Harm Reduction Subcommittee

Sustainability of Harm Reduction Services Survey

Executive Summary

Key Takeaways

- In May and June 2021, harm reduction programs in Ohio were surveyed about issues of sustainability. Harm reduction programs provide services that prevent adverse outcomes from substance use, which could include the distribution of naloxone, fentanyl test strips, sterile syringes, etc.
- While barriers still exist, all respondents reported distributing **naloxone** and most utilized one or more stable funding sources for this service. However, programs based in **metropolitan counties** cited lack of available naloxone funding opportunities as one of their top sustainability barriers.
- A minority of programs reported distributing **other harm reduction services** like fentanyl test strips, sterile syringes, safe smoking, and safe snorting kits. These other services relied more often on internal or local (e.g., ADAMH or MHAR Board) funds, or less stable sources like donations.
- The leading reported **barriers** to sustaining harm reduction programs were community perceptions/buy-in, limited staffing, and lack of support from local leadership and organizations. These barriers were cited at even higher proportions among programs based in **non-metropolitan counties**.

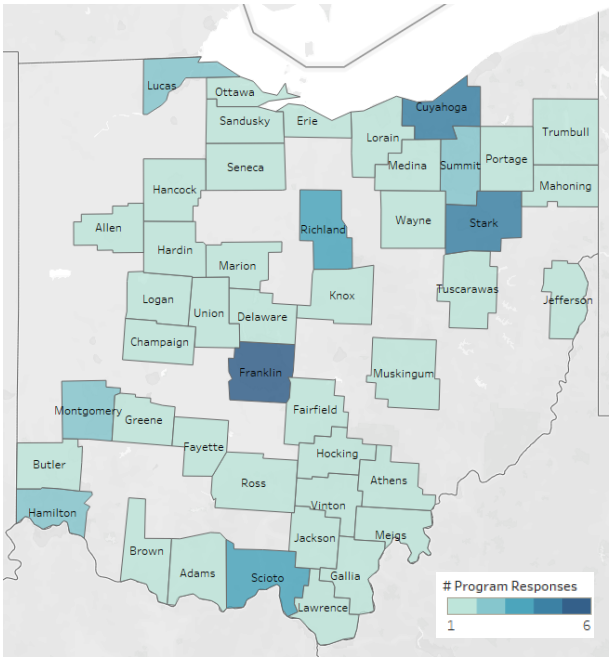
Background

According to a preliminary report, 2020 had the highest number of unintentional overdose deaths in Ohio history (5,018 as of August 31, 2021).[1] Harm reduction services like naloxone, fentanyl test strips, and syringe services programs (SSPs) help prevent overdoses, infectious disease, and other adverse outcomes from substance use.[2-4] They also are an effective way to engage with stigmatized populations and connect participants with resources like treatment.[4] To learn more about this landscape in the state, the Ohio Overdose Prevention Network's (Ohio OPN) Harm Reduction Subcommittee (HRSC) developed a survey to assess issues of sustainability among harm reduction programs. Ohio OPN is an action group of the Ohio Injury Prevention Partnership (OIPP), and the HRSC aims to promote harm reduction practices and policies.

Methods

On May 24, 2021, a REDCap survey was sent to members of Ohio OPN, Project DAWN programs, and other known harm reduction contacts via email. REDCap is a secure web application for building and managing online surveys and databases. Recipients were encouraged to share the link with those who might not have received it from the state contact lists. Anyone involved in running a harm reduction program in Ohio was eligible to participate, and responses were anonymous unless an email was volunteered at the end of the survey. The survey closed June 4, 2021.

Figure 1. Counties of Responding Programs



Results

Program Information

The Sustainability Survey received complete responses from 77 individuals representing 64 unique harm reduction programs in Ohio. Programs were based in 45 of Ohio's counties (Figure

Table 1. Services Provided by Programs (n=64)	
Naloxone	100.00%
Linkage to care (referrals)	57.81%
Fentanyl test strips	40.63%
Basic resources (personal care items, hygiene, etc.)	40.63%
Peer support services	39.06%
STI/HIV/Hepatitis prevention services	35.94%
Sterile syringes	29.69%
Other	15.63%
Safe smoking kits	6.25%
Safe snorting kits	3.13%
Missing	0.00%

1). Most programs (n=40, 62.5%) were based out of counties classified as metropolitan, while 37.5% (n=24) were in nonmetropolitan counties (using 2013 NCHS Urban-Rural Classification Scheme for Counties).[5]

Most programs were local health departments (70.3%), followed by SSPs (29.7%), and nonprofit organizations (14.1%) (agency types were not mutually exclusive). Hospital systems, behavioral health organizations, and other agency types were represented as well.

All programs reported distributing naloxone, followed by nearly 58% providing linkage to care, and 40.6% distributing fentanyl test strips and basic resources like personal care items (Table 1).

Programs reported delivering harm reduction services most frequently at local health departments (65.6%), treatment/recovery settings (48.4%), and via street outreach (39.1%). Other settings included but were not limited to community access points, quick response teams, SSPs, corrections/court systems, online mail-order, lay distribution networks, and various health settings.

Sustainability

Funding Sources

Naloxone: Of the 64 programs that reported distributing naloxone, 78.1% obtained naloxone kits from the Ohio Department of Health (ODH) General Allocation, over 56% from the Integrated Naloxone Access and Infrastructure (IN) Grant,[1] and 46.9% from the Ohio Department of Mental Health and Addiction Services (OhioMHAS) grant for County Health Departments to equip law enforcement and first responders. Most programs (over 95%) provided Narcan Nasal Spray, while mucosal atomization devices or intramuscular naloxone were both reported by only 6.25% of programs.

Sterile Syringes: Among programs that reported distributing sterile syringes (n=19), the two leading sources were donations and the ODH GRF Harm Reduction Surge Materials funds (both reported by 31.6% of programs). These were followed by their organization's general funds, county mental health and addiction recovery (MHAR) or Alcohol, Drug Addiction and Mental Health (ADAMH) boards, and buyers' clubs (all reported by 26.3% of programs).

Fentanyl Test Strips: The most common sources of fentanyl test strips among distributing programs (n=26) were MHAR or ADAMH boards (34.6%), their organization's general funds (30.8%), and buyers' clubs (26.9%).

Infrastructure: Most programs (n=64) funded their infrastructure, which could include staff salaries, travel, and other costs outside of harm reduction supplies, through their organization's general funds (over 59%). Half utilized the IN Grant, and 23.4% used federal grant funds.

[1] The ODH General Allocation is supported by state general revenue funds (GRF); the IN Grant is supported by federal (State Opioid Response) funds administered by ODH in partnership with OhioMHAS.

Barriers

Programs (n=64) reported a range of barriers to sustaining their harm reduction programs. The leading barriers were community perceptions/buy-in (50%), limited staff to implement programming (40.6%), and lack of support from local leadership or organizations (34.4%) (Table 2). Other barriers included limited capacity to apply for grants, funding restrictions, and lack of funding opportunities for various supplies.

Table 2. Barriers to Sustaining Harm Reduction Programs (n=64)	
Community perceptions/buy-in	50.00%
Limited staff to implement program	40.63%
Lack of support from local leadership/organizations	34.38%
Limited staff capacity or resources to apply for grants (e.g., need for a grant writer)	25.00%
Restrictions pertaining to existing funding sources	25.00%
Lack of available fentanyl test strip funding opportunities	23.44%
Lack of available naloxone funding opportunities	23.44%
Lack of available safe smoking kits funding opportunities	23.44%
Lack of available safe snorting kits funding opportunities	23.44%
Lack of available sterile syringe funding opportunities	21.88%
Available funding is not enough to cover program costs	20.31%
Cost of naloxone	20.31%
Lack of available infrastructure/operational cost funding opportunities	20.31%
Legal barriers	15.63%
Organization is ineligible for certain types of funding	7.81%
Other	7.81%
Unable to bill client insurance for naloxone	4.69%
Missing	10.94%

When comparing metropolitan versus non-metropolitan counties, the leading two barriers were the same but programs in non-metropolitan counties reported these at higher proportions (Table 3). They were also more likely to cite lack of support from local leadership or organizations. Programs in metropolitan counties were more likely to cite lack of naloxone funding opportunities as a barrier.

Table 3. Leading Three Barriers to Sustainability by County Type			
Metropolitan (n=40)		**Non-metropolitan (n=24)**	
Community perceptions/buy-in	42.50%	Community perceptions/buy-in	62.50%
Limited staff to implement program	37.50%	Limited staff to implement program	45.83%
Lack of available naloxone funding opportunities	30.00%	Lack of support from local leadership/organizations	45.83%

Billing

Only 9.4% of the 64 programs said they had billed or considered billing insurance for naloxone or other services (e.g., SBIRT) (Figure 2). Of those who had (n=6), 33.3% reported no challenges while 66.6% reported barriers including clients not being able to afford copays, finding personnel who can prescribe naloxone, adding provider(s) to insurance panels, submitting claims and receiving reimbursement, and clients not wanting naloxone on their insurance record (Table 4). One participant also described that it *"creates an additional barrier to effectively sending a patient/individual home with a Narcan kit in hand rather than a prescription that will go unfilled."*

Figure 2. Programs that bill or have considered billing insurance for naloxone or other services (e.g., SBIRT) (n=64)

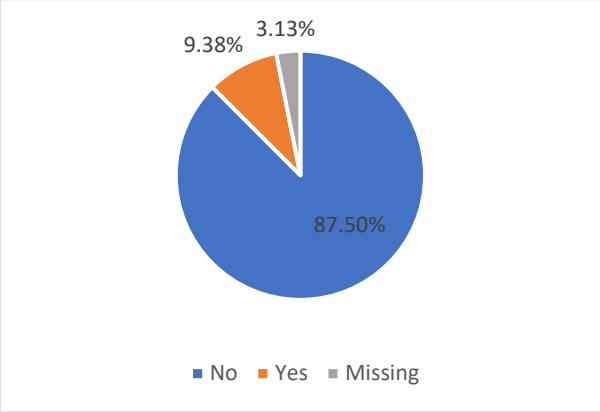


Table 4. Challenges Encountered Billing Insurance (n=6)	
Clients can't afford copays	33.33%
No challenges	33.33%
Other	33.33%
Finding or retaining personnel who can prescribe naloxone	16.67%
Difficulty adding provider(s) to insurance panels	16.67%
Challenges submitting claims and receiving reimbursement	16.67%
Clients don't want naloxone prescription on their insurance record	16.67%
Missing	0.00%

Staffing

Among individual respondents (n=77), just over half (53.3%) said their program had a coordinator or manager who dedicated 0.5 full time equivalents (FTE) or more to the program, while 42.9% said they did not. Most individual respondents said they had adequate staffing to effectively operate their program (66.2%), but nearly 30% said they did not have adequate staffing.

Disrupted Funding

When asked if they had a plan for how their program would continue if their primary source(s) of funding were unexpectedly cut, only 18% of the 77 individual respondents said they did, while 74% did not have a plan (Figure 3).

Figure 3. If your primary source(s) of funding was unexpectedly cut, do you have a plan for how your program would continue? (n=77)

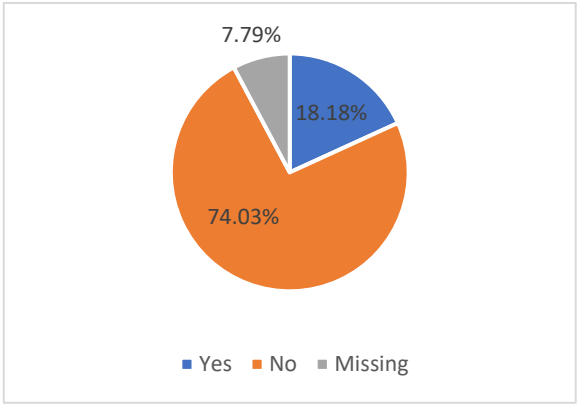


Table 5. Strategies Programs Found Helpful for Sustainability (n=64)	
Community partnerships	67.19%
Utilize grants	54.69%
Integrate naloxone into existing programs to reduce need for additional personnel	35.94%
Diversify funding	18.75%
Donations	15.63%
Fundraise	9.38%
Bill for naloxone and/or other services	7.81%
Purchase less expensive forms of naloxone (e.g., nasal atomizer spray, injectable naloxone)	6.25%
Other	1.56%
Bill for SBIRT and/or counseling	0.00%
Bill for wound care and/or other health services	0.00%
Missing	14.06%

Strategies

Programs (n=64) also reported a variety of strategies they found helpful for making their harm reduction programs more sustainable. The most frequently reported strategies were community partnerships (67.2%), utilizing grants (54.7%), and integrating naloxone into existing programs to reduce the need for additional personnel (35.9%) (Table 5).

Additional Feedback

The end of the survey offered a chance for participants to provide additional thoughts. Six individuals responded to this prompt, and three that reflected themes in the rest of the data are shown below.

"Making [intramuscular] IM naloxone available to Project DAWN, recognition of SSP and harm reduction programs as medically necessary services potentially fundable through other state funding channels like Medicaid."

"Funding for syringes is currently our largest hurdle. Since we cannot purchase syringes with federal grant funds, we must write grants to other funders. While the number of SSPs in Ohio and the nation have increased, this also means that the funders are more competitive and often exclude governmental operations. Having a secured and sustainable path for syringe purchasing is essential for the continuation of the program."

"If spacing would allow, we would likely build a harm reduction program within our LHD, but we have no space to house another staff person. I am open to applying for ODH harm reduction grant funding beyond the 2 sources we use for Naloxone currently. A grant would have to fund the personnel costs."

Limitations

The survey results should be considered with some limitations in mind. First, the sample may not be representative of all harm reduction programs in Ohio. Many programs were through local health departments (LHDs), which have different experiences compared to other agency types like non-profit, grass-root, and "underground" programs. The latter were likely underrepresented due to not being on state contact lists and out of confidentiality concerns. The HRSC tried to address this by making the survey anonymous unless participants volunteered an email address and encouraging sharing of the survey to better reach unknown programs.

In addition, because the survey was open to anyone involved in running a program, some individual respondents (n=77) worked for the same program. Because some questions would be more meaningful when considered by unique programs, responses that were highly likely to be from the same organization were combined and unduplicated (resulting in n=64). Responses were only combined if 1) they had matching organizational email domains OR 2) the agency type was a LHD, and that county only had one LHD. If participants did not volunteer an email or fall into the second category, it is possible they were incorrectly considered unique programs. However, results did not vary greatly between these datasets.

Conclusion

The harm reduction programs in this survey sample reported a range of funding sources and experiences with sustainability. Every program reported distributing naloxone, and respondents frequently obtained naloxone from more stable funding sources like the ODH General Allocation, IN Grant (federal State Opioid Response funds administered by ODH in partnership with OhioMHAS), and OhioMHAS funds for first responders. However, lack of available naloxone funding opportunities was still the third most frequently reported barrier among metropolitan counties.

Provision of other harm reduction services like fentanyl test strips, sterile syringes, safe smoking and safe snorting kits were less common. These relied more often on organizational general funds, donations, and local sources like ADAMH and MHAR boards. This suggests these other services are more reliant on local levels of support, which can vary greatly across Ohio. Similarly, the first and third leading barriers reported were community perceptions/buy-in and lack of support from local leadership/organizations, respectively. These barriers were reported at even higher proportions in non-metropolitan counties.

Finally, while about two-thirds of programs reported having adequate staffing, limited staffing was the second most reported barrier and nearly 43% said they did not have a coordinator/manager who dedicated 0.5 FTE or more to their harm reduction programming. Based off these results, while there have been advances in the support of harm reduction in Ohio, there are still gaps and barriers to sustainability.

Reference List

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5. Ingram DD, Franco SJ. 2013 NCHS urban–rural classification scheme for counties. National Center for Health Statistics. Vital Health Stat 2(166). 2014.