# California Fatal Opioid Overdose and HIV or Hepatitis C Virus (HCV) Vulnerability Assessment

## Action Planning Checklist ☑

Vulnerability to a rapid increase in HIV or hepatitis C virus (HCV) infections and/or fatal opioid overdoses varies by county. Nonetheless, all counties in California have at least some risk. For example, several incidents of rapid increase in HIV and HCV transmission in low vulnerability jurisdictions, including a 2018 outbreak among people who inject drugs (PWID) in King County, Washington, have shown that a rapid increase can happen anywhere, including in geographic settings with and without local resources.[1]

Fortunately, there is strong evidence to support scaling up existing public health interventions to prevent HIV or HCV transmission and fatal opioid overdoses in California communities. These include 1) medication-assisted treatment (MAT) for opioid use disorder (such as buprenorphine);[2] 2) distribution of naloxone (an opiate antagonist that can reverse an opioid overdose);[3,4] 3) syringe access, including through syringe exchange programs and pharmacy nonprescription syringe sales;[5,6,7] 4) HIV testing and treatment (and HIV pre-exposure prophylaxis, or PrEP);[8] and 5) HCV testing, linkage, and treatment.[9]

**The following checklist provides evidence-based strategies that local health jurisdictions, health care providers, community based organizations, local opioid safety coalitions, and other partners can use to reduce their county-level vulnerability. This list is not exhaustive; feel free to add your ideas. An accompanying Vulnerability Assessment Resource List has information to support these action items.**

## 1) Expand Access to Medication Assisted Treatment for People with Opioid Use Disorders

- ☐ Leverage federal, state, and private funding resources to support MAT expansion
- ☐ Support local safety net and jail health providers, including prescribers serving adolescents with opioid use disorders, in getting X waivered to prescribe buprenorphine[10]
- ☐ Enlist the support of available technical assistance providers to support X-waivered and emergency department providers in prescribing buprenorphine to their patients[11]
- ☐ Partner with local HIV prevention, primary care, homeless outreach, drug treatment, syringe exchange, and social service programs to develop MAT linkage pathways for PWID
- ☐ Hire navigators and leverage telehealth to offer MAT in key settings (such as emergency departments and syringe exchange programs) for people with a recent nonfatal overdose
- ☐ Train MAT providers in treating and retaining people with polysubstance use, including those who continue to use stimulants while engaging in MAT for their opioid use disorder

## 2) Distribute Naloxone to People Most Likely to Witness an Opioid Overdose

- [ ] Leverage the California Department of Public Health Statewide Standing Order for Naloxone, existing naloxone access options in California, and/or issue a local standing order to obtain and distribute naloxone to people at the highest personal risk of opioid overdose

- [ ] Ensure that new and existing naloxone distribution efforts prioritize those most likely to witness an overdose, emphasizing people who inject drugs and their friends, peers, and family members, as well as programs that serve them

- [ ] Integrate routine overdose prevention education and naloxone distribution into settings in which people may experience decreased opioid tolerance, such as jails, sober living homes, and drug treatment programs: train staff and residents in naloxone administration, keep naloxone on-site for overdose response, and distribute naloxone prior to release or exit

- [ ] Create heat maps of opioid overdose deaths within the county to identify whether naloxone is reaching people at highest risk for overdose, including by mapping overdose deaths at the zip code level through the California Opioid Overdose Surveillance Dashboard

## 3) Expand Access to Syringes and Safer Injection Equipment

- [ ] Collaborate with local pharmacies to promote nonprescription syringe sales, such as AIDS Drug Assistance Program pharmacies and HIV/HCV specialty pharmacies

- [ ] Encourage physicians and pharmacists to dispense syringes and other injection equipment, which they may do without a prescription for anyone age 18 or older

- [ ] Evaluate local syringe access policies to ensure programs can provide adequate syringes for every PWID to have a new sterile syringe for every injection through needs-based distribution

- [ ] Expand the reach and scope of existing syringe access programs by increasing secondary syringe exchange and funding core operating expenses and expanded hours, and locations

- [ ] Support the creation of new syringe services programs through local or state authorization in a variety of settings, such as MAT programs, homeless services programs, and safety net clinics

## 4) Expand HCV Testing, Linkages to Care, and Treatment, including for PWID

- [ ] Review local public health surveillance data and/or clinic-level electronic health record data to assess the hepatitis C care cascade and implement quality improvement initiatives
- [ ] Work with local public and private health plans to streamline HCV treatment prior authorization requirements, gain buy-in for primary care providers treating hepatitis C (such as from HCV Project ECHO), and develop hepatitis C-related performance improvement projects
- [ ] Work with local primary care providers, safety net clinics, tribal health clinics, and rural health centers to identify an HCV clinician champion and train primary care physicians, mid-level providers, pharmacists, and medical team members to treat hepatitis C using team-based care
- [ ] Integrate HIV and hepatitis C rapid testing and linkages to care into non-clinical settings serving PWID, prioritizing syringe access program and drug treatment program settings
- [ ] Support health care professionals in treating PWID with a harm reduction approach
- [ ] Support the hiring and cross-training of dedicated HCV patient navigators/care coordinators to conduct outreach, rapid testing, phlebotomy, patient navigation, and/or care coordination, prioritizing hiring people with lived experience with injection drug use and/or incarceration

## 5) Expand HIV Prevention, Testing, Linkages to Care, and Treatment, including for PWID

- [ ] Integrate routine, opt-out HIV testing into settings serving PWID, including drug treatment programs, syringe exchange programs, jails, and emergency departments
- [ ] Support dedicated patient navigators to assist PWID newly diagnosed with HIV or out of care to provide linkages and reengagement and to assure hepatitis C care for those with coinfection
- [ ] Assess and address local disparities in viral suppression, mortality among PWID living with HIV
- [ ] Integrate substance use disorder services into HIV care, such as by training HIV care providers
- [ ] Integrate HIV pre-exposure prophylaxis (PrEP) in services for PWID such as SSPs, HIV/HCV testing, overdose prevention, SUD treatment, and primary care and safety net clinic settings

## Action Items and Next Steps

| | Action Item/Next Step | Person Responsible | Due Date |
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# REFERENCES

[1] Golden M; et al. Outbreak of Human Immunodeficiency Virus Infection Among Heterosexual Persons Who Are Living Homeless and Inject Drugs — Seattle, Washington, 2018. *MMWR*. April 19 2019;68(15):344-349.
[2] Platt L; et al. Needle syringe programmes and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs (Review). Cochrane Database of Systemic Reviews. 2017.
[3] Wheeler E, Jones TS, Gilbert MK, Davidson P. Opioid Overdose Prevention Programs Providing Naloxone to Laypersons — United States, 2014. *MMWR*. June 19, 2015;64(23):631-635.
[4] Keane C, Egan JE, Hawk M. Effects of naloxone distribution to likely bystanders: Results of an agent-based model. Int Journal of Drug Policy. 2018;55:61–69.
[5] Des Jarlais DC, Nugent A, Solbert A, Feelemyer J, Mermin J, Holtzman D. Syringe Service Programs for Persons Who Inject Drugs in Urban, Suburban, and Rural Areas — United States, 2013. *MMWR*. 2015 Dec 11;64(48):1337-41.
[6] Stopka TJ, Donahue A, Hutcheson M, Green TC. Nonprescription naloxone and syringe sales in the midst of opioid overdose and hepatitis C virus epidemics: Massachusetts, 2015. J Am Pharm Assoc. 2017 Mar-Apr;57(2S):S34-S44.
[7] Meyerson BE; et al. Predicting pharmacy syringe sales to people who inject drugs: Policy, practice and perceptions. Int J Drug Policy. 2018 Jun;56:46-53.
[8] Note: CDC also recommends HIV pre-exposure prophylaxis (PrEP) for any adult person without acute or established HIV infection with any injection of drugs not prescribed by a clinician in past 6 months *and* at least one of the following: Any sharing of injection or drug preparation equipment in past 6 months *or* risk of sexual acquisition (see guidelines for sexual risk assessment tool). For more information on HIV PrEP, visit Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update: a Clinical Practice Guideline.
[9] Grebely J, Hajarizadeh B, Dore GJ. Direct-acting antiviral agents for HCV infection affecting people who inject drugs. Nat Rev Gastroenterol Hepatol. 2017 Nov;14(11):641-651.
[10] The American Academy of Pediatrics (AAP) “recommends that pediatricians consider offering medication- assisted treatment to their adolescent and young adult patients with severe opioid use disorders or discuss referrals to other providers for this service.” AAP Policy Statement: Medication-Assisted Treatment of Adolescents with Opioid Use Disorders. Pediatrics. 2016 Sep; 138(3): e20161893.
[11] See, for example, the Providers Clinical Support System for technical assistance on implementing MAT.