health department (please list): _____
- ☐ Waste disposal site (ex. dump or transfer station)
- ☐ Other (please list): _____

8. On which of the following topics does the syringe exchange program offer **information and educational materials** (check all that apply)?

- ☐ Overdose prevention
- ☐ How to identify and respond to an overdose, including how to use naloxone
- ☐ Drug misuse prevention
- ☐ Prevention of HIV transmission
- ☐ Prevention of viral hepatitis (including hepatitis A, B, and C) transmission
- ☐ Treatment of mental health conditions, including treatment referrals
- ☐ Treatment of substance use disorders, including referrals for medication-assisted treatment

Annual Reporting Data

9. Number of **unique individuals** served by the syringe exchange program in the past year: _____

10. Number of **total contacts** the program had with all participants in the past year: _____

11. Number of **syringes dispensed** by the program in the past year: _____

12. Number of **syringes returned** to the program in the past year (if by weight, estimate 281 syringes/lb.): _____

13. NC law asks that programs report **numbers of supplies distributed by and returned to the program**. For each supply dispensed by the exchange, please check the box and enter the total number dispensed in the past year. (For pre-bagged supplies like cottons and cookers, multiply total number of bags dispensed by average number of supplies bags contain.)

Supply	**Dispensed?**	**Number Dispensed**
Cookers	☐	_____
Cottons, filters	☐	_____
Tourniquets	☐	_____
Sterile water	☐	_____
Sharps containers	☐	_____
Acidifiers (breakdown)	☐	_____
Fentanyl test strips	☐	_____
Alcohol wipes or swabs	☐	_____
Other wound care (bandages, gauze)	☐	_____
External (male) condoms	☐	_____
Internal (female) condoms	☐	_____
Lubricant	☐	_____
Menstrual hygiene supplies	☐	_____
General hygiene supplies	☐	_____
Other: _____	☐	_____
Other: _____	☐	_____
Other: _____	☐	_____

14. Total number of **supplies returned** to the program in the past year: _____

15. Please share any **additional information about supplies** or elaborate on responses to Question 13 as needed.

16. Number of **naloxone kits distributed** by the program in the past year (if applicable): _____

17. Number of **referrals made to obtain naloxone** from another source in the past year (if applicable): _____

17a. Where were people referred? (Please list multiple referral sites as necessary.)

18. Number of **overdoses reversed with naloxone** that have been reported to the program in the past year: _____

19. Number of people the program **referred to treatment for substance use disorders** and/or **mental health services** in the past year: _____

19a. Where were people referred? (Please list multiple referral locations as necessary.)

20. Does the program offer **HIV testing**? Yes ◯ No ◯

If no, please go to Question 21.

20a. What kind of test(s) are offered? (Check all that apply.) Rapid test ☐ Blood test ☐
20b. How many **unique individuals** did the program test in the past year? _____
20c. How many **total tests** did the program conduct in the past year? _____
20d. How many **unique individuals** tested positive for HIV in the past year? _____
20e. Where did the program refer people who tested positive for treatment?
_____
20f. From where does the program get HIV tests? NC DPH ☐ Other ☐ _____ N/A ☐

21. Does the program make **referrals for HIV testing**? Yes ◯ No ◯

21a. If yes, where are people referred for HIV testing? _____

22. Does the program offer **hepatitis C (HCV) testing**? Yes ◯ No ◯

If no, please go to Question 23.

22a. What kind of test(s) are offered? (Check all that apply.) Rapid test ☐ Blood test ☐
22b. How many **unique individuals** did the program test in the past year? _____
22c. How many **total tests** did the program conduct in the past year? _____
22d. How many **unique individuals** tested positive for HCV in the past year? _____
22e. Where did the program refer people who tested positive for treatment?
_____
22f. From where does the program get HCV tests? NC DPH ☐ Other ☐ _____ N/A ☐

23. Does the program make **referrals for HCV testing**? Yes ◯ No ◯

23a. If yes, where are people referred for HCV testing? _____

NC law protects syringe exchange staff and participants from being charged with possession of syringes or other injection supplies, including those with residual amounts of drugs present, if obtained or returned to an SEP. People affiliated with an exchange must provide written verification (such as a participant card) to be granted limited immunity. NC law does not specify verification format or content.

24. Please submit an example of the written verification the syringe exchange program distributes to SyringeExchangeNC@dhhs.nc.gov. If the program is not distributing written verification of participation in a syringe exchange program, please provide details below on how the program educates staff, participants, and law enforcement on limited immunity. (To confirm that a copy of the program's written verification is already on file, please contact DPH.)

Programs are required to review security plans annually and update them as needed. Programs shall redistribute security plans annually to local law enforcement agencies with jurisdiction over areas of operation. DPH considers programs "active" in a county once the security plan is distributed to appropriate law enforcement agencies.
Please contact DPH with any questions.

25. Has the program **reviewed and made any needed updates to its security plan** in the past year? Yes ◯ No ◯

26. Has the program **re-distributed its security plan** to local law enforcement agencies in the past year? Yes ◯ No ◯

27. Please share any additional **information about program operations** (including feedback from participants or staff, interactions with community members or law enforcement, program priorities, and requests for technical assistance). Contact DPH to share additional information.