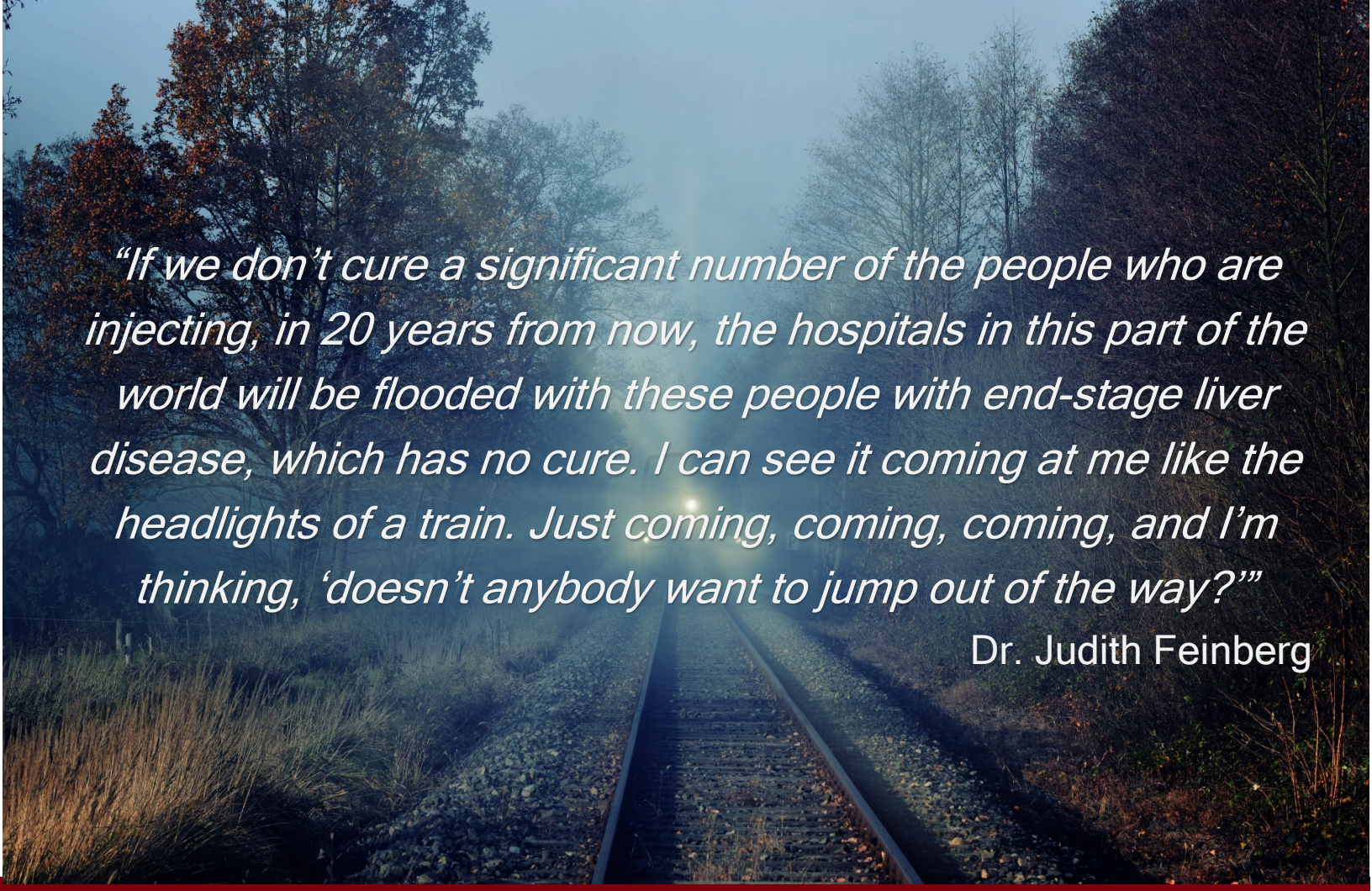


# The Syndemic Roundtable:
## Opioids & Hepatitis C

### Post Meeting Report

### San Diego, California - December 8-9, 2017

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Oregon City, OR 97045

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Caring Ambassadors

# Syndemic Roundtable Post-Meeting Report

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Thank you to our Sponsor MERCK Be well

# Why was the meeting held?

The Caring Ambassadors has been serving communities with a special focus in lung cancer and hepatitis C (HCV) since 1997 with a promise to be BOLD in delivering our mission to improve the lives of patients and communities by empowering and educating them to be advocates for their own health. Being BOLD means different things in various places: the book, *Dreamland* inspired our team to be BOLD in convening a multi-disciplinary group of people to effectively synergize messages that address the opioid and HCV syndemic. These messages will be used to incite Political (macro) and political (local) policy changes focused on the HCV and opioid syndemic.

The compelling stories told by Sam Quinones in his book, *Dreamland* shared a documented history and description of the multiple components that created our opioid epidemic: an epidemic that has caused an alarming spike in HCV rates, especially among younger generations. You don't know what you don't know – Sam, an expert on issues surrounding the opioid epidemic, did not know about the overall HCV impact in the US, let alone the synergistic relationship between opioids and HCV. Sam is not unlike most other Americans.

# Meeting Purpose and Objectives

The overall GOAL of the meeting was to craft targeted, compelling messages for key stakeholder groups that are meant to incite action in addressing the HCV/Opioid Syndemic.

There were two main OBJECTIVES of the 1.5 day roundtable meeting:

1. Convene complimentary key players in the addiction, public health, and viral hepatitis fields to discuss findings in *Dreamland*.
2. Conduct roundtable discussions around the syndemic formed by the opioid epidemic and the viral hepatitis epidemic to craft meaningful and compelling messages to media, play makers and communities.

# Attendees

| Name, City/State of residence | Position/Company |
|---|---|
| Chelsea Amato, New York City, NY | Harm Reduction Specialist/New York city Department of Health & Mental Hygiene |
| Hilary Armstrong, MPH, Chicago, IL | Project Director/Cook County Health and Hospital Systems |
| Daniel Bigg, Chicago, IL | Executive Director/The Chicago Recovery Alliance |
| Tina Broder, MSW/MPH, Oakland, CA | Program Director/National Viral Hepatitis Roundtable |
| Stephanie Cantu, Portland, OR | Program Coordinator/Caring Ambassadors Program |
| Marvin Coklow, Chicago, IL | Assistant Director/Hardin House Drexel Counseling Services |
| Jody Daitchman, San Diego, CA | Co-Founder; Mother; Chairwoman of the Board/Live4Lali |
| Amanda Dugal, PharmD, Boston, MA | Clinical Pharmacist Coordinator/Partners HealthCare Specialty Pharmacy |
| Aimee Dunkle, Rancho Santa Margarita, CA | Mother; Founder/Orange County Needle Exchange Program; Solace Foundation |
| Judith Feinberg, MD, Morgantown, WV | Professor, Behavioral Medicine & Psychiatry/West Virginia University |
| Clinton Herdegen, Libertyville, IL | Chief of Police/Libertyville Police Department |
| Saul Hernandez, Albuquerque, NM | Health Educator/New Mexico Peer Education Project at UNM Project ECHO |
| Franklin Hood, Washington, DC | Hepatitis C Policy Associate/The AIDS Institute |
| Thomas Huggett, MD, Chicago, IL | Medical Director of the Mobile Health Team/Lawndale Community Health Center |
| Robert Lubran, Bethesda, MD | Senior Advisor/National Council of Behavioral Health |
| Rachel McLean, MPH, Oakland, CA | Chief of the Office of Viral Hepatitis Prevention/California Department of Public health |
| Carissa McGee, Albuquerque, NM | Training Support Analyst/University of New Mexico Project ECHO |
| Daniel Meloy, Cincinnati, OH | Administrator and Director of Public Safety/Colerain Township |

| | |
|---|---|
| Michael Ninburg, Seattle, WA | Executive Director/Hepatitis Education Project; World Hepatitis Alliance |
| Sam Quinones, Los Angeles, CA | Author/*Dreamland* – The True Tale of America's Opioid Epidemic |
| Patrick Roberts, San Francisco, CA | Native American Health Policy Fellow/Caring Ambassadors Program |
| Lorren Sandt, Portland, OR | Executive Director/Caring Ambassadors Program |
| Sophie Sprecht Walsh, LPN, Providence, RI | Hepatitis C Program Nurse/CODAC Behavioral Healthcare |
| Scott Stokes/Madison, WI | Section Chief/Wisconsin Department of Health, Substance Abuse Services, Bureau of Prevention, Treatment & Recovery, Division of Care and Treatment Services |
| Luke Tomsha, LaSalle, IL | Executive Director/The Perfectly Flawed Foundation |
| Louise Vincent, MPH, Greensboro, NC | Director of Piedmont Xchange/Urban Survivors Union/North Carolina Harm Reduction Coalition |
| Dante Williams, Chicago, IL | Hepatitis C Program Coordinator/Caring Ambassadors Program |
| Jill Wolf, LCSW, Chicago, IL | Hepatitis C Program Director, Caring Ambassadors Program |
| Jon Zibbell, Atlanta, GA | Senior Public Health Analyst, Behavioral & Urban Health Program/ RTI International |
| Margaret Ziemann, MPH, Alexandria, VA | Program Director, My Journey My Choices/Caring Ambassadors Program |

# Core Concepts from Sam's Presentation

1. American Culture
2. Dynamic & Simultaneous Shifting
3. Pain
    a. Family experience
    b. Mexico must be a part of conversation
    c. The roots of this conversation go back to the 1980s, with a shift towards pain specialists

'We brought them our bodies to fix, like cars.'

    d. With this shift, Pharmaceutical companies saw a huge opportunity
    e. Simultaneous shift of American Culture
    f. We won the Cold War providing a place for Americans to shift to a 'kick back' attitude with a goal towards non-complexity and pursuit of comfort
    g. This transferred into pain – American's didn't want pain. Americans wanted quick miracles
    h. A simultaneous shift was occurring in the medical field to make pain the 5th vital sign. Wait! A vital sign – heart rate, blood pressure, pulse, and temperature – are things you want to maintain. Pain is NOT something you want to maintain, but something you want to get to zero
        i. Pain as the 5th vital sign served as a marketing opportunity
        ii. Drug companies were acting like heroin dealers
    i. Pain took on its own patient advocacy rights to promote the right to pain relief and worked to identify pain strategies without the use of pills
    j. With the introduction of OxyContin things changed:
        iii. The ways in which a drug was promoted changed with a focus on <u>older</u> physicians who were provided with <u>newer</u> info
        iv. More women were hired
        v. The marketing of the drug changed with an increase in 'freebies' (i.e. food, pens, trips, etc.) NOTE: The Sunshine Act was not passed until 2010.
    k. Between 1996-2005 there was a significant increase in the prescription opioid supply with a strong change in attitude on the treatment of pain

vi. This changed the heroin market
vii. This created cartels/underground 'FedEx'

'All profits are private. All costs are public.'

'It's who we are as Americans' – Pills = No Pain. No Risk. Easy.

l. Today Americans are so offended and are on the defensive
viii. Parents are fearful of their kids experiencing pain (ideas, failure, emotions)
ix. 'Being offended is such a narcotic' and as a result 'trigger warnings' are now required
x. Prosperity means big houses, in the suburbs and we isolate our kids
xi. THIS will have a generational impact because heroin's natural habitat is isolation.

'The antidote to heroin is NOT naloxone – it's community.'

'24-hour cable news is like heroin – heroin turns people into hyper-consumers'

m. No ONE thing will do the trick alone to address the heroin crisis
n. We must rethink the way we do jail in America
xii. Some of the most innovative change is being done by law enforcement.
o. We must rethink the way we do treatment in America (pain, addiction)
*xiii.* The space program's motto: *"Not because it is easy, because it's hard"*
xiv. Regiments of pain treatment are not easy, pills are easy.
p. This is no longer a quiet silent epidemic - Parents, Family members, brothers, sisters, tell the story!

'There's not one solution. There's many solutionS.'

# Highlights from Q&A

The Q&A session was filled with passionate exchanges. Some of the most notable exchanges were:

- Ruth's comment on the root cause of over-prescribing of opioids. Ruth identified that most of the over prescribing occurs when medical providers don't have an ongoing relationship with the patient.
- Louise made a very valid point when she brought attention to the fact that active drug users are noticeably absent from discussions that have an impact on them.
- The most passionate exchange was Aimme's response to Sams' use of the term "*drug user*" and "*junkie*". Sam admitted that the use of the word junkie was pejorative; he defended his position on the use of the word 'addict' by echoing what he had previously stated in his book, to paraphrase, "*we are in this mess because we are not willing to call this what it is*". This discussion highlights the power and impact of words and semantics.
- Sam also cautioned the group about asking too much of reporters when asking them to change their language. It is not realistic to ask a journalist to replace one word with 4. For example, replacing 'addict' with 'people who use drugs'. He suggested we would get farther with journalists if we are being thoughtful in our request around language.

# Top Identified Challenges to Address the Epidemic

Prior to the Roundtable, participants were asked to respond to a survey with their opinion of the top 3 challenges that must be addressed to combat the opioid epidemic. The collected responses from all participants were grouped into 7 main themes. These challenges/themes were used to guide roundtable discussion.

| | |
|---|---|
| 1 | Stigma/Public Attitudes of Drug Users/Discrimination |
| 2 | Lack of Treatment Access |
| 3 | Education |
| 4 | Over Prescribing/Over Production; Available Heroin, Fentanyl, etc. |
| 5 | Community Mobilization |
| 6 | Public Health/Social Determinants of Health |
| 7 | Politics/Funding/Policies/Regulations |

# Identified Challenges Discussed

Participants were provided the 7 main identified themes and were asked to further narrow this list by voting on the top 3 of the 7 identified challenges.
Participants discussed the following questions about each top challenge: why is this an identified challenge; in what ways is HCV impacted by the same challenge; What are common themes between the HCV & opioid challenges; and, where do opportunities exist to address the syndemic within the context of the challenge?

Top #1 Challenge: Stigma/Public Attitudes of Drug Users/Discrimination
Top #2 Challenge: Lack of Treatment Access
Top #3 Challenge: Politics/Funding/Policies/Regulations

## Top #1 Challenge: Stigma/Public Attitudes of Drug Users/Discrimination

*"Stigma impedes all kinds of reasonable, thoughtful actions and solutions."* – Dan

Stigma associated with substance use and addiction was a theme interwoven throughout the two-day roundtable discussion. Destigmatizing drug use was commonly cited by participants as a necessary step in curbing the opioid epidemic and resulting opioid/HCV syndemic.

Participants identified several stereotypes held of people who use/inject drugs that perpetuate the stigma associated with drug use, addiction, and resulting infectious diseases like HCV:

- People who use drugs (PWUD) are the *"others"* – We do not mentally identify with drug users and do not believe that we could be personally impacted by addiction.
- Addicts/Addiction looks the same across the board – There is a failure to recognize that addiction can manifest itself differently in each individual. Addiction operates on a spectrum.
- Drug use and addiction are moral failures – They are not recognized as a brain disease or medical issue.
- PWUD lack potential and future – PWUD are held back by the mentality of *"Once an addict, always an addict"*. Luke likened this mentality to addiction being a ball and chain that a drug user in recovery cannot rid themselves of.

The stigma of drug use and addiction manifests itself in many ways which have perpetuated suffering and delayed effective solutions from being implemented:

- A silent epidemic - The opioid epidemic was a silent one for so long, because many people impacted by it were ashamed to admit to it. Public discourse of opioid use did not exist for a long time, delaying effective prevention and solution efforts to the rising epidemic.
- Suffering in silence – Families and friends whose loved ones died of opioid overdoses or were addicted to opioids often suffered and grieved in silence, afraid or ashamed to reveal their loved one's cause of death or health problems. Many families impacted by the opioid epidemic felt alone in their grief. Open and honest discussions regarding drug use were stifled.
- Criminalization – Drug users have been treated as criminals, rather than as individuals suffering from a disease which needs to be addressed using evidence-based treatments.
- Policies and restrictions:
    - HCV care – HCV treatment is highly restricted, especially among Medicaid patients. Many states impose abstinence and/or liver disease stage requirements on HCV patients seeking care. HCV patients are commonly denied treatment. *"It is the only disease we treat this way."* – Rachel
    - Harm reduction opportunities – Needle exchanges and Medication Assisted Treatment (MAT) remain controversial approaches to treating opioid addiction and curbing the rise of infectious disease, despite strong evidence

for their effectiveness. Many view abstinence approaches to drug treatment as the only appropriate option.

The stigma associated with drug use and addiction has been a driver of the opioid epidemic and a barrier to identifying and implementing effective solutions. Roundtable participants discussed efforts that must be undertaken to reduce or eliminate this stigma:

- Encourage people to speak out – Sam stated that, *"We change our minds and feel empathy once we know people (who have been impacted by opioid use)".* To destigmatize drug use and addiction, we must rid the idea of *"other"*. This may most effectively be achieved by hearing from others *'like us'* – friends, neighbors, colleagues - who have been impacted by drug use and addiction. Conversations regarding drug use at large, and the opioid epidemic specifically, must be brought into the norm.
- Take proactive steps to empower current and former drug users – Those in recovery are eager to redeem themselves and grateful for a second chance. Society can leverage this motivation and spirit to support recovering drug users, enable them to fulfil their true potential, and allow them to influence positive change in their own lives and the lives of others. Current drug users and those in recovery need to be involved in discussions and solutions related to the epidemic, not left behind.
- Decriminalization of drug use and possession – Addiction is a disease, not a crime, and it should be treated as such. Decriminalization of drug use must be a priority.
- Reconceptualize treatment and recovery. *"Recovery is any positive change, whatever that means for each person."* - Dan The recovery process should not function based on all-or-nothing extremes. Harm reduction efforts must be valued and implemented as part of a comprehensive approach to drug treatment and recovery.
- Practice empathy – Look beyond an individual's drug use. "*Treat people like human beings."* - Daniel

## Top #2 Challenge: Lack of Treatment Access

Barriers, challenges, and program deficiencies were identified during the group's discussion regarding both HCV and substance use disorder (SUD) treatment access. Opportunities to improve treatment models and increase access to care were also discussed.

Several participants voiced frustration with the lack of linkage to comprehensive care after initial screening. This was true for both HCV and SUD treatment.

Louise relayed the frustrations of substance users who wanted to be screened for HCV but would not be linked to treatment following a positive HCV test. These linkage gaps, experienced by substance users and encountered repeatedly, cause frustration and a sense of helplessness that results in subsequent apathy or avoidance of HCV testing (and other healthcare needs). Participants pointed out that this represents a missed opportunity to stem the transmission of HCV and other infectious diseases, as well as to increase other health promoting behaviors.

Tom and others elaborated on the harm caused by linkage-to-care gaps in the substance use and addiction field, especially as they relate to coordinated, integrated, and wrap-around care.

The barriers that drive the linkage-to-care gaps were identified as:

1. Siloed treatment approaches: The dearth of coordinated, integrated SUD treatment was cited by several participants as being the biggest challenge to accessing proper treatment and resources. The need for integrated care and wrap-around services to treat SUD extends to the following areas:
    - HCV – SUD treatment and HCV care (screening, testing, linkage to treatment, follow-up care) should, but often do not, go *"hand-in-hand"*. This linkage requires coordination between addiction specialists, primary care providers, pharmacists, and infectious disease, or liver specialists.
    - Mental and behavioral health – SUD treatment without mental and behavioral health services is ineffective. Addiction specialists and mental/behavioral health specialists must work together to provide comprehensive addiction and SUD treatment.
    - PCPs – Primary care providers (PCPs) are often not aware of, or don't have access to the necessary resources to link those with SUD and/or HCV to proper treatment

and wrap-around services. PCPs may not be prepared to address the complex needs of substance users once they have completed treatment.

- Detox –continuity of care must be established between detox (rarely successful or beneficial on its own) and evidence-based treatment like MAT to prevent relapses, which can be especially life-threatening immediately following detox.
- Recovery – Most participants agreed that the MAT model works, when implemented correctly. However, continuity of care between completion of MAT and recovery must be prioritized to support the patient after initial treatment has ceased.
- Pain - Pain is often at the root of opioid use and addiction, yet pain and addiction specialists rarely collaborate. Alternative pain management strategies and expertise must be offered as part of a comprehensive approach to SUD treatment.

2. Policy restrictions: Many state-specific Medicaid policies impose HCV treatment restrictions. Many Medicaid patients cannot receive treatment unless they have met drug abstinence and/or liver disease stage requirements.
3. Cost: The cost of both HCV and SUD treatment were cited as being a major barrier to accessing treatment.
4. Lack of awareness and information: Individuals and their loved ones are often unaware of where to turn for support and treatment services. This is true for accessing both HCV and SUD treatment. Daniel pointed out that this is especially true for the families of drug users who have overdosed. Family members may not have been aware that their loved one was using and are overwhelmed and confused by where to turn, and who to trust, for help.

The topic of treatment access broadened to encapsulate the inherent deficiencies in many substance use treatment program designs. Louise and Luke stated that a one-size-fits-all approach, *especially an abstinence-only approach,* is often not appropriate or effective when offering treatment to people who use drugs. Many people who use drugs may not be aware that they need treatment or may not want to stop using drugs altogether. These individuals will not be responsive to abstinence-based programs.

Opportunities to improve treatment and health outcomes and access to HCV and SUD treatment were also shared. Frank cited recent evidence showing that substance use treatment outcomes are improved when patients are screened, test positive for, and receive treatment for HCV. This research highlights an opportunity for integrated care that is dually beneficial for the SUD treatment and infectious disease fields. (The referenced abstract and related research are available on the Caring Ambassadors

Program "*Dreamland* Roundtable" web page at http://hepcchallenge.org/*Dreamland*-roundtable/.)

Other participants contributed follow-up anecdotes illustrating how addressing HCV status can increase substance users' self-efficacy, thus increasing motivation to practice other health promoting behaviors, such as tobacco cessation and weight loss. Despite the stereotypes that persist in society, these antecedents and recent research outcomes contradict widely held stereotypes about drug users, which Michael made clear in his opening comment by stating, *"People who use drugs care about their health."* Roundtable participants agreed that there is an opportunity to leverage the mediating effect of HCV screening and treatment to improve substance use treatment outcomes, including harm reduction behaviors.

Primary care providers (PCPs) were identified as an underutilized resource in the comprehensive care of both SUD and HCV. Participants noted that, as many patients' initial and/or most trusted point of care, PCPs are in a unique position to screen for both SUD and HCV. Additionally, PCPs may continue to provide care for patients after SUD or HCV treatment, providing a source of care continuity. PCPs become especially relevant as specialty care providers in rural areas, where HCV specialists or SUD treatment providers may not be accessible. While most participants agree that PCPs provide an excellent opportunity for point-of-care specialty treatment, the model does not come without challenges. Bob pointed out that PCPs rarely engage in SUD treatment and recovery care due to time constraints and the lack of resources or expertise needed to provide a patient with integrated care, such as mental and behavioral health.

Regarding treatment program design, Louise suggested asking the question, *"What would you like your treatment to look like?"* to effectively engage more people who use drugs in a tailored treatment model and harm reduction practices. Many participants liked this approach. Additionally, it was noted that treatment services and outreach are most effectively offered when you meet people where they are at, rather than expect them to come to you.

### Top #3 Challenge: Politics/Funding/Policies/Regulations

National reports need to be reviewed to see where we can leverage opportunities identified in the reports at the local level. All politics are local. To be successful we need good data and a strategic plan on creating educated advocates on making local change that influences larger policies.

- It is important for everyone to understand the dynamics of local, state, and national policy and how they influence each other.
- Engaging your local opioid task force on the syndemic is a place to start local policy change.
- Educating elected officials on the infectious disease consequences of the opioid epidemic should be a priority as they are funding different opioid initiatives.
- The group discussed the need for education including HCV 101, Washington, DC 101, the appropriation process and the legislative process.
- Need to develop an infographic on the syndemic with the data coming out from Center for Disease Control (CDC) and Jon Zibbell.
- Any policies or legislation should be a 2-way highway that allows programs and funding to flow in both directions in order to address both HCV and the opioid epidemic simultaneously.

## Stakeholder Identification

The following section was designed to facilitate large group discussion around key stakeholder groups and the general messages we want to convey to those groups about the syndemic. Five main stakeholder groups were identified:

1. Primary Care/Pharmacists
2. Addiction Specialists/MAT/Pain Specialists
3. General Public
4. People who use drugs
5. Law Enforcement/Prisons

Following the large group discussion, participants split up into smaller workgroups to discuss the following questions:

- What champions exist within that group?
- What type of behavior change do we want to see from that group?
- Who/what influences them?
- What is the best platform to reach them?
- What does the group stand to gain or lose?

# Stakeholder Message Development

## 1. Primary Care/Pharmacists

| | |
|---|---|
| Overall Message | Caring is Curing, Drug Users are a part of the community |
| Incite Action | Encourage the building and cultivating of relationships between patients and providers, as well as users to treatment (HCV & SUD). |
| Outcome | Strengthen relationships between key stakeholders, bring medical leaders together with leaders from other stakeholder groups to encourage co-located testing and treatment. |
| Message/ Image | You can treat and cure your patients with hepatitis C |

## 2. Addiction Specialists/MAT/Pain Specialists

| | |
|---|---|
| Overall Message | Patients with addiction disorders have more successful and healthier futures because they are tested and cured of HCV. |
| Incite Action | Empower people in recovery to engage and empower their peers |
| Outcome | Reduce and demystify recidivism/relapse – Providers may ask 'why cure patients with HCV if they're just going to come back positive' – dispel this by showing that education of HCV and risk reduction to patients helps them not go back to high risk drug use; treatment is incentive not to return to high risk drug use |
| Message/ Image | Image of a Chevelle (patient before treatment) and a Ferrari (patient after treatment) |

## 3. General Public

| | |
|---|---|
| Overall Message | HCV is an easy win that can make people ready to address their addiction |
| Incite Action | Story sharing and 'coming out' with the realities and truth of addiction and HCV |
| Outcome | Greater comfort discussing addiction and infectious disease |
| Message/ Image | It's ok to talk about it. Learn to talk about it.<br>Healthful ripple effect of a cure |

## 4. People who use drugs

| | | |
|---|---|---|
| 1. | Overall Message | You are the experts! You have the answers! (Empowerment) |
| | Incite Action | Incite Action through stories and lived experiences; Education of stats and facts |
| | Outcome | Take people to the Hill to share stories, build movement and momentum |
| | Message/ Image | for zine/brochure with a personal story, facts and info<br>This is a (HCV)<br>  <br>Hero~~in~~<br>~~Addict~~ |
| 2. | Overall Message | Addiction is a treatable disease, not a crime;<br>If you care about the opioid epidemic, you care about HCV<br>↑ HCV ↑ drug use ↑ death<br>School Message: Young people need to know:<br>↑ HCV ↑ drug use ↑ death |
| | Incite Action | Develop a communication glossary; Develop a social media campaign framed around treating a puppy/kitten/baby who may have HCV; Develop a campaign around treating mothers of child bearing age with an emphasis on 'if you don't treat X# of mothers with HCV then X# of babies will be born in 2018 exposed to HCV'; Development of a recovery group for people with SUD & HCV; mandatory HCV screening, testing and care in any drug treatment environment |
| | Outcome | HCV testing leads to more successful treatment outcomes and a healthier future |
| | Message/ Image | Treatment Works; There are many options; We do care about our health and the care of our families.; It can happen to anyone; You can't imagine the change until you see it; Your voice matters – use it; You are worthy; Anybody BUT NOT ME! Until it's you. |

## 5. Law Enforcement/Prisons

| | | |
|---|---|---|
| 1. | Overall Message | You can eliminate HCV. We can't eliminate it without you; The State will pay for it either way. (Corrections);<br>Opioids are hard to quit. MAT can reduce injection drug use, overdose and HCV. (Law Enforcement) |
| | Incite Action | Listen: Engage Law Enforcement at opioid task forces; Include HCV in the discussion through inviting local health department officials, HCV Coordinators, survivors to speak about HCV at Opioid TF meetings<br>Implement: diversion programs that connect to coordinated care; HCV into LEAD programs |
| | Outcome | Addressing HCV can help you address opioids: it is part of the solution |
| | Message/ Image | The more people cured of HCV…<br>a. The more people will try to stop/reduce drug use (research supported)<br>b. The less overdose will happen (cost savings)<br>c. The less transmission of HCV (prevention = money saved) |
| 2. | Overall Message | Combatting Addiction in the community is not best served in handcuffs; Prisoner health is community health; Community is an extension of our homes |
| | Incite Action | Policy and Local Level change: i.e. Lake County Opioid Addictions Unit<br>Comprehensive healthcare approach to HCV – Text/Treat/Navigate -create 'baby steps' at local/state/federal level<br>Leverage the fact that law enforcement is available 24/7 |
| | Outcome | 'Lake County Help' Resources App; Identify alternatives to incarceration; Education about HCV on: cost, risk reduction and health risks |
| | Message/ Image | Treat HCV. Prescribe MAT/Naloxone<br>Visual of a poster showing what community is – showing all various faces |

# Conclusions, Next Steps, Reflections, Pre/Post Data

In conclusion, this meeting made clear the vital need to collaborate among multidisciplinary professionals and provide opportunities for cross training and collaboration. Working within a syndemic model and framework provides multiple opportunities to identify solutions to those working within these synergizing epidemics. Further, many participants had little to no knowledge on the impact of viral hepatitis and HCV among people who use drugs. This is a vital next step in our efforts to address the opioid epidemic. Messages need to be further developed and field tested. Language is important and a concerted effort by community members must include discussion around how to talk about addiction and infectious diseases. Funding needs to be secured for media campaigns and mass distribution of syndemic educational materials. The Roundtable needs to expand and include more participants from the 5 target groups identified: Primary Care/Pharmacists; Addiction Specialists/MAT/Pain Specialists; General Public; People who use drugs; and, Law Enforcement/Prisons. It was agreed among participants that a second roundtable meeting focusing on educating key policy makers was identified as an important step in the movement.

Participants were asked to say one word that reflects upon where they are left following the conclusion of the meeting. The following words are direct quotes from participants who were present at the close of day 2.

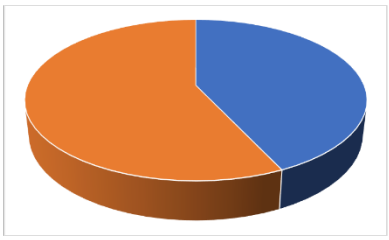
| | | | | | |
|---|---|---|---|---|---|
| Hopeful | Thankful | Passionate | Motivated | Optimistic | Grateful |
| Motivated | Connected | Closer to the Issue | Inspired | Grateful | Awakened |
| Energized | Eye-Opening | Humble | Curing is Caring | Responsible | Fired Up |
| Validated | Empowered | Called to Action | Novel | Grateful | Rejuvenated |
| Politically Motivated | Humble | Inspired & Loved | Goose Bumps | Honored | Language Matters |

## Pre-Test & Post-Test Questions & Outcomes

1. Have you heard of the term ‘syndemic’ prior to the meeting?

| | Pre |
|---|---|
| Yes | 43% |
| No | 57% |

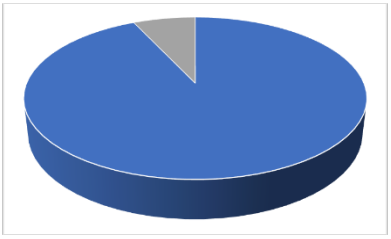
PRE



2. I understand HCV, what it is, and how it relates to the opioid epidemic.

| | Pre | Post |
|---|---|---|
| Yes | 93% | 100% |
| No | 0% | 0% |
| Unsure | 7% | 0% |

PRE



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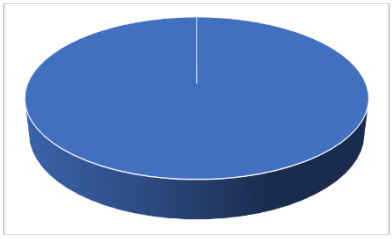
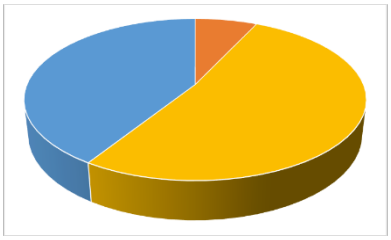


3. On a scale of 1-5, how would you rate your current ability to effectively explain the opioid/HCV syndemic (history, impact) to others?

| | Pre | Post |
|---|---|---|
| 1 – No ability | 0% | 0% |
| 2 – Minimal ability | 7% | 0% |
| 3 - Neutral | 0% | 0% |
| 4 – somewhat able | 52% | 19% |
| 5 – strongly able | 41% | 78% |

PRE



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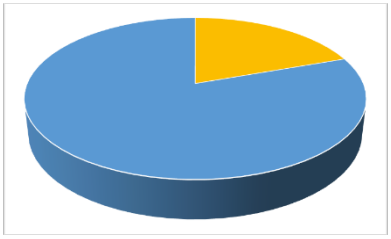
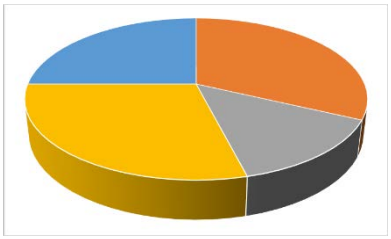


4. How confident are you that you have the ability to impact or influence the opioid/HCV syndemic within your respective field or area of affiliation?

| | Pre | Post |
|---|---|---|
| No Confidence | 0% | 0% |
| Some Confidence | 32% | 11% |
| Neutral | 14% | 4% |
| Confident | 29% | 3% |
| Very Confident | 25% | 52% |

PRE



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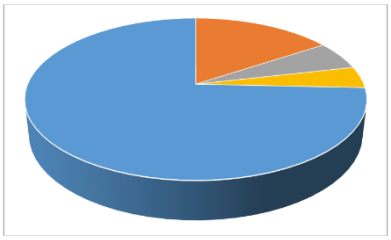
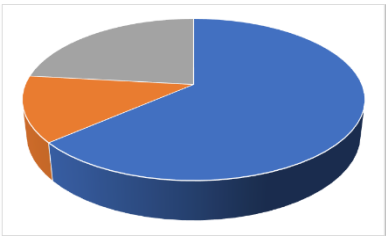


5. Do you feel that you possess the resources/network connections necessary to take action steps in communicating and addressing the opioid/HCV syndemic?

| | Pre | post |
|---|---|---|
| Yes | 63% | 89% |
| No | 13% | 0% |
| Unsure | 23% | 11% |

PRE



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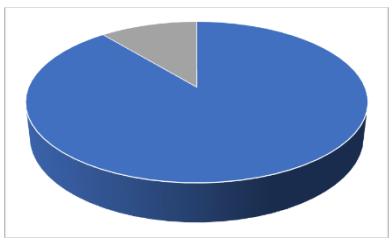
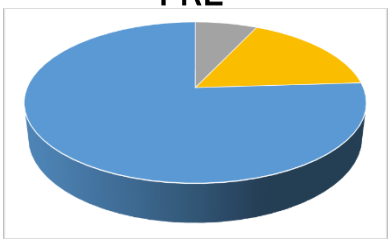


6. On a scale of 1-5, how motivated are you to take action to address the opioid/HCV syndemic?

| | Pre | Post |
|---|---|---|
| Unmotivated | 0% | 0% |
| Somewhat Motivated | 0% | 0% |
| Neutral | 7% | 0% |
| Motivated | 17% | 15% |
| Strongly Motivated | 76% | 85% |

PRE



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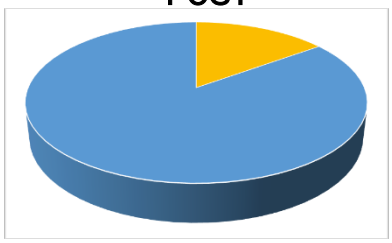
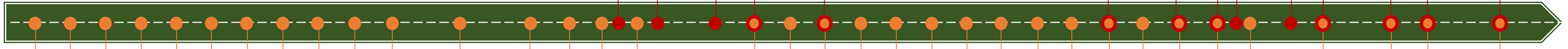


Author Sam Quinones addresses the group.

Roundtable participants pose for a group shot.

# The Syndemic Timeline



**1804**
Morphine is distilled from opium for the first time.

**1839**
First opium wars brakes out and Britain forces China to sell it's India-grown opium and British take Hong Kong.

**1853**
The Hypodermic syringe is invented. Inventors wife is first to die of injecting drug overdose.

**1898**
Bayer chemist invents diacetylmorphine, names it heroin.

**1914**
US Congress passes Harrison Narcotics Act.

**1928**
What eventually becomes known as the Committee on the Problems of Drug Dependence forms to organize research in pursuit of the holy grail: a non-addictive painkiller.

**1935**
The Narcotic Farm in Lexington, Kentucky opens as a federal prison/drug rehabilitation and research center.

**1951**
Arthur Sackler revolutionizes drug advertising with campaign for antibiotic Terramycin.

**1952**
Arthur, Raymond, and Mortimer Sackler buy Purdue Frederick.

**1960**
Arthur Sackler's campaign for Valium makes it the industry's first $100 million drug.

**1974**
The Narcotic Farm closes and is transformed into a medical center and prison.

**1980**
Stjernsward made chief of the cancer program for World Health Organization, Devises WHO ladder of pain treatment.

The *New England Journal of Medicine* published letter to editor that becomes known as Porter and Jick.

First Xalisco migrants set up heroin trafficking business in the San Fernando Valley of Los Angeles.

**1984**
Purdue releases MS Contin, a time-release morphine painkiller marketed to cancer patients.

**1986**
Drs. Kathleen Foley and Russell Portenoy publish paper in the journal *Pain*, opening a debate about he use of opiate painkillers for wider variety of pain.

**1987**
Arthur Sackler dies, having revolutionized pharmaceutical advertising.

**1989**
Discovery of hepatitis C Virus

**1990**
Xalisco Boys heroin cells begin expanding beyond San Fernando Valley to cities across western US. Their pizza-delivery-system evolves.

**1991**
First hepatitis C treatment approved

**1992**
Testing virtually eliminates hepatitis C virus from US blood supply

**1996**
Hepatitis C infections continue to dramatically decline.

**1996**
Purdue releases OxyContin, time-released oxycodone, marketed largely for chronic-pain patients.

Dr. David Procter's clinic in South Shore, Kentucky, is presumed the nation's first pill mill.

President of American Pain Society urges doctors to treat pain as a vital sign.

**1998**
CDC issues recommendations on hepatitis C prevention and control.

**1998**
"The man" takes Xalisco black tar heroin east across the Mississippi river for the first time, lands in Columbus, Ohio.

In Portsmouth, Ohio, Dr. David Procter has an auto accident that leaves him unable to practice medicine But still capable of running a pain clinic. He hires doctors who go to open clinics.

**Late 1990's**
Xalisco Boys heroin cells begin to spread to numerous cities and suburbs east of Mississippi River.

**1998-1999**
Veteran's Administration and JCAHO adopt idea of pain as fifth vital sign.

**2000**
Operation Tar Pit targets Xalisco heroin networks – the largest joint DEA/FBI operation and first drug conspiracy case to stretch from coast – to-coast.

**2001**
Injured workers covered under Washington States workers comp system start dying of opiate painkillers.

**2002**
Dr. David Procter pleads guilty to drug trafficking and conspiracy and serves eleven years in federal prison.

**2004**
Washington State Department of Labor and Industries Drs. Gary Franklin and Jaymie Mai publish findings on deaths of injured workers due to overdoses on opiate painkillers.

**Mid 2000's**
Xalisco black tar heroin cells are now in at least seventeen states. Portsmouth, Ohio, has more pills per capita than any US town.

Florida's lax regulations make it another center of illicit pill supply.

**2006**
Operation Black Gold Rush, a second DEA operation targeting Xalisco heroin cells across the country.

**2007**
Deaths from hepatitis C surpass HIV in US.

**2007**
Purdue and 3 executives plead guilty to misdemeanor charges of false branding of OxyContin; fined $634 million.

**2008**
Drug Overdoses, mostly from opiates, surpass auto fatalities as leading cause of accidental death in the US.

**2010**
Institute of Medicine report issued on viral hepatitis .

**2010**
Drug violence between Los Zetas and Sinaloa cartels spreads to Xalisco, Nayarit.

**2011**
National Action Plan released and July 28 declared World Hepatitis Day.

**2011**
Ohio passes House Bill 93, regulating pain clinics.

**2012**
First National Testing Day and CDC recommends testing all people born 1945- 1965 for hepatitis C.

**2013**
The College on the Problems of Drug Dependence turns seventy-five without finding the Holy Grail of a nonaddictive painkiller.

**2013**
CDC study shows that annual hepatitis C-related mortality surpassed the total combined number of deaths from 60 other infectious diseases reported to CDC, including HIV, pneumococcal disease, and tuberculosis.

**2014**
Actor Philip Seymour Hoffman dies, focusing widespread attention for the first time on the US opiate-abuse epidemic and the transition from pills to heroin in particular.

The FDA approves Zohtdro, a time-released hydrocodone pain-killer with no abuse deterrent. It also approves Purdue's Targiniq ER, combining timed-release oxycodone with naloxone, the opiate-overdose antidote.

FDA approves Naloxone, the injectable drug that reverses opioid overdoses.

**2014**
FDA Approves Harvoni (ledipasvir and sofosbuvir) for Hepatitis C,

The 2014 World Health Assembly requested the World Health Organization (WHO) to examine the feasibility of eliminating hepatitis B and C

**2015**
FDA approves Narcan, the nasal spray version of Naloxone.

DEA issues Nationwide Alert on Fentanyl (synthetic opioid) as Threat to Health and Public Safety.

**2015**
WHO Agenda for Sustainable Development commits to combating viral hepatitis.

**2016**
Legendary singer Prince dies of a Fentanyl overdose.

Federal government releases ban on federal funds being used for syringe exchange programs.

**2016**
Eliminating the Public Health Problem of Hepatitis B and C in the United States: Phase One Report.

President Obama signed the Comprehensive Addiction and Recovery **Act** (**CARA**) in to law.

**2017**
President Trump declares the opioid crisis a public health emergency.

The President's Commission on Combatting Drug Addiction and the Opioid Crisis Final Report is released *JAMA*-published study finds that average life expectancy gains between 2000 and 2015 were reduced by more than 3 months, mostly due to opioid-related deaths.

**2017**
The Committee on a National Strategy for the Elimination of Hepatitis B and C released its phase two report