

KANAWHA-CHARLESTON
HEALTH DEPARTMENT
Harm Reduction Syringe Services Program
Program Procedure Manual

May 1, 2017



Parts of this manual were adapted from the
Kentucky Harm Reduction and Syringe Exchange Program (HRSEP)
Kentucky Department of Health

Per CDC guidance, HRSEP (Harm Reduction and Syringe Exchange Program) and HRSSP (Harm Reduction and Syringe Services Program) are used interchangeably throughout this document.

Harm Reduction Syringe Services Program

Program Procedure Manual

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INTRODUCTION

SYRINGE POSSESSION ORDINANCE

The first step of establishing a Harm Reduction Program is assessing the city ordinance where the program will be housed. Under SEC.78.396-Needle Exchange Program Authorized, sets for that:

The City of Charleston, by and through its Chief of Police, may sponsor, approve, or participate in a program or programs within the City of Charleston for the distribution or exchange of hypodermic syringes, needles and other similar objects used or designed for injecting substances into the human body (Bill No. 7666, 9-21-2015).

This ordinance was established September 21, 2015 and heralded the establishment of legal Harm Reduction Programs in the City of Charleston. The second ordinance gives authority to the Chief of Police to establish programs within the City of Charleston, SEC. 78-397-Rules and Regulations; Chief of Police authorized:

The Chief of Police of the City of Charleston Police Department is authorized to promulgate reasonable rules or regulations deemed necessary to implement and administer a program within the City of Charleston provided for in Section 78-396 for the distribution or exchange of hypodermic syringes, needles and other similar objects used or designed for injecting substances into the human body (Bill No. 7666, 9-21-2015).

Harm Reduction and Syringe Exchange Programs (HRSSPs) are comprehensive programs designed to provide safe disposal of needles for injection drug users (IDUs), testing for blood borne viral infections for those at greater risk of infection due to injection drug use, supply clean needles to lessen the possibility of infection from shared needles, and to help IDUs find treatment and social services with which they may not otherwise be familiar. HRSSPs can also provide resources and education to the family members and friends of IDUs.

HRSSPs are designed to reduce the likelihood of transmission of blood borne diseases by providing sterile injection equipment to IDUs and reducing the potential of sharing syringes among this population. IDUs account for approximately 16 percent of new HIV infections in the United States¹ and almost one half (48 percent) of newly reported acute hepatitis C virus (HCV) infections are IDU related. Currently, there are no commercially available vaccines for HIV and HCV.⁵

⁵ Hall HI, Song R, Rhodes P, Prejean J, An Q, Lee LM, Karon J, Brookmeyer R, Kaplan EH, McKenna MT, Janssen, RS for the HIV Incidence Surveillance Group. Estimation of HIV incidence in the United States. JAMA. 2008;300(5):520-529.

² Des Jarlais DC, Hagan H, Friedman SR, et al. Maintaining low HIV seroprevalence in populations of injecting clients. JAMA. 1995;274:1226-1231.

Scientific evidence indicates one of the most effective strategies for combating HIV infections among IDUs is ensuring access to sterile syringes by IDUs who cannot or will not stop injecting drugs. The Institute of Medicine of the Academy of Sciences has said: “For injection clients who cannot or will not stop injecting drugs, the once-only use of sterile needles and syringes remains the safest, most effective approach for limiting HIV transmission.”

Therefore, the public health benefits of HRSSPs arise from (1) removing potentially infectious syringes from the community, (2) providing IDUs with sterile syringes and other clean injection equipment, and (3) distributing condoms. Several studies have found that HRSSPs reduce HIV incidence among IDUs. Most studies of injection-related HIV and HCV risks have found HRSSPs to be associated with a lower likelihood of syringe sharing or reductions in syringe sharing. Ecological studies have found that locales with HRSSPs tend to have lower HIV seroprevalence among IDUs,^{2,3,4,5} and one study reported that closing a HRSSP resulted in increased prevalence of HIV risk behaviors among IDUs. Other public health benefits of HRSSPs include the linkage of IDUs to critical services and programs and promoting integrative care among drug treatment programs, HIV/AIDS prevention and treatment services, HCV prevention and treatment programs and social and behavioral health services. The evidence for the public health benefits of HRSSPs is strong and consistent over time. See Appendix A for a list of relevant journal articles, survey results and research specifics. HRSSPs have successfully operated in the United States since the late 1980s.

Syringe access saves lives and is cost effective. The CDC has stated a public health goal of 100% coverage, with all injections performed with a sterile syringe, noting that the onetime use of sterile syringes remains the most effective way to limit HIV transmission associated with injection drug use. HRSSPs reduce the spread of infection and address the personal and public health risks of injection drug use in a cost-effective, comprehensive fashion. A sterile syringe costs approximately \$0.97 and the average IDU injects approximately 1,000 times per year. While the lifetime cost of treating someone with HIV can be as high as \$618,000 and the lifetime cost of treating someone with HCV is estimated between \$100,000 and \$300,000.

HRSSPs are comprehensive service programs that include appropriate linkage and referral to substance abuse prevention and treatment services, behavioral health, blood borne pathogen prevention and treatment and other support services. Harm reduction is a set of practical strategies and ideas aimed at reducing the harm to the individual and society associated with

³ Heimer R, Kaplan EJ, Khoshnood K, et al. Needle exchange decreases the prevalence of HIV-1 proviral DNA in returned syringes in New Haven, Connecticut. *Am J Med.* 1993;95:214-220.

⁴ Vlahov D, Junge B. The role of needle exchange programs in HIV prevention. *Public Health Reports.* June 1998; vol.113(Supp 1):75-80.

⁵ Bluthenthal RN, Ridgeway G, Schell T, Anderson R, Flynn NM, Kral AH. Examination of the association between syringe exchange program (SEP) dispensation policy and SEP client level syringe coverage among injection clients. *Addiction.* 2007;102(4):638-646.

drug use. Harm reduction incorporates a spectrum of strategies from safer use to meeting clients “where they are,” addressing conditions of use along with the use itself.

LAYING THE GROUNDWORK FOR PROGRAM IMPLEMENTATION

This chapter discusses the various factors that health departments will need to consider as they plan and implement HRSSPs in their jurisdictions, including the importance and necessity of assessing the community’s need and readiness for HRSSPs, ways of working with law enforcement and strategies for building strong community relationships. General principles of community inclusion and creating programs and policies that are culturally and linguistically appropriate and reflect the makeup of the community should be incorporated.

All HRSSP programs should be designed in a manner that will enable local health departments to effectively serve culturally diverse communities. Specifically, all program components, materials and marketing messages should reflect the history and culture of the target population and be linguistically-appropriate. Additionally, local health departments should have a culturally competent workforce, including a diverse management team, have organizational policies that support the delivery of culturally competent services and care and a process for identifying if cultural competency goals have been met.

I. Assessing the Community’s Need for HRSSPs

The first step in considering whether to implement a HRSSP is to determine whether the need exists in the health department jurisdiction. Local health departments and community partners may identify IDUs as a target population by using community needs assessments of key epidemiological factors including HIV and/or HCV prevalence and demographics of risk groups⁶ and select the HRSSP as an appropriate intervention.

After the needs assessment is complete, health departments may work with community planning partners and other partners to (1) identify ways to tailor services based on the specific needs of special risk subgroups of IDUs in the community, (2) select the types of syringe distribution and service delivery models most appropriate given resources and context and (3) identify potential locations for HRSSPs. Health departments may need to educate community partners about IDU-related epidemiological data and the importance of HRSSPs as an intervention to further address the shared goal of reducing the incidence of blood borne pathogens in the community.

II. Assessing the Community’s Readiness for HRSSPs

Once the health department has determined that a HRSSP is needed to address the HIV/HCV prevention needs of IDUs, the next step is to assess whether the community is “ready for” or

⁶Heinzerling KG, Kral AH, Flynn NM, Anderson RL, Scott A, Gilbert ML, Asch SM, Bluthenthal RN. Unmet need for recommended preventive health services among clients of California syringe exchange programs: implications for quality improvement. *Drug and Alcohol Depend.* February 1 2006;81(2):167-178.

receptive to a HRSSP. West Virginia's law requires the development of a HRSSP in any given county to be a local decision. Approval of three separate entities is required. The local health department's Board of Health must agree to operation of a HRSSP. Then, the legislative bodies of both the city and county governments for which the program will be operated must give consent for the operation of the program. Therefore, gaining community approval of a HRSSP is a very important step. Community support is necessary before a HRSSP can be implemented. The following sections outline ways to build community support.

III. Building Community Support for HRSSPs

Providing sterile syringes to IDUs has been shown to reduce sharing of syringes. But like other important public health interventions, to successfully implement HRSSPs, there must be an enabling environment consisting of support from key stakeholders such as selected public officials, other government agencies, the public and consumers. Building community support for HRSSPs is an integral part of successful HRSSP implementation. A careful and systematic process can help build community support for HRSSPs, including assembling the facts and intervention options, assessing stakeholder knowledge and attitudes, and developing an action plan. HRSSPs operate best in a supportive community environment. Staff, volunteers and HRSSP participants should be involved in community engagement programs. Several strategies have proven effective across a broad range of programs and locations, including: (1) building relationships with community leaders, officials, opinion leaders, law enforcement, public health officials, religious leaders and groups, and businesses most affected by HRSSP site location; (2) educating the community about drug use, HRSSPs, and safe syringe disposal; (3) framing messages about HRSSPs to emphasize the community benefits, including reduced HIV and HCV infection rates, proper syringe disposal, and cost-effectiveness; (4) understanding and addressing the concerns of resistant stakeholders in the community; (5) recruiting staff and volunteers who represent the community where the site is located; and (6) involving IDUs in the HRSSP planning process so their voices and concerns are heard. As described below, several steps can be taken to successfully implement HRSSPs.

(a) Assemble the Facts and Intervention Options

Start by assessing the characteristics of the local IDU epidemic and identifying current modes of syringe access. HRSSPs take many forms, and depending on the spatial distribution of IDUs, the accessibility of other health care facilities, and other relevant factors, more than one approach may be worth considering. Having identified potential HRSSP models, health departments will also need to consult with their legal counsel and other stakeholders to discuss the viability of each prospective HRSSP option for the specific jurisdictions.

(b) Assess Stakeholder Knowledge and Attitudes

Identify key stakeholders and assess their knowledge of and attitudes toward HRSSPs. A HRSSP may fail if it is framed negatively or communities resist it. Police, prosecutors, and public defenders are encouraged to be engaged in the HRSSP development from the outset to help ensure the program's success.

I. An Opportunity for Collaboration

Local health departments that desire to operate a HRSSP should contact local law enforcement leadership prior to approaching city or county units of government, if possible. Harm reduction should be explained in a three-part application to include: reducing harm to the community, reducing harm to addicted persons and officer safety. The array of services offered immediately, as well as those planned, should be fully explained. The goals of the program should be clearly outlined as well as the expectations of clients. Data concerning the increase and dangers of Viral Hepatitis and HIV often spread by IDUs, the goals and benefits of a HRSSP and the success of existing programs in other states should be discussed. Details such as location, mobile or stationary, and expectations of clients and staff may benefit from law enforcement input.

Current partners for the Kanawha-Charleston Harm Reduction include:

Local

- Cabin Creek Health Systems
- Charleston Area Medical Center (CAMC)
- Charleston Police Department
- City of Charleston
- Family Care
- First Choice Services
- Fruth Pharmacy
- HEAT Taskforce
- HELP 4 WV
- Highland Hospital
- Kanawha Coalition for Community Health Improvement
- Kanawha County Substance Abuse Coalition: Kanawha Communities that Care
- Partnership for African American Churches
- Pretera Center
- Putnam Wellness Coalition
- Recovery Point
- Regional Family Resource Network
- Roark Sullivan Lifeway Center
- Thomas Hospital
- University of Charleston
- WV Health Right

State Level

- ACES Coalition
- Drug Enforcement Administration 360
- WVU Osteopathic School of Medicine
- WVU School of Medicine and Public Health

National/Federal

- Appalachian High Intensity Drug Trafficking Area (HIDTA)
- Johns Hopkins University
- National Harm Reduction Coalition

II. Waste Management for Syringe Disposal

As part of building community partnerships, it is useful to engage city, county or state waste management boards and their leadership, meet with them to introduce the program, and outline waste management plans. Collaborating with waste management staff is a good way to discuss how to expand syringe disposal through hazardous waste disposal programs already in place or through stand-alone syringe disposal kiosks. Hospitals or physician offices may provide in-kind support of the HRSSP through an agreement to provide disposal services of used syringes for the HRSSP. Because the primary goal of the HRSSP is to protect IDUs and the public from dirty needles and syringes, a HRSSP must have a waste management plan in effect from its outset.

(a) Infectious Waste Protocol

The following is a copy of the Infectious Waste Protocol for Kanawha-Charleston Health Department. All volunteers and employees working the Harm Reduction Program are asked to sign the agreement form.



Kanawha-Charleston Health Department

PROCEDURE TITLE: Infectious Waste Management Plan

PROGRAM AREA: Clinical

PROCEDURE NUMBER: CL-016

PURPOSE STATEMENT: All personnel that generate or handle infectious waste are responsible for reading, understanding, and implementing the following infectious waste management policies and procedures. Definition: Infectious waste is an untreated solid waste capable of causing an infectious disease via an exposure to a pathogenic organism of sufficient virulence and dosage through a portal of entry in a susceptible host. Infectious waste includes the following types of waste: (refer to infectious waste definitions in the regulations for specific types).

- A. Sharps (i.e. Needles, syringes with attached needles, scalpel blades, glass slides, broken glass, etc.).
- B. Cultures and stocks of infectious waste agents (i.e. blood specimen tubes, culture plates).
- C. Blood and blood products in a free flowing or unabsorbed state, blood saturated gauze, or bandages.
- D. Pathological waste.

STEPS INVOLVED IN ACTIVITY:

The infectious waste coordinator or committee member responsible for implementing the infectious waste procedures is/are:

Stephanie DeWees, RN BSN
Nursing Director
108 Lee Street, East
Charleston, WV 25301
Phone: 304.348.8080
Fax: 304.348.6499

Alternate contact person:

Candace Nunley, LPN
Office Practice Manager
108 Lee Street, East

Charleston, WV 25301
Phone: 304.348.8080
Fax: 304.348.6499

1. The following is an explanation of the infectious waste management plan:
 - A. Sharps will be segregated and collected in plastic needle boxes provided. A sharp includes all items of glass, needles, blades, etc. Saturated dressings, gauze, plastic blood specimen tubes, and culture plates will be segregated and collected in a trash container lined with a red plastic bag. Sharps containers will not be filled over $\frac{3}{4}$ full and the container's lid will be tightly secured at all times. Once containers have reached $\frac{3}{4}$ full capacity, the needle box lid will be secured in its closed position and place in the lab closet.
 - B. Sharps containers are found in the following locations: clinic lab, clinic rooms, clinic pharmacy, HIV room, sexually transmitted disease (STD) doctor desk and the harm reduction room.
 - C. Sharps can also be found in the 24-hour tamper-proof community disposal kiosks located in the side parking lot of the Kanawha Charleston Health Department. In the future other kiosks may be added out into the community.
 1. Transport employees will monitor the community disposal kiosks weekly.
 2. The kiosks will be locked always and only unlocked by the transport employees
 3. All sharps must be placed in approved leak proof, plastic and rigid, puncture-resistant containers that are conspicuously labeled "contains sharps".
 4. If there are single sharps present, the transport employee will use a grip and grab reach tool to pick up the sharps and place them in the sharps container. At no time, will the transport employee use their hands to pick up any of the sharps.
 5. Once all sharps are in the above container, the lid will be placed on it and the container will be sealed.
 6. The transport employee will place a new sharps container in the kiosk and lock the door.
 - D. Infectious waste containers are not to be accessible to patients, the public, vectors, or exposed to the elements.
 - E. Storage rooms, cabinets, and containers used for infectious waste will be labeled and identified with the words Infectious Waste or the international biohazard symbol.
 - F. In the event of the waste container being contaminated by infectious waste, decontamination of the container will be accomplished by application of a sanitizer (i.e. 1:10 solution of household bleach and water to the contaminated area) then wiping the area clean with paper

towels or a sponge. The person cleaning the waste container will wear latex gloves and other appropriate gear (i. e. nose and mouth mask, moisture resistant apron or gown, eye protection) to prevent exposure to infectious waste.

- G. Filled infectious waste containers at KCHD-PC will be stored in the designated clinic lab closet prior to disposal/treatment.

2. Treatment of infectious waste:

Onsite treatment of infectious waste:

- A. The Kanawha- Charleston Health Department-Putnam County is using a device (Sterilis Medical Waste Processing System) that combines steam sterilization with a grinder, allowing it to be treated on-site and at point-of-care in about 60 minutes and requiring no dedicated plumbing, drainage, or fixtures
- B. The Sterilis Medical Waste Processing System will be install, operated and maintained in accordance with manufacturer's specifications and recommendations as described in the Sterilis Operating Manual, Version 3.2.
- C. The system will not be used to treat chemotherapy, radioactive, gross anatomical wastes, hazardous or pharmaceutical waste, suction canisters and bulk liquid waste greater than 300 ml of liquid.
- D. The medical waste will be placed into the device, shutting the lid, and pushing the green start icon on the touchpad, the waste will be sterilized at 138 C^o.
- E. The waste is held at this temperature for about 30 minutes, and then is released into a grinding mechanism that transforms the waste into a confetti-like substance and drops it into a collection drawer that contains a bag with all corresponding regulatory markings.
- F. The collection bag will then be placed into a solid waste receptacle.
- G. The Sterilis system will be evaluated no less than forty (40) hours under full load conditions for effectiveness with spores of *Bacillus stearothermophilus*.
- H. Logs will be maintained that record the weight and volume of daily output, operational temperatures, servicing both regular and emergency, and efficacy monitoring for three (3) years.

Offsite treatment of infectious waste:

- A. A regulated infectious waste disposal company: Accu-Medical PO Box 797 Marietta, Ohio 45750, 1-866-696-8379, using a designated

truck, will then pickup and transport infectious waste to a treatment facility for final disposal. In case of change of ownership this waste management policy and procedure will remain in effect. Effective May 1, 2017 the regulated infectious waste disposal company that will be used is Medical Waste Services, 2826 Holt Street, Ashland KY 41101, 1-855-880-7008.

- B. Infectious waste will be picked up monthly.
 - C. Kanawha Charleston Health Department- Putnam County infectious waste policy state no infectious medical waste will be knowingly transported or knowingly received by the facility without being packaged/labeled in accordance with rule 64 CSR 56, Section 5.
 - D. Kanawha Charleston Health Department- Putnam County maintenance department will be in charge of loading the biohazard waste on the designated waste disposal truck, ensuring prevention of exposure of personnel/clients to infectious medical waste.
 - E. Final offsite treatment of infectious waste will be accomplished by incineration.
3. In the event of an infectious waste spill, administrative services personnel will follow the attached *West Virginia Department of Health and Human Resources (WVDHHR) Emergency Response Spill Clean Up* policy.
- F. The cleanup kit for Kanawha Charleston Health Department will be stored in the clinic maintenance hall closet, room 128.
 - G. The cleanup kit for Kanawha Charleston Health Department- Putnam County will be stored in the nurse's office.

Resources:

- H. Emergency Response Spill Clean Up
<http://www.wvdhhr.org/wvimw/spillkit.asp>

NAME	Date
Nursing Director	
ORIGINAL DATE ADOPTED:	11/21/2013
REVIEW/REVISION DATES:	04/06/2017
REVIEW FREQUENCY:	Annually
TOTAL # OF PAGES	Four



Infectious Waste Management Acknowledgement Form

I, _____ have been provided with a copy of the Infectious Waste Management Policy and have read, understand, and agree to abide by the terms and conditions of the Infectious Waste Management Plan.

1. Loose sharps (needles/syringes) will be placed in red puncture proof sharps container.
2. Trash or empty containers will not be placed in the red puncture proof sharps container or the large cardboard box.
3. The red puncture proof sharps container and the large cardboard box will not be filled over $\frac{3}{4}$ full.

Signature

Date

VI. Community Syringe Disposal Kiosks and Sterilis Machine

The Kanawha-Charleston Health Department worked to establish community syringe disposal kiosks externally on its premise and with partnering organizations. The purpose of the kiosk to give community members a safe place to dispose of syringes. The steps KCHD followed to establish community kiosks were as followed:

Outdoor Sharps Disposal Kiosks

1. Contact City and County Commission to see if there are any regulations pertaining to the placement of the kiosks in the community
2. Contact Donna Gorbey-Michael, OEHS Marion County Donna.R.Gorbey-Michael@wv.gov (304) 368-4420 to notify her that your agency is interested in placing a kiosk in the community. Your agency must update their infectious waste management plan and apply for a major change to your facilities infectious waste medical plan (IW-14 application is online <https://www.wvdhhr.org/wvimw/forms.asp>) and follow the procedure
3. Once approval is given, the kiosks can be ordered and is roughly \$1,000.00 plus shipping and supplies.

APPLYING FOR A MAJOR CHANGE TO A FACILITY'S INFECTIOUS MEDICAL WASTE PLAN

A permittee must submit an application for approval of a major change in the permittee's infectious medical waste management plan before implementing the change. Minor changes in the infectious medical waste plan may be made without notifying the Secretary and should be included in the next application for permit renewal. All major changes must be approved prior to implementation. However, no prior approval is necessary in the case of a hospital which may, in emergency, make an immediate change in the plan necessary to protect the safety and care of patients, employees or the public. In such an event, the hospital is to notify the Secretary immediately followed by written notification within fifteen (15) days. An application for approval of any change in the plan which is beyond the control of the permittee must be submitted within fifteen (15) days of its occurrence.

Major changes consists of any of the following:

- Installing a new unit for the treatment of infectious medical waste or replacing existing units not including improvements, or repairs to existing units;
- Changing the location of treatment;
- Permanently increasing the volume of infectious medical waste by at least twenty percent (20%), if the amount of increase is fifty (50) pounds or more.

In order to apply for a major change, please supply to the Infectious Medical Waste Program a copy of a completed application for major change and a copy of an updated Infectious Medical Waste Management Plan for the facility.

After the completed application has been reviewed notice will be given to publish a Class II Legal Advertisement in a local newspaper and in a newspaper of an adjacent county when the site is within two (2) miles of a county line.

A copy of the complete application package must be posted at the county courthouse, at the city/town hall, and primary county library. The package must contain: application for permit, a copy of the approved infectious medical waste management plan, a topographical map with location of facility marked, a reference to dates of all previously published public notices, and a statement that any interested party may submit a written comment to the applicant or to the Infectious Medical Waste Program. ***Note: application package should be posted when first ad is published and may be removed after permit is issued or denied.***

Thirty days following publication of the second class II legal advertisement, provided no hearing is requested and comments received do not indicate a problem with proposal, the Secretary will approve the proposed major change.

If a hearing is requested, the Secretary will conduct the hearing in the county of the proposed facility. The notice of hearing date will be published in the local newspaper immediately upon receiving a hearing request. The Secretary will rule on the acceptability of the permit application following the public hearing.

A scheduled inspection must be conducted by the Infectious Medical Waste Program upon completion of a major change and before any new treatment method is placed into operation.

All official copies of the West Virginia Infectious Medical Waste Rule may be obtained from the West Virginia Secretary of State's office. To download a copy of the rule:

<http://apps.sos.wv.gov/csr/verify.asp?TitleSeries=64-56>

A printed copy of the rule may be obtained by contacting:

WV Secretary of State
Building 1, Suite 157-K
1900 Kanawha Blvd., E
Charleston, WV 25305-0770
Email: wvsos@secretary.state.wv
Phone: (866)767-8683

The following information is provided as a guide for putting together an Infectious Medical Waste Management Plan. The plan must be submitted along with the completed application, topographical map with your facility's location indicated, and a copy of the public participation file (any correspondence sent or received). The plan should include **detailed information** for the facility's waste management policies and procedures.

64 CSR 56, Section 5
Infectious Medical Waste Management Plan

- 5.1. All infectious medical waste management facilities shall develop an infectious medical waste management plan.
- 5.2. The infectious medical waste management plan shall set forth policies and procedures for managing infectious medical waste which are consistent with this rule and shall include, at a minimum, the following:
 - 5.2.a. A projection of the weight of the infectious medical waste which will be generated monthly;
 - 5.2.b. A description of infectious and noninfectious medical waste handling, storage, separation and volume-reduction procedures;
 - 5.2.c. The methods which will be used to treat the infectious medical waste;
 - 5.2.d. Transportation method;

- 5.2.e. Manifest systems or shipping documents and labeling; 5.2.f. Disposal methods consistent with Section 10.4 of this rule;
- 5.2.g. The name, mailing and email addresses, and telephone numbers and public service commission or other permit or license number of any infectious medical waste transporter, if applicable;
- 5.2.h. Training procedures, including an outline of training programs, and procedures for the certification of personnel involved in the treatment of infectious medical waste;
- 5.2.i. The name, mailing and email addresses, and telephone numbers of the person responsible for infectious medical waste management at the generator or the facility, and the name, mailing and email addresses, and telephone numbers of an alternate person to contact in the event the manager is not available;
- 5.2.j. Policies requiring that no infectious medical waste will be knowingly transported or knowingly received by the generator or facility without being packaged and labeled in accordance with this rule;
- 5.2.k. Contingency plans for effective action to minimize damage from any interruption in treatment, storage or disposal of infectious medical waste;
- 5.2.l. A description of the procedures used to:
 - 5.2.l.1. Prevent hazards in loading and unloading operations;
 - 5.2.l.2. Prevent run-off from infectious medical waste handling areas to other areas of the facility or environment;
 - 5.2.l.3. Prevent contamination of water supplies;
 - 5.2.l.4. Mitigate effects of equipment failure and power outages; and
 - 5.2.l.5. Prevent exposure of personnel to infectious medical waste;
 - 5.2.l.6. Address spill prevention and spill mitigation procedures;
 - 5.2.l.6.a. Include procedure for use of personal protective equipment (PPE);
 - 5.2.l.6.b. Include contents of the required spill kit, set forth in section 7 of this rule.

- 5.2.m. Procedures for continuity of operations during a change of ownership;
 - 5.2.n. Any other information pertinent to the evaluation of compliance with this rule.
- 5.3. Infectious medical waste management facilities which are willing to accept infectious medical waste generated off-site for treatment shall also include the following in their infectious medical waste management plan:
- 5.3.a. Procedures for receiving off-site infectious medical waste which are consistent with this rule;
 - 5.3.b. A statement as to whether the facility plans to receive from off-site more than thirty-five (35) percent by weight of the total amount of infectious medical waste at the facility;
 - 5.3.c. A statement that the facility will not knowingly accept any infectious medical waste which is not properly packaged and labeled in accordance with Section 6 of this rule;
 - 5.3.d. Procedures for keeping records in accordance with Section 13 of this rule;
 - 5.3.e. Procedures for returning manifests or other shipping documents to the generator after treatment of the infectious medical waste;
 - 5.3.f. Procedures for reporting to the secretary as required by this rule; and
 - 5.3.g. Procedures to be followed for closure of the facility including, but not limited to, notification of all facilities using the treatment service thirty (30) days prior to closure.

Procedures To Apply For A Major Change To Facility's Infectious Medical Waste Management Plan

1. Provide a notice of intent to the persons on the enclosed mailing list. A sample of the required letter is enclosed, "Notice of intent to apply for a major change."
2. Submit to the Infectious Medical Waste Program:
 - a completed application for major change,
 - two copies of an updated Infectious Medical Waste Management Plan, and
 - a copy of the letters required in #1 above.

When it is determined that the application package is complete you will be notified in writing to publish a class II legal advertisement (see enclosed sample) in a paper of local circulation, and in the paper of adjoining counties when the site is within two (2) miles of a county line.

3. Publish the class II legal advertisement. The ad must run twice, seven days apart. After the second publishing date, submit a notarized certification of publication of the class II legal ad.
4. Send a second letter to persons on mailing list (see enclosed sample second letter), and submit a copy of that correspondence to the Infectious Medical Waste Program.
5. Post a copy of the complete application package at the county courthouse, at the city/town hall, and the primary county library. This package must contain: the application for permit, a copy of the approved management plan, a topographical map with the location of the facility marked, a reference to the dates of all previously published public notices, and a statement that any interested party may submit a written comment to the applicant or to the Infectious Medical Waste Program.

Note: the application package should be posted when first ad is published, and may be removed after the permit is issued or denied.

Thirty days following the publication of the second class II legal advertisement, if no hearing is requested and any comments received do not indicate a problem with the proposal, the Secretary will approve the proposed major change.

If a hearing is requested the Secretary will conduct a hearing in the county of your proposed facility. As soon as the Secretary receives a request for a hearing a notice of hearing will be published in a newspaper of local circulation announcing the hearing. Following the hearing the Secretary will rule on the acceptability of the permit application.

Note: Upon completion of major change you will need to contact the Infectious Medical Waste Program to schedule an inspection before any new treatment method is put into operation.

Major Change - defined in Section 4.16 of the West Virginia Infectious Medical Waste Rule:

- Installing a new unit for the treatment of infectious medical waste or replacing existing units, not including improvements or repairs to existing units, as determined by the secretary;
- Changing the location of treatment; or
- Permanently increasing the volume of infectious medical waste by at least twenty percent (20%), if the amount of the increase is fifty (50) pounds or more.

How To Obtain A Copy Of 64CSR56, the West Virginia Infectious Medical Waste Rule

All official copies of the Rule should be obtained from the West Virginia Secretary of State's office. You can order a printed hard copy of the Rule by contacting the Secretary's office.

Building 1, Suite 157K
1900 Kanawha Blvd., East
Charleston, WV 25305-0770
E-mail: wvsos@secretary.state.wv
Phone: (304) 558-6000

The Rule is also available for download in WordPerfect and MS Word formats the Secretary of State's web site:

<http://apps.sos.wv.gov/csr/verify.asp?TitleSeries=64-56>

CONTACT MAILING LIST

Salutation	Name	Address	City	State	Zip Code
Sirs	WV Environmental Council	2206 Washington Street	Charleston	WV	25311
Ms.	Rachel Belcher, MCCA	144 Willodbrook Road	Princeton	WV	24740
Mr.	Frederick Daugherty	Route 4, Box 210	Philippi	WV	26416
Mr.	Tom Degen	HC 75, Box 324	Chloe	WV	25235
Mrs.	Mary Poling	Rt. 1, Box 331	Moatsville	WV	26405
Mr.	William Poling	Rt. 1, Box 331	Moatsville	WV	26405

64CSR56, Section 5

Infectious Medical Waste Management Plan

- 5.1. All infectious medical waste management facilities shall develop an infectious medical waste management plan.
- 5.2. The infectious medical waste management plan shall set forth policies and procedures for managing infectious medical waste which are consistent with this rule and shall include, at a minimum, the following:
 - 5.2.a. A projection of the weight of the infectious medical waste which will be generated monthly;
 - 5.2.b. A description of infectious and noninfectious medical waste handling, storage, separation and volume-reduction procedures;
 - 5.2.c. The methods which will be used to treat the infectious medical waste;
 - 5.2.d. Transportation method;
 - 5.2.e. Manifest systems and labeling;
 - 5.2.f. Disposal methods consistent with Section 10.4 of this rule;
 - 5.2.g. The name, address, telephone and fax numbers and public service commission or other permit or license number of any infectious medical waste transporter, if applicable;
 - 5.2.h. Training procedures, including an outline of training programs, and procedures for the certification of personnel involved in the treatment of infectious medical waste;
 - 5.2.i. The name, address, telephone and fax numbers of the person responsible for infectious medical waste management at the generator or the facility, and the name, address, telephone and fax numbers of an alternate person to contact in the event the manager is not available;
 - 5.2.j. Policies requiring that no infectious medical waste will be knowingly transported or knowingly received by the generator or facility without being packaged and labeled in accordance with this rule;
 - 5.2.k. Contingency plans for effective action to minimize damage from any interruption in treatment, storage or disposal of infectious medical waste;
 - 5.2.l. A description of the procedures used to:
 - 5.2.l.1. Prevent hazards in loading and unloading operations;

- 5.2.1.2. Prevent run-off from infectious medical waste handling areas to other areas of the facility or environment;
 - 5.2.1.3. Prevent contamination of water supplies;
 - 5.2.1.4. Mitigate effects of equipment failure and power outages; and
 - 5.2.1.5. Prevent exposure of personnel to infectious medical waste;
 - 5.2.m. Procedures for continuity of operations during a change of ownership;
 - 5.2.n. Any other information pertinent to the evaluation of compliance with this rule.
- 5.3. Infectious medical waste management facilities which are willing to accept infectious medical waste generated off-site for treatment shall also include the following in their infectious medical waste management plan:
- 5.3.a. Procedures for receiving off-site infectious medical waste which are consistent with this rule;
 - 5.3.b. A statement as to whether the facility plans to receive from off-site more than thirty-five (35) percent by weight of the total amount of infectious medical waste treated at the facility;
 - 5.3.c. A statement that the facility will not knowingly accept any infectious medical waste which is not properly packaged and labeled in accordance with Section 6 of this rule;
 - 5.3.d. Procedures for keeping records in accordance with Section 13 of this rule;
 - 5.3.e. Procedures for returning manifests to the generator after treatment of the infectious medical waste;
 - 5.3.f. Procedures for reporting to the secretary as required by this rule; and
 - 5.3.g. Procedures to be followed for closure of the facility including, but not limited to, notification of all facilities using the treatment service thirty (30) days prior to closure.

**MAJOR CHANGE
SAMPLE LETTERS**

Notice of Intent to Apply for Approval of a Major Change to Management Plan

(Names on mailing list provided by IMW Program),

It is the intent of (facility) to make application to the Department of Health and Human Resources' Infectious Medical Waste Program for approval of a major change to our Infectious Medical Waste Management plan. This letter is being sent to you as required by the Infectious Medical Waste Rule 64CSR56 Section 4.4. Any questions concerning this proposal should be directed to (name, address, phone number and fax number of facility contact person).

Sincerely,

Second Letter

(Names on mailing list provided by IMW Program)

Attached is a copy of the information that is to be published in the (name of newspaper where the notice will be published as a Class II legal advertisement) by (facility) as part of the application process required for approval of a major change to the Infectious Medical Waste Management plan at (facility). This letter is being sent to you as required by the Infectious Medical Waste Rule 64CSR56 Section 4.11. And questions concerning this proposal should be directed to (name, address, phone number and fax number of facility contact person).

Sincerely,

MAJOR CHANGE
LEGAL AD REQUIREMENTS

A class II legal notice must be published once a week for two successive weeks, pursuant to Section 59-3-1 of the West Virginia State Code. The minimum content of all notices shall be as specified in section 4.11.c. of 64CSR56. The following is an example:

Facility name located at facility location is applying to the West Virginia Infectious Medical Waste Program located at Capitol & Washington Streets, 1 Davis Square, Suite 200 Charleston, West Virginia 25301-1798, for a Major Modification of its Infectious Medical Waste Management Plan. This major modification is being sought to change (methods, location) of infectious waste treatment employed from method currently employed to new method, or permanently increase the amount of Infectious Medical Waste generated at this facility. The following is an estimation of the waste generated at the facility:

- 1. cultures and stocks of microorganisms and biologicals _____
- 2. blood and blood products _____
- 3. pathological wastes _____
- 4. sharps _____
- 5. other _____

The following is an estimate of wastes that will be received from off-site:

- 1. cultures and stocks of microorganisms and biologicals _____
- 2. blood and blood products _____
- 3. pathological wastes _____
- 4. sharps _____
- 5. other _____

The following site improvements will be made to accommodate our new treatment process or increase in volume. Further information on the proposed project can be obtained by contacting facility contact at address, phone, fax. Copies of the application are available at the county courthouse, the city city/county building, the county County Public Library, and at the Office of Environmental Health Services located at Capitol & Washington Streets, 1 Davis Square, Suite 200 Charleston, West Virginia 25301-1798.

Previous notices and articles concerning this project were published on dates. Written comments shall include a concise statement of the nature of the issues raised and shall be submitted to the Secretary of the Department of Health and Human Resources, Infectious Medical Waste Program within thirty (30) days of this publication at the address above. Anyone may request a hearing on this proposal by submitting the same to the Secretary with a concise statement of the issues raised at the address above within the thirty (30) day comment period.

Provide a description of the general location of the project facility and include any streams within the vicinity, and include a 2"X 2" Map with Latitude and Longitude indicating the center of the project.

IW-14
01/10

West Virginia Department of Health and Human Resources
Office of Environmental Health Services
Infectious Medical Waste Program

Application For A Major Change

Current IMW Permit No. _____ FEIN _____

Owner _____ Agent _____

Name of Facility _____

Type of Facility _____ Units _____

Address _____ City _____ State _____ Zip _____

Location _____

Telephone No. _____ Fax No. _____

Contact Person _____ Title _____

Email address _____

Briefly describe the major change.

Date of Application

Signature of Applicant
() Owner () Agent

Mail completed application to: Infectious Medical Waste Program
Office of Environmental Health Services
1 Davis Square, Suite 200
Capitol & Washington Streets
Charleston WV 25301-1798

Attach **two (2)** copies of an updated infectious medical waste management plan and copies of the letters sent to those on the notification mailing list.

For Department Use Only

Date application and plan received _____ Notices mailed _____

Date reviewed _____ By _____ Date plan approved _____

Date notified to publish _____ By _____ Dates ad published _____

Hearing requested _____ Date of notice _____ Date held _____

Date major change approved _____ By _____

Date denied _____ By _____ Attach denial letter.

VII. Steering Committee and Community Meetings

It is important to establish a steering committee with internal and external stakeholders that will help make decisions about the HRSSP after its inception. The steering committee will help with logistics, syringe exchange model decisions, procedural decisions, etc. It is also important to keep your community members informed. Community members will include lay persons from the community but also partnering organizations such as law enforcement, poison control, etc. During these meetings, it is a time to highlight the success of the programs, the progress made thus far, and to reaffirm community partner collaboration for the HRSSP. This is an especially important step if community organizations are providing in-kind staff or supplies for the program.

REACHING POTENTIAL HRSSP PARTICIPANTS

After the health department, has developed collaborative relationships and earned community support, it must next consider how the HRSSP will reach potential participants. There are many options and what works best in one community may not work in another. Street outreach, referrals from emergency department staff or pharmacists may also be effective.

I. Street Outreach

To reach potential program participants, outreach workers need to have the IDU community's support and trust. Contacting IDUs initially may require time and patience but will help build a good foundation for the outreach effort. When outreach workers first approach potential HRSSP participants, they should introduce themselves and indicate the agency for which they work. Initially, outreach workers should be sensitive to any cues the potential participant provides to indicate she/he is not interested in talking at that moment. They can simply let people know what services are provided and when they are offered. It is important for outreach workers to develop a comfortable relationship IDUs while also keeping outreach and service delivery as priorities. Maintaining potential HRSSP participants' confidentiality is of the utmost importance, especially when program staff is talking with people in groups and personal information might be overheard. As they build a relationship with participants, outreach workers can discuss safer injection methods and health matters with them in a way that does not seem threatening. Furthermore, culturally competent outreach practices consider the distinct needs of IDU subpopulations and help build support for the program within the community.

Another good resource for conducting street outreach is peers as they have access to social networks of IDUs. Since they are a part of the IDU community, they may be able to gain peoples' trust faster than non-peer workers. In addition, peers often know the best locations for outreach efforts, can foresee potential challenges to getting IDUs into the program, and can help outreach workers assess situations and offer solutions.

When an agency engages in street outreach, it is important to consider the safety of outreach teams; culturally appropriate personnel and attire; culturally relevant educational materials and supplies; training and materials for safe syringe disposal; outreach worker training in overdose

prevention, recognition, and response; and procedures for documentation of outreach activities, including any adverse incidents.

II. Emergency Departments

For some IDUs seeking health care services for detoxification, wound infections, abscesses and overdose, emergency departments may serve as access points to identify and recruit IDUs for HRSSPs. Emergency departments can refer IDUs to HRSSPs for not only sterile syringes, but also for wound care and overdose prevention education, HIV and STD screening and referral to substance abuse treatment services. HRSSPs can provide information about the partnering medical facility and refer IDUs for medical care. Other potential partnership strategies may include having a medical practitioner embedded within a fixed site or mobile-based HRSSP and have HRSSP staff navigate IDUs to appropriate medical care.

Emergency departments may consider a screening tool in specific populations to identify at risk populations. For example, the CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) screen, which is a short, self-administered behavioral health screening tool developed to screen adolescents for high risk alcohol and other drug use disorders simultaneously, could be incorporated as routine protocol. Recently, the CRAFFT was recommended for adolescents presenting with trauma. Other screening tools are available and would need to be tailored to reflect the needs and the profile of the community. This screening tool can be found at http://www.ceasar-boston.org/CRAFFT/pdf/CRAFFT_English.pdf

III. Pharmacies and Pharmacists

Pharmacies and pharmacists can be a good resource and a strong ally for HRSSP modalities. As health care providers who generally work with large and highly diverse populations, pharmacists may be willing to speak directly with their colleagues about HRSSPs. Pharmacists have daily contact with the public and can be a valuable resource for referring IDUs to the HRSSP directly or through the IDUs' family members with whom the pharmacist may have contact.

OPERATING PRINCIPLES OF HRSSPS

Several elements should be considered in developing local operating principles for HRSSPs. Among these, registration, transaction model, delivery model and worker/volunteer safety are of primary concern.

I. Program Registration

Any local health department planning to implement a HRSSP will need to decide if it will institute a formal registration process for participants. In many HRSSPs, the formal establishment of a relationship between IDUs and the HRSSP begins with intake or enrollment. It should be noted that HRSSPs often do not have established enrollment or program registration procedures. However, the enrollment experience can be important in gaining the participant's trust and setting the tone for future interactions. To accommodate participant needs and encourage enrollment, initial intake procedures should be kept to a minimum. However, HRSSP

staff may need to use a longer intake process for referral to additional services, such as medical care or social services. Collecting information may decrease participants' anonymity, which may reduce the likelihood that participants will access services. Asking participants to provide government issued identification (ID) at enrollment may also deter people from using the HRSSP as some may not have ID cards. By registering participants, the HRSSP can collect statistical data that staff can use to monitor the program. The purpose of program evaluation is to ensure that the program is operating in conformity to its design, reaching its specific target population and achieving anticipated implementation goals. The Kanawha-Charleston Health Department's intake process consists of two different forms for either new or returning patients. The data collected is then input into a centralized database where it can be pulled for reporting for grants, community meetings, and outreach events. Future monitoring activities can then be linked to the same participant through a unique participant code. Table 1 presents the types of information that might be collected at intake/enrollment. This list offers a range of ideas and is not an intake template.

Table 1. Types of Information Potentially Collected at HRSEP Intake

Information	Purpose
Initials	As an alternative to participants' names
Birth year	To describe the service population
ZIP code or area of current residence	To describe the program's reach and identify geographic areas where there are gaps
Sex or gender	To describe the service population
Sexual Orientation	To describe the service population
Race/ethnicity	To describe the service population
Preferred Language	To tailor program services to participants' needs
Injection frequency	To estimate syringe needs for needs based negotiation models
Drug preferences	To evaluate program services and tailor them to participants' needs.
Medical Home	To identify access point for medical care for program planning and referrals
Access to Other Services	To identify needed medical, substance abuse, and mental health services for program planning, referrals, and quality improvement
Social Determinants of Health	To identify homelessness, unemployment, and other social factors for program planning and referrals, to include access to health insurance where applicable.

(a) New Patient Intake Form

The new patient intake form collects basic demographic data from all new patients, that can then be used for reporting and grant applying purposes later in the program.

(b) Return Patient Intake Form

The return patient intake form is a lot simpler than the new patient form, in that a lot of the demographic data does not need to be recollected.

(c) Patient Rights and Responsibilities Form

New patients to the KCHD HRSSP are also given a copy of the patients' rights and responsibilities forms, which outlines their rights as a patient of the program and their responsibilities as a participant of the program.

(d) Patient ID Cards

Every new patient is given a Patient ID Card. The front of the card includes their ID number and clinic information, as well as information for local recovery agencies. The back of the card consists of a table to write down the date, number of needles given, and initials for room attendant. This documentation lets the room attendant next week know how many needles were given to the patient last week, which depending upon how many they return, will influence how much they are given this week. Unfortunately, participants will start to lose their cards to avoid being taken down in numbers of syringes given. The Kanawha-Charleston Health Department enforced a 5-needle reduction to any return patient that loses his or her card.

Date: _____

Kanawha-Charleston Health Department
Syringe Access Program

New Patient

ID Number: _____

First and last initial: _____

Birth month: _____

Last two digits of Birth year: _____

Circle One: Male or Female or
Transgender

Race/Ethnicity:

- White Black
- Asian Native American
- Pacific Islander Other
- Latino Hispanic

Sexual Orientation:

- Heterosexual
- Homosexual
- Bisexual
- Questioning
- Declined

Last Grade of School Completed: _____

Contraceptive Method:

- Condoms
- Birth Control Pills/Injection
- IUD/Nexplanon
- Other: _____

Residence:

- Apartment
- Home
- Homeless

Zip code: _____

Drug of Choice:

- Heroin
- Rx Opioids
- Cocaine
- Methamphetamine
- Other: _____

Route:

- Oral
- Inject
- Snort

Insurance:

- Private
- Medicare
- Medicaid
- None

Hepatitis/HIV Status:

- Hepatitis B: Positive/Negative
- Hepatitis C: Positive/Negative
- HIV: Positive/Negative
- When were you last tested? _____
- Age of first Drug Use: _____
- Have you ever been in recovery? Yes or No
- Have you ever overdosed? Yes or No
- Have you ever been with someone who has overdosed? Yes or No
- Are you currently waiting for a bed in a recovery program? Yes or No
- How long is your wait? _____ Months

Are you interested in other services?

- Hepatitis B and C Testing
- STD/HIV Testing
- Speaking to a Recovery Coach
- Condoms/Contraceptive Counseling
- Naloxone
- IUD (Female Birth Control Device)
- Signing Up for Health Insurance
- Flu Shot
- Information on STD Testing/Results
- Wound Assessment

Of times you inject per day when you use: _____

Needles: Short or Long

Below For Clinical Use Only

Was your patient seen by a nurse or doctor? Yes or No

Did your patient receive any of the above other services? If so, what? _____

of needles returned today: _____ # of needles given today: _____

Revised 5/8/2017

Kanawha-Charleston Health Department
Syringe Access Program
RETURN PATIENT

Date: _____ ID number _____

Any changes? Yes or No

Explain: _____

of times you inject per day when you use: _____ Length of needle preferred: Short or Long

FOR CLINIC USE ONLY:

Was your patient seen by a nurse or doctor? Yes or No

Did your patient receive any of the below other services? If so, what? _____

of needles returned today: _____ # of needles given today: _____

Supply List: (please check which items you would like)

- Syringes
- Alcohol Swabs
- Cotton Pellets
- Tourniquet
- Cooker
- Sharps Containers

Recovery coaches are available today to speak with you if you would be interested in information regarding recovery.

Are you interested in other services?

- Hepatitis B and C Testing
- STD/HIV Testing
- Speaking to a Recovery Coach
- Condoms/Contraceptive Counseling
- Naloxone
- IUD (Female Birth Control Device)
- Signing Up for Health Insurance
- Flu Shot
- Information on STD Testing/Results
- Wound Assessments

Kanawha-Charleston Health Department

Patient Rights and Responsibilities



The Kanawha-Charleston Health Department (KCHD) seeks to provide exceptional care to every client. We want to work together with you to ensure you receive the clinical care, compassion and services that you need. Use and distribution of illicit drugs is **strictly prohibited** on the Kanawha-Charleston Health Department property. If caught, you may face immediate removal from the program and may be subject to arrest and prosecution. Please remember the Harm Reduction Syringe Exchange program is a volunteer and donation based program, illegal activity on the premise could cause the permanent closure of the harm reduction clinic.

What you can expect

First visit

1. You will be asked to create a member ID# that you will use every time you participate in the program.
2. You will be asked several questions that will be used for statistical data.
3. You will be educated about the program including your rights and responsibilities, needle exchange, referrals and available testing.
4. You will be given the number of needles you need as well as supplies for safe drug use.
5. You will be given a card with your member ID# that identifies you as a participant in the KCHD needle exchange program **(IF WE HAVE TO ISSUE YOU A NEW CARD, IT WILL COST YOU 5 NEEDLES)**

Return visit

1. You will be asked your member ID#.
2. You will be asked follow-up questions.
3. You will dispose of your used needles in the sharps containers.
4. You will be given the number of needles and supplies that you will need until the next clinic.
5. **You are required to return used needles.**

A MAXIMUM of 10 WILL BE GIVEN TO THOSE WHO DO NOT RETURN NEEDLES

Needles will only be available for pick-up and disposal on Wednesdays from 10:00am-3:00pm.

Services are only available to those 18 years of age and older.

You have the right to...

- Be treated with respect and dignity regardless of race, ethnicity, sex or gender orientation, national origin, religion, class, medical status, or physical or mental ability.
- Feel safe in an environment free from violence, threats and hateful language.
- Receive available services, supplies, information and education to keep you safe.
- Be respected and have the right to privacy.
- Be provided confidential case management upon request.

You have the responsibility to...

- Be responsible for the syringes you are given and to return used syringes to KCHD in safe disposable containers.
- Treat staff, interns, volunteers and community members with courtesy and respect without physical, sexual, verbal and/or emotional abuse, threats or intimidation.
- Keep the area around the health department safe and do not engage in any drug activity that puts the KCHD at risk of closure.
- Do not buy, sell or loan money or property while on the premises.
- Protect the confidentiality of other participants encountered while participating in the harm reduction program.
- Take only what is needed and dispose of used materials and supplies properly.
- Notify the KCHD of any areas in the community where used needles are located.

Nov. 2015

Revised December 2016

Resource Contacts:
9-1-1
Help for mental health or addiction:
1-844-HELP4WV
Suicide Prevention Lifeline
1-800-273-8255
WV 211 Hotline: Dial 2-1-1
For Crisis Services and Providers

**Kanawha-Charleston Health Department
Harm Reduction Program**

ID # _____



**108 Lee St. E. Charleston, WV 25301
(304) 348-8080**

Resource Contacts:
9-1-1
Help for mental health or addiction:
1-844-HELP4WV
Suicide Prevention Lifeline
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Suicide Prevention Lifeline
1-800-273-8255
WV 211 Hotline: Dial 2-1-1
For Crisis Services and Providers

**Kanawha-Charleston Health Department
Harm Reduction Program**

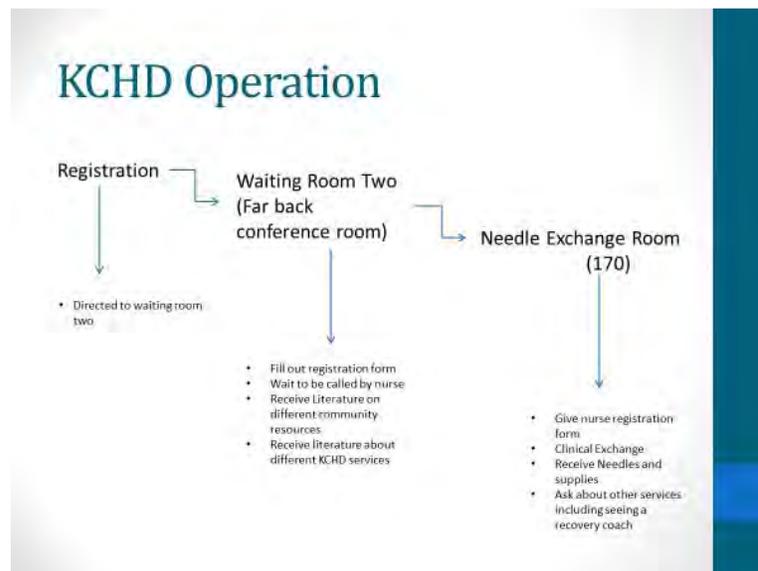
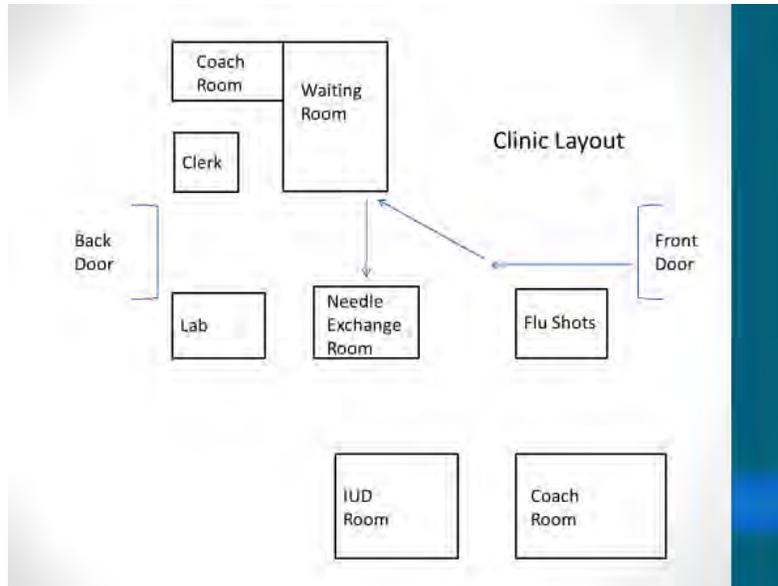
ID # _____



**108 Lee St. E. Charleston, WV 25301
(304) 348-8080**

II. Clinical Process Map

The clinical process map was a way for the Kanawha-Charleston Health Department to discuss logistics across departments and to convey process flow to outside partners when planning our first Harm Reduction clinic.



I. Program Operations

(a) Supplies

The Kanawha-Charleston Health Department gives the following supplies during its Harm Reduction Syringe Service Program:

- Dental Cotton
- Alcohol Swabs
- Syringes Two Sizes 50 and 100 units (shorts, 5/16” 31 gauge and longs 1/2” 30 Gauge)
- Tourniquets
- Cookers
- Small Clear Bags
- Condoms
- Sharps Containers (individual and clinic use)
- Bags

Most program supplies are donated or purchased through grants. A copy of a supply donation letter drafted by the local substance abuse coalition, Kanawha Communities that Care is located in Appendix A. Two resources for discounted and free supplies include the North American Syringe Exchange Network (NASEN) and Americares.

(b) Room Protocol

The room protocol establishes a check list for standardized messaging for those that run rooms. Below are the items that are discussed with new patients during their first exchange.

(c) Informed Consent

The informed consent form should be signed by all patients before the any medical professional performs wound assessments and/or other procedures.

Room Protocol

New Patient

- Review form
- Look for any blanks not completed (i.e. zip code, Hepatitis/HIV status, etc.) and complete them.
- Talk about their current Hepatitis/HIV status (recent testing and how often they should be tested, encourage to be tested if has not been recent. Inform they can have it done at the health department and when those times are available).
- Discuss whether they share needles and equipment and educate that they can contract Hepatitis/HIV through sharing syringes and equipment to include cooker, water, cotton, etc.
- Discuss how many times they inject and their needle preference.
- Review services available to them and answer any questions they may have regarding services

Review Program and inform them of their responsibilities to the program

- Inform it is an Exchange Program – what they receive they need to bring back (used) the next time they come. Explain if they bring back what they were given they will always get the maximum allowed (30). If for whatever reason they do not bring back any they will be reduced to 10 needles but will be able to get back to the maximum over a couple of weeks.
 - o Explain why this is important. Explain about the city allowing this program to take place and they look at the needle exchange rate so their responsibility to the program is to bring back dirty syringes. They will be counted when returned. (never to be touched by staff or volunteers)
 - o Review the Syringe Possession Ordinance and what that involves and let them know that only involves the city in which the Syringe Service Program exists.
 - o Let them know about the card they are given and why it is important to carry it and have it with them for the exchange.
- Inform them that wounds can be evaluated and treated if necessary if there is a physician, nurse practitioner or physician assistant is available.

Allow for questions and answers

Returning Patients

- Count the returning syringes and dumped into a puncture proof sharps container.
- Ask if any changes since last visit.
- Based on number of dirty syringes returned inform person bagging supplies on the number of clean syringes and other supplies they request.

5/2/2107



Kanawha-Charleston Health Department

POLICY TITLE:	Disclosure and Informed Consent
PROGRAM AREA:	Clinical
POLICY NUMBER:	

PURPOSE STATEMENT: To ensure a uniform policy for all treatment(s) or procedure(s) performed.

SCOPE: It is the policy and responsibility of the Kanawha-Charleston Health Department to provide descriptive information on treatment(s) or procedure(s) to be performed so informed consent can be given. All employees of the Kanawha Charleston Health Department shall adhere to the standards set forth in this policy directive.

DISCLOSURE AND INFORMED CONSENT

I hereby request, consent and authorize Doctor _____ (and his/her assistants) to perform upon me the following treatment(s) or procedure(s):

(State procedure in lay language)

- I consent to the administration of procedural analgesia, which my physician may deem necessary.
- I understand that during the course of a treatment or procedure unforeseen conditions may be revealed which necessitates an extension of the original procedure(s) different from that authorized from above. Therefore, I authorize and request the above the named physician (and/or assistants) to perform such additional procedures as are necessary in the exercise of their professional judgement. The authority granted under this paragraph shall extend to treatment and all conditions that require treatment and are not known to the above named physician at the time the operation hereby authorized is commenced.
- Potential risks and/or side effects are:

- **I have been given the opportunity to ask questions about my condition and the planned procedure.** The potential benefits, risks, side effects, likelihood of achieving the goals, alternatives to the procedures and their associated benefits and risks as well as the potential

risk related to not receiving the proposed care have been explained to me in a manner I understand. I request that the procedure described in the paragraph above be performed.

- For the purposes of advanced medical education, I consent to the admittance of students in the room in which the procedure(s) is being performed.
 - **By signing below I am agreeing to come in for the follow-up specified. -**
-

General Consent/Permission

Date

ORIGINAL DATE ADOPTED:	March 24, 2017
REVIEW/REVISION DATES:	March 24, 2017
TOTAL # OF PAGES	2

IV. Syringe Transaction Models

The goal of HRSSPs is to provide as close to 100 percent syringe coverage as possible, which means a sterile syringe for every injection of every IDU in a jurisdiction. HRSSPs typically use one of three types of syringe transaction models: needs based negotiated model, strict one-for-one exchange and one-for-one plus exchange. Although there is little published research on the comparative efficacy of the three model types, subject matter experts agree that all three types are in common usage and that each has a set of strengths and limitations. Programs will need to consider available resources and public expectations when selecting the type of syringe transaction model to implement. The Kanawha-Charleston health department utilizes a one-for-one plus exchange. All returning participants are encouraged to bring back their syringes to receive more. Individuals that bring back their syringes, are asked to assess their daily use to see if they need the same amount, less, or more needles than they were previously given, and are given syringes accordingly. Individuals that do not bring back syringes are given a maximum of 10. If the individual brings back all ten the following clinic, they are bumped back up by 5-10 syringes. All new patients receive the amount of syringes based upon their reported daily use, with a maximum of 30 allowed.

(a) Needs Based Negotiation

In the needs based negotiation model, the program does not set a limit on the syringes a participant can receive regardless of the number of returned syringes. Although HRSSPs using this model generally encourage participants to return used syringes, participants can still receive sterile syringes even if they do not. The number of syringes distributed is negotiated based on the participant's need, the frequency of injection and the length of time until she/he can next access the HRSSP. Some HRSSPs place an upper limit on the number of syringes distributed under this model (e.g., 100 or 500-syringe limit), but they do not place a limit on how often a participant can access services.

(b) Strict One-for-One Exchange

Strict one-for-one exchange programs provide HRSSP participants with the exact same number of sterile syringes that the participant brings in for disposal. For example, if the participant disposes of 14 used syringes at the HRSSP, then she/he receives 14 new, sterile syringes in return. With this model, participants cannot get sterile syringes if they do not bring in any used syringes for disposal. However, some HRSSPs that employ strict one-for-one exchange models issue one or more syringes at the outset of client participation when participants enroll in the program to lessen the risk of syringe sharing. For example, the HRSSP might provide 10 sterile syringes the first time someone comes to the HRSSP even if the participant has no used syringes for disposal.

In cases where participants do not want to receive as many syringes as they returned during a single transaction, the HRSSP using the one-for-one exchange model can issue a voucher

(similar to an “IOU”). For example, someone may return 300 syringes but only wants 10 syringes at that time. The HRSSP can give the participant a voucher for the other 290 syringes that she/he can redeem at another time. Vouchers are also useful when HRSSPs do not have enough supplies to complete the exchange or when there are limits on the number of syringes a participant can get during a single transaction. HRSSPs should consider recording the voucher on-site in case participants lose their vouchers, but recording this information would affect anonymity unless HRSSPs use a unique participant code.

(c) One-for-One Plus Exchange

One-for-one plus exchange programs modify the basic concept of the strict one-for-one exchange programs by providing a predetermined number of extra syringes beyond one for one. For example, these programs often provide 10 extra syringes regardless of the number of disposed syringes brought in, and even if no syringes were returned for disposal they could receive 10 new syringes. Other such programs allow two-for-one exchange models up to a certain limit. For example, if a participant disposes of eight syringes, she/he receives 16 sterile syringes. A voucher system can also be used with one-for-one plus exchange models.

(d) Strengths and Limitations of Each Syringe Transaction Model

Prior research has shown that the needs based negotiated distribution model is best at achieving the goal of reaching as close to 100 percent coverage as possible, followed by the one-for-one plus exchange model and then the strict one-for-one exchange model.⁷ The main drawback of the strict one-for-one exchange model is that people who have no used syringes to dispose of are unable to receive any sterile syringes. People could have many legitimate reasons for not returning their used syringes. For example, their syringes may have been confiscated by law enforcement, stolen by peers or taken by family members. For reasons of public safety or fear of law enforcement action, IDUs may choose to safely dispose of syringes at the time of injection as opposed to carrying them around until the next time they access a HRSSP. If IDUs are not provided sterile syringes at a HRSSP because they did not have any used syringes to dispose of, they may use unsterile syringes from their associates, which defeats the purpose of HRSSPs.

Another potential drawback of a strict one-for-one exchange model may be a lack of uniformity in its implementation by staff. Staff members may relax the strict one-for-one exchange rule to further encourage safer injection, which can create a scenario in which participants favor certain staff members who appear to be willing to bend the rules. The legitimacy of the program can be called into question by participants and/or the community if there are inconsistencies in applying the rules. Thus, the one-for-one plus exchange model provides staff a built-in alternative to denying syringes without returns.

⁷ Kochems LM, Paone D, Des Jarlais DC, Ness I, Clark J, Friedman SR. The transition from underground to legal syringe exchange: the New York City experience. *AIDS Educ Prev*. December 1996;8(6):471-489.

Although the needs based negotiated model is better at increasing syringe coverage, programs may have other reasons for using a one-for-one plus exchange model. In some communities, it is more politically palatable to assure everyone that the program is exchanging needles as opposed to distributing them. The one-for-one plus exchange model may also be better than the needs based negotiated model at encouraging IDUs to access the HRSSP more often, which may increase opportunities for them to dispose of used syringes and the chances they will use other services, including HIV/HCV testing and drug treatment referrals. Lastly, the needs based negotiated model may require spending more money on syringes, which depends on budgets and funding agencies. HRSSPs should consider working with their local partners to develop the best funding mode

V. Worker and Volunteer Safety

(a) Volunteer Protocol and Confidentiality Agreement

Kanawha-Charleston Health Department has implemented the following protocol for all volunteer staffing working in the HRSSP clinic. The protocol outlines what is expected of them during the clinic and what they are and are not allowed to do in their capacity as a volunteer.



www.kchd.wv.org

KANAWHA-CHARLESTON HEALTH DEPARTMENT

108 Lee Street, East /PO Box 927

Charleston, WV 25323-0927

(304) 344-KCHD (5243)

Michael R. Brumage, MD, MPH, FACP
Executive Director/Health Officer

2-13-17

Harm Reduction/Syringe Exchange Volunteer Protocol

1. Volunteers are to check in at the registration desk upon arrival.
2. Clerk at the registration desk or KCHD staff member will escort the volunteer to the nurses' desk in the clinic.
3. Volunteer will sign in at the nurses' desk and wait for assignment.
4. One of the KCHD staff will review the confidentiality and the protocol form. Volunteer will then sign both forms.
5. Prevention and Wellness Staff will assign volunteers roles and review the procedures for each position: runner, needle room assistant or data entry.
6. **Runner** will be responsible for bringing patients from the front lobby to the waiting room in the back of the clinic in groups of 4.
 - a. Volunteer gets the red folders which are inside the registration area in a black plastic tray. They then call the patient number of 4 patients and take them to the back waiting room. The volunteer lays the red folders in order on the nurses' station. When a needle room opens up, they go to the waiting room and call the patient number. The patients are then escorted to the needle rooms and the folder is given to the nurse running the room.
7. **Needle Room Assistant** will be responsible for putting the supplies in the brown paper bag. Volunteer is to be a silent partner and not interject anything during the interview.
 - a. The nurse will review the intake form with each patient and the assistant will put the requested supplies in the brown bag and hand them to the patient after the interview is complete.
8. **Data Entry** will be responsible for entering the intake forms in the computer. The intake forms will be put in the tray by the computer after the syringe exchange is complete.

Administration		Clinic		Environmental		Epidemiology & Threat Preparedness		Prevention & Wellness	
Phone:	304.348.6494	Phone:	304.348.8080	Phone:	304.348.8050	Phone:	304.348.1088	Phone:	304.348.6493
Fax:	304.348.6821	Fax:	304.346.4756	Fax:	304.348-8054	Fax:	304.348.8149	Fax:	304.348.6821

Name
Date
Page #

- a. Volunteer needs to periodically make sure all the information on the forms are complete, if not ask the interviewer for the information.
- b. Volunteer needs to keep the forms together and give them the nursing director at the end of the clinic.

At NO time is a volunteer allowed to put their hands on a patient OR offer medical advice of any kind unless under the direct supervision of Dr. Brumage or having first consulted with the KCHD nursing staff. For any questions, please contact Dr. Brumage or one of the KCHD team.

Name (print) _____
Signature _____
Date _____



Kanawha-Charleston Health Department

POLICY TITLE: Confidentiality Policy

PROGRAM AREA: All Kanawha-Charleston Health Department (KCHD) programs and divisions shall adhere to the standards as described in this policy.

POLICY NUMBER: KCHD-ADMIN- 014

PURPOSE STATEMENT: Federal laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996, as well as all other applicable federal and state laws require that certain information be safeguarded. Kanawha-Charleston Health Department (KCHD) must ensure its compliance with those laws and the desire to protect citizens' and employees' privacy.

SCOPE: This policy applies to all employees, students, and volunteers of KCHD and includes and all other individuals performing functions on behalf of the KCHD.

PUBLIC HEALTH ESSENTIAL SERVICE:

1. Develop policies and plans that support individual and community health efforts.
2. Enforce laws and regulations that protect health and ensure safety.

DEFINITIONS:

Confidential Information includes, but is not limited to, demographic, medical, and financial information in any form protected by statute or when the release of which would constitute an unreasonable invasion of Privacy, unless the public interest by clear and convincing evidence requires Disclosure in the particular instance. Confidential Information also includes Personally Identifiable Information (PII), as that term is defined below. Confidential Information may be in paper, electronic and verbal forms, and includes images as well as text. Confidential Information includes all information designated confidential by law, rule, policy or procedure, as may be amended from time to time, such as passwords, client name, trade secrets, information concerning any taxpayer (from any return, declaration, application, audit, investigation, film, record or report) and security audits.

Confidentiality: The assurance that data will only be exposed to those with a lawful right and need to use.

Disclosure: is the release, transfer, provision of access to or divulging or communicating in any other manner information outside the entity holding the information in accordance with KCHD policies and procedures.

Need to know is the principle that states that a recipient shall only have access to the minimum information necessary to perform a particular function in the exercise of his or her responsibilities.

Personally Identifiable Information or PII is all information that identifies, or can be used to identify, locate, contact, or impersonate a particular individual. PII also includes Protected Health Information (PHI) as that term is defined below. PII is contained in public and non-public records. Examples may include but are not limited to a specific individual's: first name (or initial) and last name (current or former); geographical address; electronic address (including an e-mail address); personal cellular phone number; telephone number or fax number dedicated to contacting the individual at his or her physical place of residence; social security account number; credit and debit card numbers; financial records, including checking, savings and other financial account numbers, and loan accounts and payment history; consumer report information; mother's maiden name; biometric identifiers, including but not limited to, fingerprints, palm prints, facial recognition, full face image and iris scans; driver identification number; birth date; birth, adoption or death certificate numbers; physical description; genetic information; medical, disability or employment records, including salary information; computer information, including information collected through an Internet Cookie; and criminal records and history.. When connected with one or more of the items of information specified above, PII includes any other information concerning an individual that, if disclosed, identifies or can be used to identify a specific individual physically or electronically.

Protected Health Information or PHI is a subset of PII and means, with regard to HIPAA covered entities (see 45 C.F.R. §106.103), individually identifiable health information, including demographic information, whether oral or recorded in any form or medium that relates to an individual's health, health care services and supplies, or payment for services or supplies, and which identifies the individual or could reasonably be used to identify the individual. This includes information that relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual including, but not limited to, preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care as well as counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status of an individual or that affects the structure or function of the body; or the past, present, or future payment for the provision of health care to an individual; and which includes identity information, such as social security number or driver's license number, even if the name is not included, such that the health information is linked to the individual. Protected Health Information does not include records covered by the Family Educational Right and Privacy Act and employment records held by the entity in its role as employer.

POLICY:

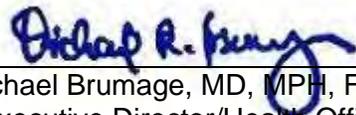
It is KCHD's policy that all members of its workforce and volunteers, sign an appropriate confidentiality agreement.

- A. Administrative Services shall ensure that each employee, including temporary and contract employees ("employee"), receives an Overview and signs a Confidentiality Agreement prior to accessing the Division's information. The Overview is found in Attachment A and the Confidentiality Agreement is in Attachment B.

- B. Confidential information shall only be used or disclosed in the official capacity of employment or contract whichever is appropriate, and at no time shall it be disclosed or used for a personal or non-work related purpose.
- C. No employee shall have ownership rights or interests in any confidential information. All data in KCHD's possession is owned by KCHD.
- D. At no time shall an employee use confidential information in any way detrimental to KCHD or to any individual whose records reside in KCHD's control. This prohibition shall not be construed to curtail an employee's whistleblower rights under federal and state law. If, in the process of making a good faith report under the provisions of the Health Insurance Portability and Accountability Act of 1996 or any other relevant law, an employee finds it necessary to disclose confidential information to an appropriate authority in accordance with the applicable statute(s), the disclosure will not be treated as a breach of KCHD's security or privacy policies.
- E. KCHD will periodically monitor use of the information systems to ensure compliance with this policy.
- F. All employees who become aware of a violation of this policy must report any violations to the Director of Administrative Services, within one business day of acquiring knowledge of a violation.
- G. Any collection, use or disclosure of information contrary to the confidentiality agreement, law or KCHD policy may result in disciplinary action consistent with the Division of Personnel policy.
- H. The confidentiality agreement shall survive termination of employment or contract, whichever is applicable.

- LEGAL AUTHORITY:**
- Privacy Act of 1974, Section 7 5 U.S.C. § 552a
 - Omnibus Reconciliation Act of 1990, Omnibus Reconciliation Act of 1990, § 2201(c) 42 U.S.C. § 405(c) (2) (C) (viii) (I)
 - HIPAA "Privacy Rule" 45 C.F.R. §§ 160 and 164
 - HIPAA "Security Rule" 45 C.F.R. § 164.302 -§ 164.318
 - Health Insurance Portability and Accountability Act of 1996, ("HIPAA") Public Law 104-191

RELATED PROCEDURES: Kanawha-Charleston Health Department Privacy Manual



Michael Brumage, MD, MPH, FACP
Executive Director/Health Officer

August 8, 2016
Date

ORIGINAL DATE ADOPTED: September 7, 2012
REVIEW/REVISION DATES: August 8, 2016
REVIEW FREQUENCY: Annual
TOTAL # OF PAGES 3

KANAWHA-CHARLESTON HEALTH DEPARTMENT

ADMIN POLICY 14 – CONFIDENTIALITY - ATTACHMENT A

CONFIDENTIALITY AGREEMENT OVERVIEW

The purpose of the Confidentiality Agreement is to secure the Kanawha-Charleston Health Department's (KCHD) information as required by federal and state law. KCHD collects, stores and transmits confidential information. Accordingly, KCHD is concerned with protecting the confidentiality and integrity of this information, in its paper, electronic and verbal forms.

The attached Confidentiality Agreement is being instituted to ensure that all persons with access to protected health information and/or personally identifiable information any other information deemed confidential, fully understand their obligations to limit their use of such information and to protect such information from disclosure. Special attention items, as well as definitions, are highlighted below. If you have any questions about this agreement or fail to understand the contents, please contact Administrative Services.

Special attention items:

- Collection of confidential information is permitted only in accordance with KCHD policy, procedure and rules;
- Use of confidential information, is permitted only when the user has a need to know such information;
- Disclosure of confidential information is only permitted when the individual who is the subject of the information consents in writing, or in conformity with KCHD's policies and procedures, as may be amended from time to time; and
- Confidential information is protected in all forms including, but not limited to, paper, electronic and verbal.

Kanawha-Charleston Health Department

CONFIDENTIALITY AGREEMENT

As an employee, volunteer, student, or others with privileges at the Kanawha-Charleston Health Department, you may have access to *confidential information*, as defined in KCHD-Admin-014. The purpose of this agreement is to ensure that you understand your duties regarding confidential information so that you fully comply with all local, state, and federal regulations regarding confidentiality and the requirement to follow the Kanawha-Charleston Health Department's Confidentiality Policy (KCHD-Admin-014). By signing this statement, I agree to the following:

1. I understand that confidential information includes, but is not limited to, demographic, medical, and financial information. It may consist of verbal communications or be stored in written, printed or electronic format and may include electronic images.
2. This policy applies to all staff, volunteers, students, or others with or without current access to confidential data and information which is stored electronically, in hard copy, and/or the forms, papers, and/or other media used to replicate copy or disseminate any, private, or otherwise confidential information.
3. I agree not to disclose or otherwise make known to any unauthorized persons any information unless authorized to do so by an appropriately authorized representative of the Health Department. No privileged information (whether electronic, written, or verbal) will be shared with family members, friends, or acquaintances.
4. I understand that I am not to access or read information, records, or health care information concerning clients or employees, or any other confidential information for my own personal use except to the extent needed to enable me to perform the appropriate duties afforded to me.
5. Discussions regarding clients will be held in staff offices/areas or other places where privacy is ensured. I will not discuss any identifying information except in the performance of job-related duties, being mindful that these discussions do not occur in hallways, elevators, bathrooms, lunchrooms, or other public areas.
6. All charts, notes, and other written material concerning a client or an employee, will be kept in a secure place when I am not using the information.
7. When working on electronically maintained information, I will log off, lock or take other action(s) when I am finished or leave my work area to prevent access to confidential files, databases, or other information.
8. I will not disclose my computer password, program specific passwords, or voice mail security code. I will guard against others overhearing verbal conversations by using, when appropriate, hand-held telephone rather than speaker phone when retrieving messages or engaging in discussions.
9. I understand that a breach of confidentiality and/or security may be grounds for disciplinary action up to and including termination, dismissal, and/or removal from my position or other appropriate action.

I have read, understand, and agree to abide by the terms and conditions of this Confidentiality Agreement.

_____ Signature

_____ Date

Although prevention of occupational blood borne transmission is the most important strategy, HRSSPs should have plans in place for post-exposure management of staff. CDC has issued guidelines for management of health care worker exposure to blood borne pathogens and recommendations for post-exposure prophylaxis (PEP).⁸ The PEP guidelines provide considerations in determining whether health care workers should receive PEP and in choosing the type of PEP regimen. Issues such as delayed exposure reporting, pregnancy in the exposed person, resistance of the source virus to antiviral agents and toxicity of PEP regimens are also discussed in the guidance. Occupational exposures should be considered urgent medical concerns.

HRSSPs should demonstrate continued due diligence to reduce the risk of occupational HIV transmission by:

- at least annually training all staff in infection control procedures and the importance of reporting occupational exposure;
- promoting and monitoring the availability and use of safety devices to prevent sharps injuries, and developing a post-exposure management plan; and
- implementation of a PEP policy for HRSSP health care workers

(d) Health and Social Services: Provision and Linkage

IDUs participating in HRSSPs may need services to prevent HIV and HCV infection and to address other health and basic human needs. The CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) programs have developed a strategy called "Program Collaboration and Service Integration (PCSI)" to help health departments improve health outcomes, efficiency and cost-effectiveness. PCSI is a mechanism for organizing and blending interrelated health issues, activities and prevention strategies to facilitate a comprehensive delivery of services. HRSSPs can use PCSI to structure health delivery to populations of IDUs and specifically address the challenges associated with integrating services at a HRSSP location or through linkage to community service providers. The CDC's White Paper on PCSI (2009) can be found at:

[http://www.cdc.gov/nchhstp/ProgramIntegration/docs/207181C_NCHHSTP_PCSI%20White Paper-508c.pdf](http://www.cdc.gov/nchhstp/ProgramIntegration/docs/207181C_NCHHSTP_PCSI%20White%20Paper-508c.pdf). 9

(e) Strategies to Increase Access to Services

HRSSPs can enhance their success by employing the following strategies:

- Establish collaborative relationships with referral agencies.

⁸ Centers for Disease Control and Prevention. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis. MMWR2005;54(RR09):1-17.

(b) Safe Syringe Disposal

Local health departments must ensure proper disposal of syringes collected through their HRSSPs. Proper disposal of used syringes is critical to protecting individual health and public safety. Safe disposal procedures help prevent accidental needle stick injuries among staff, law enforcement, volunteers, participants and the public. Infectious diseases can be transmitted during an accidental needle stick; therefore, the experience can be very stressful for the people involved. Furthermore, making disposal resources available to IDUs helps reduce the number of syringes and other injection equipment inappropriately discarded, helping to protect the HRSSP from public scrutiny.

Health departments are in an advantageous position as they likely have procedures in place for the disposal of syringes in the daily practice of the regular services provided at the health department. HRSSPs must document policies and procedures governing disposal of syringes and other medical waste and supervise disposal to ensure that staff and volunteers are adhering to the rules as outlined by the local health department's policies and protocol.

The following suggestions may help guide safe disposal procedures:

- Develop or expand partnerships with waste management companies to obtain and dispose of medical waste.
- Do not require that returned syringes be counted by hand. Estimates can be made by observation or by weighing the returned syringe containers to determine the number of syringes disposed of for monitoring purposes.
- If the HRSSP uses a mobile unit, close sharps containers when the vehicle is moving in case the vehicle stops short or there is an accident. Similar strategies should be used when conducting street outreach.
- Provide individual disposal containers to clients (i.e. syringe and needle collection boxes, laundry detergent bottles, etc.)

(c) Prevention of Occupational Blood Borne Pathogen Transmission among HRSSP Staff

As is the case for other health care workers, HRSSP staff can be at risk for acquiring HIV/HCV from needle stick injuries and cuts during syringe exchange and disposal. To prevent the occupational transmission of blood borne pathogens, HRSSP staff should assume that blood and other bodily fluids from HRSSP participants are potentially infectious, therefore requiring infection control precautions at all times including:

- routine use of barriers (e.g., gloves, goggles, closed-toe and heel shoes) when anticipating contact with blood;
- immediate washing of hands and other skin surfaces after contact with blood or body fluids; and
- careful handling and disposal of sharp instruments during and after use.

- Make referrals, when possible, to social service agencies that aim to reduce drug use and its consequences.
- Address barriers to accessing services (e.g., financial, transportation, child care, bench warrants).
- Have designated staff call ahead and provide transportation to referral sites (i.e. assisted referrals).

Health departments can work with community agencies to ensure that HRSSP participants are able to access services. Specific strategies include the following:

- Develop protocols for referrals to relevant medical, behavioral health, substance abuse treatment and social services.
- Identify points of contact within each referral agency that can facilitate HRSSP participant access to needed services.
- Work with HRSSPs to train other agencies about HRSSPs.
- Address barriers to care at community programs, including stigmatization of clients as a requirement for receiving services.
- Support flexible community programs that are inclusive of clients.
- Involve state hepatitis/HIV/sexually transmitted disease (STD) coordinators. Using a combination of motivational interviewing and incentives has shown promise in increasing enrollment of referred participants in drug abuse treatment.⁹

VI. Specific Health and Social Services

HRSSPs play an important role in providing information and counseling to IDUs that allow them to reduce the consequences associated with drug use and to increase their general well-being. HRSSP staff can benefit from training on providing accurate information and using evidence-based approaches to counseling.

(a) Education and Counseling

Educational materials need to be accurate, up to date and matched to the population served in terms of cultural relevance, language and reading level. Specific content areas to be covered can include:

- HRSSP services, location and hours;
- local health centers and clinics locations and hours;
- safer injection practices and vein care;
- safer sex practices;
- identification and treatment of soft-tissue infections;

⁹ O'Kidorf M, Disney ER, King VL, Neufeld K, Peirce J, Kolodner K, Brooner RK. Improving substance abuse treatment enrollment in community syringe exchangers. *Addiction*. 2009;104:786-795.

- HIV, HBV, HCV, and STD prevention and treatment associated with unsafe drug injection and sexual practices;
- drug abuse treatment options;
- overdose prevention and response; and
- accidental needlestick response.

(b) Media and Community Outreach

Kanawha-Charleston Health Department advertised for its Harm Reduction Program through press releases, facebook, and community partners. One of the easiest ways to advertise for the program was to have a brochure that could be handed out at various events.

Drug Overdose

Overdose is most common when:

- Your tolerance is lower due to a break from using, or you are new to drug use.
- You have been sick, tired, run down, dehydrated or have liver issues.
- You mix drugs: prescribed or not, legal or illegal.
- The drugs are stronger than you are used to due to changes in supply, dealer or town.

To prevent overdose:

- Know your health status and your tolerance
- Do not mix drugs and alcohol. If you do mix, choose to use drugs before alcohol.
- Be aware, using drugs while on prescribed medications can increase overdose risk.
- Don't use alone. Leave door unlocked. Tell someone to check on you.
- Do test strips to check strength. Use less. pace yourself.
- Talk to an experienced person or a trusted healthcare provider about reducing risk.
- Know CPR and get trained on giving Naloxone.
- Choose a **safer** route of taking drugs. The safest being no use, followed by swallowing then snorting / smoking / inserting and injecting being the **least** safe.

Resources

CAMC Neonatal Drug Program
304-388-2252

CAMC Ryan White Program
(HIV Program)
304-388-8106

First Choice Services
1-844-HELP4WV

Highland Hospital
304-926-1600

**Kanawha Charleston Health
Department**
304-348-8080

Pretera Center
304-341-0511

St. Francis Hospital
304-347-6500

Thomas Hospital
304-766-3600

WV Health Right
304-414-5930



Harm Reduction and Needle Exchange Program

108 Lee Street, East
Charleston, WV 25301
Phone: (304) 344-KCHD
E-Mail: clinic@kchdvw.org

www.kchdvw.org

JOIN US ON
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twitter

Our Goals

- Reduce incidence of substance-related health and social harms, including transmission of blood-borne pathogens through substance abuse.
- Promote and facilitate referrals to primary health care and mental health and substance use services.
- Reduce stigma and discrimination against people who use drugs.
- Ensure full and equitable reach of Harm Reduction services and education to all who use substances.
- Raise awareness about the risk of drug overdoses and associated fatalities.
- Provide safe disposal of used needles.

Anonymous Clean Needle Exchange and Supplies

Kanawha Charleston Health Department
Every Wednesday
10:00 am—3:00 pm

Information on safer injection practices

Information on wound prevention and care

Non-Anonymous Services Available

Pregnancy Tests
Monday through Friday 8:00 am-4:00 pm

STD Clinic
Tuesday 12:00 pm-2:45 pm
Thursday 12:00 pm-2:45 pm

Household Disposal of Syringes

- Put used syringes, needles, lancets, and other sharp objects in a hard plastic or metal container with a screw-on lid or tightly secured lid.
- **DO NOT USE GLASS OR CLEAR PLASTIC CONTAINERS**
- Place container where you will be using your syringes to minimize handling.
- Be sure your location is child and animal free
- Place the sharps in the container immediately after use. Do not try to recap, remove, bend or break the needles.
- When the container is nearly full, add a solution of 1 teaspoon of household bleach to 1 pint of water, then seal the container.
- With a permanent marker, print “**NOT RECYCLABLE TREATED SHARPS**” on the outside of the container.
- Place the container in a plastic bag and seal it with tape in case of leak. Discard the bag with the rest of your trash
Or
- You may exchange your needles for clean ones at Kanawha Charleston Health Department.



Harm Reduction and Needle Exchange Program

Wednesdays 10am-3:00 pm

Anonymous Clean Needle Exchange and Supplies

- Information on safer injection practices
- Information on wound prevention and care
- Optional other services including recovery coaches and testing available

**108 Lee Street East
Charleston, WV 25301**

Revised 3-21-16

(c) Social Services

HRSSPs can help participants meet basic needs and increase engagement by providing information and referral on an array of services that are appropriate for the population.

Potential services include:

- Help4WV Navigator Services referrals for uninsured clients;
- food and clothing distribution;
- hygiene supplies (e.g., feminine products, soap);
- child care;
- telephone, mail, and computer access;
- vocational assistance;
- legal aid;
- housing; and
- treatment services.

(d) Medical Care

IDUs have the same preventive and basic medical care needs as the general population. However, they also are at higher risk for specific health problems, such as blood borne infections and wounds. HRSSPs serve as a good opportunity for IDUs to meet and build a relationship that will encourage participation in routine services provided by the local health department, such as:

HIV, HBV, HCV, tuberculosis (TB) and STD screening;

- linkage to and retention in care for IDUs living with HIV and/or HCV;
- primary medical care;
- pregnancy testing and prenatal care;
- vaccinations (hepatitis A/B, influenza, pneumonia);
- TB prophylaxis; and
- wound care.

IDUs using HRSSP services have a high prevalence of psychiatric disorders, such as major depression and antisocial personality disorder. HRSSP staff may benefit from training on recognizing the signs and symptoms of common psychiatric disorders and suicide prevention so that appropriate referrals can be made.

(e) Drug Abuse Treatment

The HRSSP may partner with local community treatment providers to combine services in one location. Each community will have different needs and resources. Therefore, consideration should be given to the best way to achieve all the goals of the HRSSP. At a minimum, resources and referrals to treatment services in the community should be provided to HRSSP participants. The Kanawha-Charleston Harm Reduction Program refers to the

HELP4WV line. It is a mental, substance abuse, and rehabilitation call service that facilitates an individual's contact with services in the West Virginia area.

(f) Overdose Prevention

In coordination with its Harm Reduction Syringe Service Program, the Kanawha-Charleston Health Department offers Naloxone training every Wednesday at 12:30 pm for its participants. Upon completion of the 15 minute training, participants receive an auto-injector trainer and two doses of Naloxone. This program is provided as a free service, thanks to contributions from Kaleo Pharma. Overdose is a major cause of mortality among clients and HRSSPs can address overdose prevention and response with both staff and participants. Naloxone is a drug used to counter the effects of opiate overdose. Making naloxone available is a recommended evidence-based strategy that reduces opioid overdose fatalities. Key overdose prevention strategies include:

- providing comprehensive training on overdose prevention, recognition and response for all HRSSP staff and volunteers, including rescue breathing and the use of naloxone;
- developing protocols for responding to overdoses on-site;
- educating program participants about overdose prevention and response; and
- educating the IDUs' family members and friends as well as the community at large how to recognize and respond to overdoses.

The following is an example KCHD protocol for overdose prevention and response on-site:



Naloxone (Narcan) Protocol

1.0 Purpose:

Naloxone is only indicated for the complete or partial reversal of opioid overdose induced by natural or synthetic opioids and can cause difficulty in breathing, sedation and even death. The effect of Naloxone begins taking effect in three to five minutes and last sixty to ninety minutes. The objective is to treat opioid/opiate overdoses. It is contraindicated in patients known to have a hypersensitivity to naloxone hydrochloride.

2.0 Policy:

Naloxone should be given to someone that is experiencing an/or is suspected of opioid overdose. Examples of Opioids include: Morphine (MS Contin®) Codeine

Hydrocodone (Vicodin®, Norco®)	Hydromorphone (Dilaudid®)
Oxycodone (Percocet®, OxyContin®)	Oxymorphone (Opana®)
Fentanyl (Duragesic®)	Buprenorphine (Subutex®)
Methadone	Heroin

Overdose most often occurs when one takes a large or increased amount of opioids, mix opioids with alcohol or other drugs, or have had recent changes in tolerance levels.

If a person is not responding, not breathing, or is struggling to breathe, they may be experiencing an overdose and may need naloxone administered. Unresponsiveness may also be due to other conditions such as sudden cardiac death or choking with hypoxia. In addition to considering and treating overdose, standard Basic Life Support (BLS) measures must be initiated and sustained until either the patient becomes responsive or medical transport arrives.

3.0 Procedure:

3.1: Identify Overdose/Unresponsiveness

- 3.1a** If someone is not breathing or is struggling to breathe try calling the patient's name and rubbing your knuckles on their chest.
- 3.1b** If he/she are still unresponsive, they may be experiencing an overdose. Other signs that may help you identify an overdose are: blue or pale skin color, small pupils, slow heartbeat, snoring sound, gasping for breath and

- 3.5a** Continue rescue breathing after naloxone is given with one breath every 5 seconds, if needed
- 3.5b** If victim is still not responding in three to five minutes, give a second dose of Naloxone in the same manner as above.

3.6: Stay until help arrives, continuing BLS as appropriate

- 3.6a** It is important to stay with patient until help arrives
- 3.6b** Naloxone can reverse an overdose, but can also cause withdrawal symptoms, as well as rapid heartbeat, chest pain, seizures, hallucinations and/or loss of consciousness.

3.7: Documentation of events

- 3.7a** It is essential to document in patient's chart the following:
 - Overdose signs you observed
 - What drug was involved, if known
 - How long the Narcan took to revive the victim
 - The patient's response to the Narcan
 - What else was done to revive the patient
 - His/her disposition once he or she was revived

This protocol and procedure shall remain in effect for all patients of the Kanawha-Charleston Health Department until rescinded.

Medical Director's signature _____ Effective date: _____

December 30, 2015



Naloxone Standing Order

This standing order, consistent with WV Code Chapter 16, Article 46, authorizes:

Dr. Michael Brumage, Executive Director/Health Officer at the Kanawha Charleston Health Department to prescribe and distribute the opioid antagonists EVZIO, Narcan, or naloxone, as available to:

Persons who have satisfactorily completed the Opioid Antagonist Act Naloxone Administration Training Module for Initial Responders at the Kanawha Charleston Health Department at 108 Lee Street East, Charleston, WV, 304-348-8080, and who meet the criteria of the law including being: 1) initial responders, 2) an individual at risk of an opiate-related overdose, 3) a relative of a person at risk of experiencing an opiate-related overdose, 4) a friend of a person at risk of experiencing an opiate-related overdose, or 5) (a) a caregiver or (b) person in a position to assist a person at risk of experiencing an opiate-related overdose.

For the purpose of dispensing, this order will stand as a prescription for those persons meeting the above qualifications. However, said person must provide Name, Date of Birth, Address, Phone Number, and drug allergies consistent with the requirements of WV prescribing regulations.

Prescriptions may be written consistent with WV Code Chapter 16, Article 46, and all other laws and regulations pertaining to prescribing authority.

All dispensed units are to be labelled according to WV prescribing regulations.

Products which may be dispensed, as available, include:

EVZIO, naloxone HCL injection, USP 0.4mg auto-injector

Dispense: 1 (One) prepackaged kit containing three units, 2 (Two) Evzio Auto-injectors and 1 (One) Trainer

Sig: Use in case of suspected opioid overdose intramuscularly. Call 911. Repeat in 2 minutes if no response.

Refills: 1 (One)

NARCAN, nasal spray

Dispense: 1 (One) prepackaged kit containing 2 (Two) individual doses of 4mg naloxone in 0.1ml

shallow breathing.

3.1c Call for assistance, including activating 9-1-1.

3.2: Call 9-1-1

3.2a After identifying an overdose it is very important to get help as quickly as possible. Make sure to say the person is unresponsive and not breathing or struggling to breath. Give a clear address and location.

3.2b If you have to leave patient at any time to call for help or get naloxone, make sure that you put the patient in the rescue position. Put the patient on his/her side with the top leg and arm crossed over the body.

3.3: Initiate BLS, Starting with Rescue Breaths

3.3a Obtain CPR breathing face mask from emergency kit located in the pharmacy

3.3b Place patient on their back and tilt chin to open the airway

3.3c Look and listen for breathing and check patient for pulse

3.3d If patient found without pulse, start chest compressions and rescue breathing combined

3.3e If pulse is present then administer two even regular breaths through face mask over patient's nose and look for the chest to rise

3.3f Continue administering 1 breath every 5 seconds until the person starts breathing on their own. Continue this for **at least 30 seconds**. If the person is still unresponsive, you can give naloxone.

3.4: Give Naloxone

3.4a Remove the cap from the naloxone vial

3.4b Insert at least 5/8 or 1 inch long needle into the vial and draw back 1 ml (0.4mg) of naloxone.

3.4c Inject dose into muscle of upper arm or upper thigh IM (1" needle) or SQ (5/8" needle)

3.5: Resume rescue breathing and BLS, as appropriate

Sig: In case of suspected opioid overdose, spray the contents of one unit into one nostril. Call 911. Repeat in 2 minutes if no response.

Refills: 1 (One)

Naloxone, 1mg/1ml solution, 2ml prefilled syringes

Dispense: 2 (Two) syringes

Sig: In case of suspected opioid overdose, apply atomizer (available separately) and spray 1 cc in each nostril. Call 911. Repeat in 2 minutes if no response.

Refills: 1 (One)

Atomizers, 2 (Two) should be dispensed with naloxone, 1mg/1ml, 2ml prefilled syringes

A previously prepared naloxone take-home kit, or separate nasal atomizer units, may be dispensed along with a prescription for naloxone solution, 1mg/1ml, 2ml prefilled syringes.

Prescribers must file an annual report with the WV Board of Pharmacy recording the number of prescriptions issued to each of the 5 responder subtypes listed previously.

This order will be effective from March 25, 2016. This order will remain in effect until superseded or cancelled, but will require review and reauthorization annually.

Michael R Brumage, MD, MPH, FACP
Physician Director

Date

(g) NAS

One of the focuses of the Harm Reduction Syringe Service Program is to prevent incidences of Neonatal Abstinence Syndrome (NAS). NAS, is a group of problems that occur in a newborn who was exposed to addictive opioid drugs while in the mother's womb. The KCHD program provides contraceptives as well as facilitates IUD placement through Charleston Area Medical Center, a local hospital.



Dear (physician),

West Virginia has one of the highest rates of neonatal abstinence syndrome in the U.S. At CAMC Women and Children's Hospital, nearly 40 percent of babies born have some sort of addictive substance in their systems.

At the Women's Medicine Center, our goal is to reduce this rate. Our Women's Health Addictions Program is staffed with highly-trained clinicians to provide a fully licensed and certified medication assisted treatment program using Subutex for pregnant patients.

Our medical director is a board certified OB/GYN physician, maternal fetal medicine specialist and is also board certified in addiction medicine. An additional board certified OB/GYN is also on staff to assist in prescribing Subutex and overseeing the care of our pregnant patients. The program is coordinated by a full-time registered nurse experienced in caring for pregnant women.

The Subutex program is offered with the goal of abstinence, not maintenance. We work with our patients through weekly therapy sessions and monthly individual counseling to help them through the process.

CAMC Women and Children's Hospital is the only freestanding women and children's hospital in the state, and our Level-IV NICU is right across the hall from the labor and delivery unit. The NICU has 24/7 neonatologist coverage, and our staff is experienced in caring for NAS babies.

For more information about the program or to refer a patient, please contact us at (304) 388-2427.

We look forward to hearing from you.

Byron Calhoun, MD, FACOG, ASAM, MBA

Medical Director
Board Certified in Maternal/Fetal Medicine
Board Certified in Addiction Medicine

Jennifer DePond, MSN, RN

Program Coordinator

CAMC Women's Medicine Center Health Addiction Program

West Virginia has one of the highest rates of neonatal abstinence syndrome in the U.S. At CAMC Women and Children's Hospital, nearly 40 percent of patients that present to the Women's Medicine Center seeking obstetrical care have a positive drug screen. At the Women's Medicine Center, our goal is to reduce this rate. Our Women's Health Addiction Program prescribes Subutex and oversees the care of our pregnant patients.

CAMC Women's Medicine Center.
800 Pennsylvania Ave. Charleston, WV 25362
(304)388-2427 |



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(304)388-2427 |



(h) Mandatory Reporting Protocol

The KCHD Harm Reduction Program does not allow anyone under the age of 18 to participate in its program. Adults are also not allowed to bring children into the clinic, rather someone must sit with the child in the lobby. A copy of KCHDS mandatory reporting protocol is shown below.



Kanawha-Charleston Health Department

POLICY TITLE: Child Welfare/Reporting

PROGRAM AREA: Clinical

POLICY NUMBER:

PURPOSE STATEMENT: To ensure a uniform policy and procedure for reporting all abuse/neglect allegations.

SCOPE: It is the policy and responsibility of the Kanawha Charleston Health Department to report all allegations of abuse/neglect to the West Virginia Bureau for Children and Family Services within the required time frames and in the appropriate and thorough manner. All employees (which includes volunteers) of the Kanawha Charleston Health Department shall adhere to the standards set forth in this policy directive.

LIST OF SUPPLIES/EQUIPMENT

STEPS INVOLVED IN ACTIVITY: The Administrator and Supervisors shall ensure that all employees (which includes volunteers) are made aware of this policy and are held responsible for carrying out the designated duties set forth in WV Code §49-6A-6.

Definitions: Terms defined by Statute

1. **Abandoned:** means to be without supervision or shelter for any unreasonable period of time in light of the child's age and ability to care for him/herself in circumstances presenting an immediate threat of serious harm to such child (49-1-201)
2. **Abused Child:** means a child whose health or welfare is harmed or threatened by a parent, guardian or custodian who knowingly or intentionally inflicts, attempts to inflict or knowingly allows another person to inflict, physical injury or mental or emotional injury, upon the child or another child in the home; or sexual

abuse or sexual exploitation; or the sale or attempted sale of a child by a parent, guardian or custodian and domestic violence. In addition to its broader meaning, physical injury may include an injury to the child as a result of excessive corporal punishment. (49-1-201)

3. **Child:** means any person less than eighteen years of age. (49-1-202)
4. **Child abuse and neglect services:** means social services which are directed toward: protecting and promoting the welfare of children who are abused or neglected; identifying, preventing and remedying conditions which cause child abuse and neglect; preventing the unnecessary removal of children from their families by identifying family problems and assisting families in resolving problems which could lead to a removal of children and a breakup of the family; in cases where children have been removed from their families, providing services to the children and families so as to restore such children to their families and placing children in suitable adoptive homes when restoring the children to their families is not possible or appropriate; and assuring the adequate care of children away from their families when the children have been placed in custody of the department or third parties (49-1-201)
5. **Custodian:** a person who has or shares actual physical possession or care and custody of a child regardless of whether such person has been granted custody of the child by a contract, agreement or legal proceedings (49-1-201)
6. **Imminent danger:** an emergency situation in which the welfare of the life of the child is threatened. Such emergency exists when there is reasonable cause to believe that any child in the home is or has been sexually abused or sexually exploited or reasonable cause to believe that the following conditions threaten the health of life of any child in the home:
 - a. non accidental trauma inflicted by a parent, guardian, sibling or a babysitter or other caretaker; or
 - b. a combination of physical and other signs indicating a pattern of abuse which may be medically diagnosed as battered child syndrome; or
 - c. nutritional deprivation; or
 - d. abandonment by the parent, guardian or custodian; or

- e. inadequate treatment of serious illness or disease; or
- f. substantial emotional injury inflicted by a parent, guardian or custodian; or
- g. sale or attempted sale of the child by the parent, guardian or custodian

7. **Neglected child:** means a child whose physical or mental health is harmed or threatened by a present refusal, failure or inability of the child's parent, guardian or custodian to supply the child with necessary food, clothing, shelter, supervision, medical care or education, when such refusal, failure or inability is not due primarily to a lack of financial means on the part of the parent, guardian or custodian; or who is presently without necessary food, clothing, shelter, medical care, education or supervision because of the disappearance or absence of the child's parent or guardian.(49-1-201)
8. **Sexual abuse:** means (A) as to a child who is less than sixteen years of age, any of the following acts which a parent, guardian or custodian shall engage in, attempt to engage in, or knowingly procure another person to engage in, with such child, notwithstanding the fact that the child may have willingly participated in such conduct or the fact that the child may have suffered no apparent physical injury or mental or emotional injury as a result of such conduct: sexual intercourse or sexual intrusion or sexual contact (B) as to a child who is sixteen years of age or older any of the following acts that a parent, guardian or custodian shall engage in, attempt to engage in, or knowingly procure another person to engage in, with such child, notwithstanding the fact that the child may have consented to such contact or the fact that the child may have suffered no apparent physical injury or mental or emotional injury as a result of such conduct: sexual intercourse, or sexual intrusion or sexual contact, or (C) any conduct whereby a parent, guardian or custodian displays his or her sex organs to a child, for the purpose of gratifying the sexual desire of the parent, guardian or custodian, of the person making such display, or of the child, or for the purpose of affronting or alarming the child (49-1-201).
9. **Physical injury:** non-accidental trauma to the body, such as bruises, bites, scratches, cuts , abrasion, scars, burns, fractures, asphyxiation, internal injuries, or poisoning.

Reporting

In the event child abuse may be witnessed, the employee is to notify immediately the Executive Director/Health Officer along with the Clinical Nursing Director and/or the Community Impact Officer.

The parent/guardian is to be escorted to a private room along with the Executive Director/Health Office and the Clinical Nursing Director or the Community Impact Officer.

Counseling and dialog will take place between the two parties to reach an acceptable and agreeable solution for all parties.

If an agreement cannot be met between the two parties then steps will be followed as listed below.

The duties of a mandated reporter include:

- When a mandated reporter has reasonable cause to suspect that a child is abused or neglected or observes the child being subjected to conditions like to result in abuse or neglect, the person must immediately and not more than forty-eight hours after suspecting the abuse or neglect, report the circumstances or cause a report to be made to the Department of Health and Human Resources (DHHR). Reports of child abuse or neglect shall be made immediately by telephone to the local DHHR at 304-357-9859 or the hotline number of 1-800-352-6513.
- In any case where the reporter believes that the child suffered serious physical abuse or sexual abuse or sexual assault, the reporter must also immediately report, or cause a report to be made to law-enforcement. The report must be made to the State Police **and** to any law-enforcement agency having jurisdiction to investigate the report, which would either be municipal police or the county sheriff's department. This is in addition to the report made to Child Protective services (CPS).
- A mandated reporter who is a member of the staff of a public or private institution, school, facility or agency must immediately notify the person in charge of such institution, school, facility or agency or a designated agent thereof, who shall report or cause a report to be made. Nothing in the law precludes individuals from reporting on their own behalf.

- Any person of official who is included in the list of mandate reporters, including those who has reasonable cause to suspect that a child has died as a result of child abuse or neglect, shall report that fact to the coroner or medical examiner.

Information that is required by law to be reported is as followed:

- Demographic information of the victim(s)
- Type of abuse or neglect suspected
- Is the victim in imminent danger?
- Location of the victim and caregivers
- Is there a protective caregiver present?
- Does the alleged perpetrator have access to the victim?
- General functioning of victim and caregivers
- Any safety threats for first responders

REFERENCES: West Virginia State Code Chapter 49 and the Child Protective Service Policy from WV DHHR

NAME	Date
TITLE	

ORIGINAL DATE ADOPTED: 08/15/2016
REVIEW/REVISION DATES: 08/15/2016
REVIEW FREQUENCY: Annually or as necessary when there is a change in WV state code
TOTAL # OF PAGES 6

VII. Provision or Linkage

Based on multiple factors, including location, financial constraints, availability of community resources and participant preference, HRSSPs will need to decide whether to co-locate services or provide linkages to community resources. Research and HRSSP experience¹⁶ suggest that co-location of services has advantages in both acceptability and effectiveness for HRSSP participants¹⁰ because IDUs have relatively low rates of utilization of community services. Consequently, the HRSSP may be the participant's only or most trusted point of contact with service agencies. Moreover, partnering with agencies that can provide services on-site increases utilization rates. Using community linkages to provide services also has advantages, because these collaborations can help organizations broaden their mission, develop more comprehensive strategies, ensure that participants receive high-quality services, minimize duplication of services and maximize the utilization of available resources.

SERVICE DELIVERY MODELS

Various service delivery models can be used to make syringes available. HRSSPs may find that the best approach is to use a single model exclusively or to combine models to expand the program's reach. When choosing a service delivery model, HRSSPs will find the results from the needs assessment process helpful. Model selection should be driven by numerous factors such as available resources and budget, the organizational infrastructure, local political concerns, availability of staff and volunteers, and the local drug subculture and geographic context. Staffing needs may vary depending on service modality as well as participant volume. For solely distributing and disposing of syringes in low volume programs, adequate coverage can be achieved with as few as two people. However, a minimum of four workers would be preferable for high volume programs. Job tasks include the following:

- syringe distribution;
- syringe collection;
- tracking of basic demographics; and
- referrals to services.

Staffing needs increase as more services are added to accompany syringe distribution and collection. The following sections briefly outline the inherent strengths and potential limitations of different HRSSP models, including fixed site, mobile/street based, and delivery.

I. Fixed Site

Fixed-site models include hospital/clinic-based settings, integrated syringe access services, and collaboration or satellite structures. Typically in fixed-site models, the HRSSP is located in a building or specific location, such as the local health department building, a storefront, office, or other space with street-level access. Fixed sites work best in health jurisdictions where IDUs are

¹⁰Heinzerling KG, Kral AH, Flynn NM, Anderson RL, Scott A, Gilbert ML, Asch SM, Bluthenthal RN. Unmet need for recommended preventive health services among clients of California syringe exchange programs: implications for quality improvement. *Drug and Alcohol Depend.* February 1 2006;81(2):167-178.

clustered in a somewhat centrally located area. The strengths of fixed-site models include the following:

- It is easier for other social service agencies to refer their clients to the HRSSP because there is a set location with predictable hours.
- Other services can be integrated with HRSSP activities, including HIV, HBV, and HCV testing; STD testing; TB screening and prophylaxis; food provision; clinical treatment; abscess and wound care; and overdose prevention.
- Having a permanent site makes it easier to tailor the space to the needs and preferences of the participants.
- Computer-based systems (e.g. electronically tracking inventory of syringes) can more easily be supported in a set indoor location.
- HRSSP services can be provided in a private setting.
- The location provides shelter from weather and street-based activities.
- On-site storage space may be available to house materials.

The potential limitations of fixed-site models include the following:

- A fixed-site may be costlier to maintain because of higher overhead and upkeep.
- Clients may be reluctant to go to the site because of concerns about stigma.
- It can be challenging to stay abreast of and adapt to changes in the drug scene (e.g., if the HRSSP's location is no longer close to where IDUs congregate).
- The community may not support the site's location.
- Participants must come to the site, which can be a barrier if IDUs are spread apart geographically and they do not have transportation.

II. Collaboration or Satellite Structure

In the collaboration or satellite structure model, existing HRSSPs provide syringe services at partner social service agencies in fixed sites in the community (e.g., homeless shelters). It requires that the HRSSP provide capacity-building training for the partner agency. This approach works best in health jurisdictions where HRSSPs are supported and there is a need to increase access through multiple modalities. The strengths of collaboration or satellite structures include the following:

- Access to services may be enhanced through additional locations and expanded operating hours.
- The existing participant base of IDUs can help advertise the availability of syringe services with their peers.
- The parent program has experience managing public relations, which may help increase community support for syringe services. Additional operational and human resource costs may be offset because the parent organization already has the requisite systems and expertise, an established training program and sufficient staff to implement the additional services. It may expand the program's reach by attracting new groups of IDUs.

The potential limitations of collaboration or satellite structures include the following:

- It may be challenging to keep track of inventory if specific systems for doing so are not in place.

- The parent organization and satellite site may have different policies or procedures, which can lead to inconsistencies or discord.

III. Mobile/Street Based Programs

Mobile/street-based programs are conducted on foot, by bicycle or by vehicle (e.g., van, bus or recreational vehicle). This method is also referred to as an outreach program. Many mobile HRSSPs stop at specified locations and times. Although this model is often combined with a fixed-site program, it may also operate independently. This model is well suited to health jurisdictions where IDUs do not congregate in centralized locations or where participants have limited transportation options. Note that jurisdictional approval for all areas of operation and stops for a mobile unit is required.

The cost for mobile sites can vary based on the style of outreach implemented and the transportation needs. For example, some mobile sites involve setting up a cart with supplies on a street corner, whereas others use recreational vehicles. Aside from the cost of a vehicle, other costs must be considered, including automobile insurance, parking, maintenance and gasoline. Training should emphasize security and safety. To ensure staff safety, it is also important to collaborate with law enforcement and other community stakeholders about the program.

The strengths of mobile/street-based sites include the following:

- The program may encounter less resistance from the local community because it will not attract congregations of IDU clients.
- Mobile sites offer heightened flexibility and the advantage of being closer to a street drug market, increasing accessibility for IDUs who are unable to come to a fixed site.
- The program can adapt to changes in the drug scene or neighborhood and can relocate to places where IDUs congregate.
- The existing participant base of IDUs can help promote the time and place of services to their peers.
- The informal and easily accessible location may help put participants at ease.

The potential limitations of mobile/street-based sites include the following:

- It is less anonymous, because people can see who is using the services in the community.
- Staff needs to have a valid driver's license if a motor vehicle is involved.
- Services can be interrupted if the vehicle needs to be repaired.
- It can be harder to provide additional services that require a physical location.
- The work conditions can be stressful for staff because of inclement weather or concerns about safety.
- Supplies need to be stored elsewhere and transported to the sites.
- Participants may be reluctant to come to the HRSSP in inclement weather.
- It can be costly to maintain because of expenses related to vehicle maintenance and insurance.
- Groups of IDUs who may be less likely to visit a HRSSP can still get sterile syringes and dispose of used ones safely.

- Peers may feel empowered by conducting a public health service in their community.

IV. Delivery Models

The delivery model involves the delivery of injection supplies to a prearranged site, such as a house, apartment, hotel, or other prearranged location. Service delivery can take place on a regular schedule or by appointment. It is a direct means of observing the more private aspects of participants' living situations, and services can be developed and tailored to meet those needs. Medical and nutritional services, overdose prevention, directly observed therapy and safer injection education, for example, can all occur in the privacy of a person's home. It is important for the HRSSP to deliver only in its jurisdiction as approved by its Board of Health and county and city officials for that specific delivery site.

It may be best if site managers and landlords of the facilities are informed that unspecified social services are coming to the location. Promotion can occur by outreach workers and through the facility's management, as well as through IDU networks. Delivery is an excellent option in rural jurisdictions, where there are often large geographical areas to cover and privacy is of utmost importance. Delivery may be combined with mobile or fixed sites. Enhanced training for staff and volunteers on safety and confidentiality of participants' needs is necessary.

The strengths of delivery models include the following:

- This form of syringe access is more discreet and consequently reduces negative reactions from the neighboring community, which is rarely aware of the program activity.
- Since participants do not have to transport used injection equipment, it reduces needle stick risk and potential involvement with law enforcement.
- It can be easier to begin a delivery program than other program models due to the reduced need for a physical space.
- Information sharing about injection practices, health, and other issues can occur more privately.
- Participants' safety is enhanced if they do not need to leave their home.
- It increases access to IDUs who may be less likely or unable to attend a fixed site.
- HRSSP staff has more opportunities to interact with family and peer networks.

The limitations of delivery models include the following:

- It requires the HRSSP to have and use transportation to provide services.
- It can be challenging to sustain because of staff burnout.
- It can be potentially time consuming, depending on the geographic dispersion of participants.
- It may take time to overcome potential privacy concerns and build a foundation of trust.
- Worker and volunteer safety is a concern.
- It can be expensive to maintain and insure vehicles.

I. Using Multiple Program Models

Incorporating multiple models may be the most effective way for programs to expand syringe coverage and reach the greatest number and diversity of IDUs within a given health jurisdiction. Combining models—for example, a fixed site with a mobile van increase the likelihood that diverse populations have access to syringes. Also, using multiple program models is more flexible and can direct resources to the most affected areas, allowing programs to respond to changes in patterns among local IDUs. Using a multiple-model approach can require significant resources and demand more effort from staff. This can make them less sustainable. However, multiple program models can be a valuable, comprehensive approach when they are well executed and have sufficient resources.

FUNDING HRSSP

Funding sources for a Harm Reduction Program can be in many forms including community donations, in-kind donation of personnel, grants (federal and local), or money from the health departments County Commission.

II. Local

- (a) Greater Kanawha Valley Foundation

III. State

- (a) County Commission Funding
- (b) Great Rivers Coalition

IV. National

- (a) ARC
- (b) Aids United
- (c) CDC
- (d) SAMHSA

MONITORING HRSSP

The main goal of monitoring local HRSSPs is to assess whether a program is operating in conformity to its design, reaching its specific target population and achieving anticipated implementation goals. Health departments are strongly encouraged to require HRSSPs to continually conduct process monitoring and periodically conduct outcome monitoring. 21 5.1 Process Monitoring The overarching goal of process monitoring is to document whether the program is being implemented as intended. The process outcomes to be monitored depend on the type of service delivery model selected and the type and number of additional services provided. In general, it is recommended that programs minimize the data collection burden associated with monitoring so they do not interfere with IDUs participation or HRSSP operations.

Process monitoring serves a number of important and valuable functions for HRSSPs:

- assesses which services are being used and how often they are used;
- facilitates accounting practices;
- allows HRSSPs to report back to regulators, funders, and others (such as their communities) about program reach; and
- maintains or increases program support.

Three minimum essential data elements are recommended for every syringe transaction occurring at HRSSPs, without regard to the type of service delivery model:

- number of participant contacts (i.e., duplicated participant counts);
- number of syringes distributed; and
- estimated number of syringes returned for disposal (refer to Section 3.3 for safe syringe disposal strategies).

In addition to these core data elements, additional data can be used to monitor process outcomes depending on the type of service delivery model and types of services provided. Appendix B lists additional process indicators that programs may wish to monitor, depending on the service delivery model and types of services that are provided in addition to syringe exchange.

Most programs use service logs to obtain data on the number of syringes provided per transaction and the estimated number of syringes returned. In these programs, HRSSP staff writes the site name and the date at the top of the log daily and record transaction data as participants access services. Then staff enters the data into a software program on a daily or weekly basis. Using a handheld electronic device programmed for data input is preferable if the program can afford it because it eliminates the need for entering data from paper forms.

Process monitoring does not require sophisticated statistical methods. Descriptive statistics are usually sufficient to answer process monitoring questions, such as comparing actual program outputs (e.g., number of HIV tests conducted) with target outputs (e.g., projected number of HIV tests conducted).

I. Program Database

The purpose of the harm reduction database is to capture demographic and program data from your participating population which is then reported to community members. Data to record is up to the discretion of the program staff. However, common data collected in Harm Reduction Programs include: Date, Client ID, Patient Type, Race, Sex, Sexual Preference, Education, Contraception Method, Residence, Zip code, Drug of Choice, Route, Insurance, Hepatitis/HIV Status, Last Test Date, Age of First Use, Been In Recovery, Experienced an Overdose, Been with Someone Who has Overdosed, Waiting For Recovery, Wait Time, Other Services (if Applicable), Frequency of Use per Day, Preferred Needle Size, Share Needles, Needles Returned, and Needles Given. It is important to point out a few things when recording the above data. When recording items with multiple answers such as drug of choice, contraception method, other services, etc. type in all responses in the same order, separating individual responses with a comma. The database at the Kanawha-Charleston Health Department is kept in an excel spreadsheet, but other programs such as Access can also be used.

II. Outcome Monitoring

Quantitative assessments should occur periodically with HRSSP participants for outcome monitoring. Outcome monitoring provides important information for improving program efficiency, quality and effectiveness. In general, outcome monitoring methods should aim to minimize participant burden, not disrupt normal program activities and only collect information that is critical for understanding process outcomes. Utilizing a variety of data types and sources, together with program specific outcome monitoring activities, enhances the assessment of the HRSSP. For example, data that provide information on HIV/ HCV incidence rates, crime statistics, incarceration rates, and arrest rates may provide system level indicators for the impact of the program on outcomes related to the overarching goals of the HRSSP. Quantitative assessments conducted with HRSSP participants should occur, at a minimum annually or every other year and include a representative sample of participants. Choosing participants randomly is preferable but may not be feasible in all locations or for all syringe modalities. Participants may be incentivized for providing their expertise to the HRSSP by participating in outcome monitoring surveys. Key domains for HRSSP outcome monitoring include:

- types of services used at the HRSSP;
- frequency and duration of HRSSP use, including estimation of numbers of syringes distributed in a given period;
- receptive and distributive syringe sharing;
- disposal practices;
- overdose risk and history;
- access and linkage to drug treatment and medical and social services (e.g., referrals and linkage to medical homes, behavioral health services and homes and substance abuse treatment facilities);
- participant satisfaction with program elements, such as hours, locations and staff interactions;
- client characteristics (e.g. demographics, injection drug use history, medical history, and substance abuse treatment history);
- drug use preferences (e.g. types of drugs used, including hormones or steroids) and practices (e.g. with whom and how often participants use drugs);
- estimates of number of IDUs reached through outreach; and
- changes in drug use, injection and treatment as a result of HRSSP participation.

An individual trained in epidemiological and statistical methods and familiar with the literature on factors associated with HIV, HCV, and overdose risk and HRSSPs should analyze the data. HRSSP staff should be involved in interpreting the results. See appendix B for process monitoring indicators.

(a) Customer Satisfaction Survey

The Kanawha Charleston uses a customer satisfaction survey to evaluate the Harm Reduction Syringe Service Program.

10. What is your race?

- African American
- Caucasian
- Other
- Prefer not to answer

11. What describes your employment status?

- Disabled
- Employed
- Not Employed
- Retired

12. Your Zip Code:

83 Comments

Please return to:

Kanawha-Charleston Health Department
108 Lee St.

Charleston, WV 25301

Phone: 304-348-6494

Fax: 304-348-6821

Email: John.D.Law2@wv.gov

Customer Satisfaction Survey



Please return to:
Kanawha-Charleston Health Department
108 Lee St., Charleston, WV 25301

1. How long have you been receiving services/education/information from Kanawha-Charleston Health Department?
- This is my first time
 - Once a year
 - Every six months
 - More than every six months
2. WHICH health department service(s) did you use on this visit/encounter?
- Clinical Services** (Family Planning , Harm Reduction/Needle Exchange, Immunizations, STD/HIV)
 - Epidemiology/Threat Preparedness** (Communicable Disease Contact, Disease Outbreak, etc.)
 - Environmental** (Restaurant and Permitted Facility Inspection. Sewage Permits, etc.)
 - Prevention and Wellness** (Chronic Disease Management)
 - Administration** (Resolving issues. Working with budgets, etc.)
3. How FREQUENTLY do you access KCHD services?
- Once a week
 - Once a month
 - More than twice in a 12-month period
4. Overall, how would you RATE your level of satisfaction with us?
- Highly satisfied
 - Somewhat satisfied
 - Neutral
 - Somewhat dissatisfied
 - Highly dissatisfied
- Before we go any further, let's offer some brief definitions about the following several questions.
- Customer service**—Was our staff responsive to your needs? Did we explain what we were doing in terms you could understand?
- Timeliness**—Were the services provided in a manner you thought timely and reasonable?
- Professionalism**—Were our employees clean and neat in appearance? Did they respect your property and feelings? Did they answer your questions in terms you could understand?
5. How would you RATE us on customer service?
- Highly satisfied
 - Somewhat satisfied
 - Neutral
 - Somewhat dissatisfied
 - Highly dissatisfied
6. How would you RATE us on timeliness?
- Highly satisfied
 - Somewhat satisfied
 - Neutral
 - Somewhat dissatisfied
 - Highly dissatisfied
7. How would you RATE us on professionalism?
- Highly satisfied
 - Somewhat satisfied
 - Neutral
 - Somewhat dissatisfied
 - Highly dissatisfied
8. What is your gender?
- Male
 - Female
 - Prefer not to answer
9. What is your age?
- Younger than 18
 - 18-24
 - 25-44
 - 45-54
 - 55-64
 - 65 or older
 - Prefer not to answer

III. Program Quality Improvement

Program quality improvement relies on the systematic collection and use of process monitoring and periodic outcome monitoring to determine if and how well program objectives are being met and to reassess program goals. If goals are not being met, program quality improvement can help HRSSPs decide if and how to change services to better meet the needs of the target population. Based on program goals, working with a research partner can be an appropriate method for assessing program quality.

Quality improvement may include perspectives from community stakeholders, HRSSP participants, and others with important perspectives regarding the usefulness and effectiveness of the HRSSP. For instance, programs can use methods such as key informant interviews and focus groups to assess participant satisfaction with program elements, such as hours, locations and staff interactions; learn how HRSSP participants use program services; or understand how new services might be received.

Using unobtrusive approaches, programs can observe HRSSP transactions systematically to identify opportunities to provide more education, counseling, or other services or simply time them to determine barriers to providing other activities. Many quality improvement ideas can also be discussed through a participant or community advisory board if the HRSSP has one.

IV. Building Capacity of HRSSP Staff

Building capacity of staff increases individual skill level and overall service quality and productivity. In addition to improving service delivery, training staff on the program's philosophy and mission helps ensure that participants feel welcome at the HRSSP and are comfortable accessing services.

HRSSPs may have staff or volunteers who can provide training on a regular or ad hoc basis. Other times in-house training is not available on important topics. In such cases, training and technical assistance can be obtained through other mechanisms. A number of organizations and institutions provide training and technical assistance to HRSSPs. Additionally, staff and volunteers can attend conferences and off-site trainings that can be good opportunities to interact with other providers and gain relevant experience and insight. It is recommended that all staff and volunteers complete a basic training curriculum that encompasses the core topics shown in Table 2. In addition to the core training program, health departments should prioritize ongoing staff development by offering advanced training on topics such as those shown in Table 2.

Table 2. Basic and Advanced Training Topics for HRSEP Staff

Basic Training Topics	Advanced Training Topics
<ul style="list-style-type: none">• Standard operating procedures	<ul style="list-style-type: none">• Polysubstance use
<ul style="list-style-type: none">• Referral to medical, substance abuse treatment, behavioral health, other service agencies• Cultural sensitivity• Overview of neighborhood concerns• Outreach strategies• HIV and viral hepatitis transmission and prevention• Overdose prevention• Syringe safety/disposal• Plan for accidental needle sticks• Legal and law enforcement climate	<ul style="list-style-type: none">• Conflict resolution and de-escalation• Specialized interviewing techniques (e.g. motivational interviewing)• Principles of case management• Abscess and cellulitis treatment and prevention• Domestic violence issues• Co-occurring behavioral health and substance use disorders

CONCLUSION

HRSSPs have proven to be an effective model for combating blood borne pathogens and helping IDUs find much needed treatment and services. As the community works to implement the program that is best suited to its needs, this guidance offers viable the options. The Kanawha-Charleston Health Department Division of Prevention and Wellness is available to answer any questions or address any concerns, 304-348-6493.

APPENDIX

The following are additional resources used for educational and data gathering purposes. The Anti-stigma survey was a campaign ran by the local substance abuse coalition, Kanawha Communities that Care, identifying the sigma PWIDs suffer in daily interactions.



WEST VIRGINIA
NAVICARE

Yes, I, _____ want
to learn more about my health insurance options.

Phone: _____

- I do not currently have health insurance.
- I need to renew my coverage.
- I'm looking for better coverage.
- I recently lost my coverage

By signing this form, I agree to have a staff member of WV Navicare contact me



WEST VIRGINIA
NAVICARE

Yes, I, _____ want
to learn more about my health insurance options.

Phone: _____

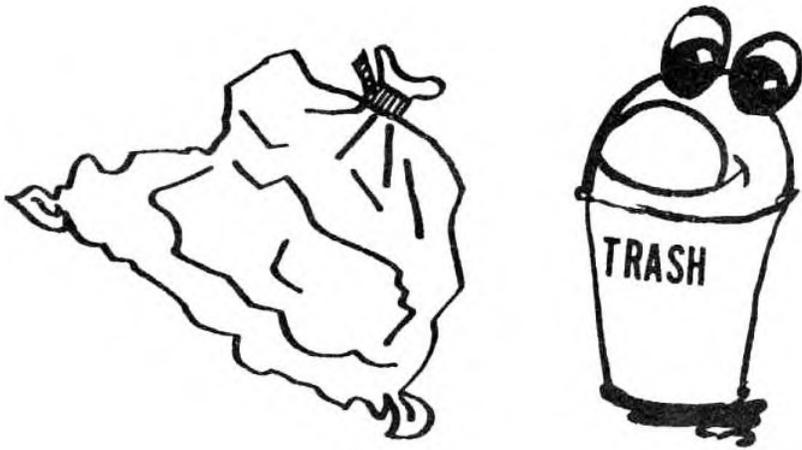
- I do not currently have health insurance.
- I need to renew my coverage.
- I'm looking for better coverage.
- I recently lost my coverage

By signing this form, I agree to have a staff member of WV Navicare contact me

7. We also recommend that:

- a. Soiled bandages,
- b. Disposable sheets, and
- c. Medical gloves

be placed in securely fastened plastic bags before you put them in the garbage with your other trash.



For more information contact:

West Virginia Department of Health & Human Resources
Bureau for Public Health
Office of Environmental Health Services
Public Health Sanitation Division
Infectious Medical Waste Program
350 Capitol Street, Room 313
Charleston, WV 25301-3713

Telephone (304) 558-2981
Fax (304) 558-1071

Web site <http://www.wvdhhr.org/wvimw>

A HOUSEHOLD GUIDE FOR THE PROPER DISPOSAL OF SYRINGES AND SHARPS



The responsible disposal of syringes and sharps can be your part in protecting the public and the environment. You can help prevent injury, illness and pollution by following some simple steps when you dispose of the sharp objects and contaminated materials you use in administering health care in your home.

1. You should place:

- Needles
- Syringes
- Lancets, and
- Other sharp objects

In a hard-plastic or metal container with a screw-on or tightly secured lid.

A coffee can will do if the plastic lid is reinforced and sealed with heavy duty tape.

DO NOT USE GLASS OR CLEAR PLASTIC CONTAINERS.



2. Place the container where you will be using your syringes and sharps to minimize handling.

Make sure your storage location is child and animal proof.

3. Place the sharps in the container immediately after use.

DO NOT try to **RECAP**, **REMOVE**, **BEND** or **BREAK** the needles. This is where most injuries occur.

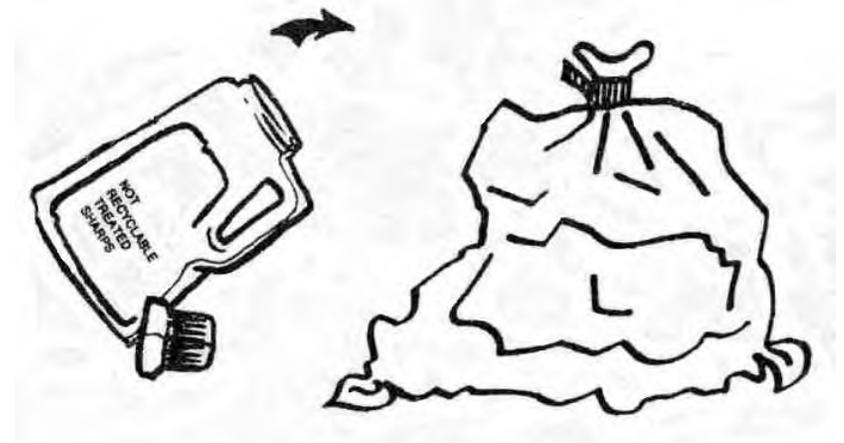
4. When the container is nearly full add a sanitizing solution, made by adding one teaspoon of household bleach (5.25%) to one pint of water, then seal the container.



5. With a permanent marker, print

“NOT RECYCLABLE TREATED SHARPS”

on the outside of the container with a contrasting color. Place the sharps container in a plastic bag and seal it with tape in case leakage occurs.



6. Discard with the rest of your garbage.

“Please tell us about your experiences with STIGMA, DISCRIMINATION, NEGATIVITY, and PREJUDICE.”

“Stigma is a perceived negative attribute that causes someone to devalue or think less of the whole person.”

County:	Marital Status:
Age:	Length of Recovery:
Gender:	Drug of Choice:

For each item identified below, circle the number to the right that best fits your judgment of its quality. Use the rating scale to select the quality number.

Survey Item	Scale				
	N o n e	Some			M u c h
1. I experience stigma from home.	1	2	3	4	5
2. I experience stigma from employers.	1	2	3	4	5
3. A background report indicating drug use or a felony impacted my ability to get/maintain a job	1	2	3	4	5
4. I experience stigma from my church.	1	2	3	4	5
5. I experience stigma from law enforcement.	1	2	3	4	5
6. I experience stigma from the court system.	1	2	3	4	5
7. I experience stigma from a healthcare worker.	1	2	3	4	5
8. I experience stigma from a hospital or clinic.	1	2	3	4	5
9. I experience stigma in local stores.	1	2	3	4	5
10. I experience stigma from banks.	1	2	3	4	5
11. I experience stigma from restaurants.	1	2	3	4	5
12. I experience stigma from schools.	1	2	3	4	5

Have you ever overdosed?	If yes, what substance?
--------------------------	-------------------------

If possible, use a new sterile syringe every time. If you have to re-use a syringe,

Clean Your Works With Bleach Including Your Cooker!



Get clean syringes at:
Kanawha-Charleston Health Department
108 Lee St. East Charleston, WV 25301
WEDNESDAYS 10am to 3pm

Three Step Method

1. **Rinse with cold water**

-Hot water causes blood to clot, cold water is best

2. **Flush with bleach**

-Use straight household bleach, fill the whole syringe with bleach

-Make sure all surfaces are touched by bleach

3. **Rinse the needle with cold water again**

-Throw out bleach and water

Created 9-30-16

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