NACCHO
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2019 Model Practices

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Size

Select a size: *

☐ Small (0-50,000) ☐ Medium (50,000-499,999) ☑ Large (500,000+)

Application Information

Local Health Department/Organization Name: *
Tri-County Health Department

Title of Practice: *
Aurora Syringe Access Services

Submitter Name: *
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Size

Select a size::

- [ ] Small (0-50,000)
- [ ] Medium (50,000-499,999)
- [x] Large (500,000+)

Practice Categories

Model and Promising Practices are stored in an online searchable database. Applications may align with more than one practice category. Please select the top three that apply most to your practice: : *

- [ ] Access to Care
- [ ] Advocacy and Policy Making
- [ ] Animal Control
- [x] Coalitions and Partnerships
- [ ] Communications/Public Relations
- [ ] Community Involvement
- [ ] Cultural Competence
- [ ] Emergency Preparedness
- [ ] Environmental Health
- [ ] Food Safety
- [ ] Global Climate Change
- [ ] Health Equity
- [x] HIV/STI
- [ ] Immunization
- [ ] Infectious Disease
- [ ] Informatics
- [ ] Information Technology
- [ ] Injury and Violence Prevention
- [ ] Marketing and Promotion
- [ ] Maternal-Child and Adolescent Health
- [ ] Organizational Practices
- [ ] Other
- [ ] Primary Care
- [ ] Quality Improvement
- [ ] Research and Evaluation
- [ ] Tobacco
- [ ] Vector Control
- [ ] Water Quality
- [ ] Workforce

Overview: Provide a brief summary of the practice in this section (750 Word Maximum)

Your summary must address all the questions below:

- Brief description of LHD- location, demographics of population served in your community.
- Describe public health issue.
- Goals and objectives of the proposed practice.
- How was the practice implemented/activities.
- Results/Outcomes (list process milestones and intended/actual outcomes and impacts.
- Were all of the objectives met?
- What specific factors led to the success of this practice?
- Public Health impact of practice.
- Website for your program, or LHD.

Please use this portion to respond to the questions in the overview section. : *

Brief description of LHD. The Tri-County Health Department (TCHD) serves 1.5 million residents (about 26% of Coloradans) in Adams, Arapahoe, and Douglas Counties in the Denver Metro area. The City of Aurora (population 366,000) is directly east of Denver and is part of all three Counties. The Aurora Syringe Access Services (ASAS) program serves people who inject drugs (PWID), living on the street (52%) and using Heroin (47%) and/or Methamphetamine (58%).

Describe public health issue. While facing the opioid and heroin overdose death epidemic[1], PWID suffer from high Hepatitis C (HCV) infection[2]. In 2016, 46.3% of Colorado's acute HCV cases were attributed to injection drug use (IDU). PWID are also at risk for HIV through sharing injection equipment and high-risk sexual behaviors[3]. The TCHD residents represented 13.4% of Colorado's acute HCV cases in 2016. The TCHD area had 128 new HIV cases (8.6 per 100,000)[4] and 17 cases (13.3%) were associated with IDU in 2017.

Goals and objectives of the proposed practice. Comprehensive syringe service programs (SSP) are effective in reducing harms (HIV and HCV infection, opioid overdose deaths[5]) and promote utilization of resources and treatment services. In October 2016, TCHD implemented the ASAS, offering a fixed site (fixed location) and street outreach services. The objectives are: 1) to distribute 6,666 sterile syringes monthly, 2) to distribute 300 Naloxone (opioid antagonist) yearly, 3) to enroll 10 new participants monthly, and 4) to make active referrals (10% of participants) monthly.

How was the practice implemented/activities. In 2015, the Harm Reduction Action Center (HRAC) (a downtown Denver SSP) approached TCHD to offer SSP in Aurora to address the service gap and the opioid epidemic. HRAC recently experienced high volume of TCHD residents (921 participants) accessing their services. Of these, 31% of them came from Aurora, and many were experiencing transportation barriers. After conducting the brief needs assessment (the analysis of secondary data [HIV, HCV, overdose deaths] and qualitative data [key stakeholder interviews]) and the stakeholder engagement activities (key stakeholder meetings and the community forum), in 2016, TCHD received approval from its Board of Health to begin SSP in Aurora. ASAS currently partners with HRAC and two community based organizations, offering the fixed site service at It Takes a Village (ITAV) and street outreach with Aurora Mental Health Center's Homeless Services Program (AuMHC).

Results/Outcomes (list process milestones and intended/actual outcomes and impacts.

Were all of the objectives met? The street outreach has been successful in locating new participants who have never accessed HRAC and/or any other SSP locations. Between 10/5/16 and 9/30/18, ASAS served 328 participants; provided 1,174 interactions; enrolled 148 new participants; distributed 78,590 sterile syringes; and collected 67,956 used syringes. ASAS distributed 364 Naloxone kits, and 56 (15.3%) of Naloxone-trained participants reported the recent use of Naloxone to reverse an overdose. Thus far, ASAS has referred 13 participants to substance use treatment and 36 participants to the long term case management services with AuMHC. Finally, we initiated training/provision of fentanyl test strips in July 2018, thus far training 33 clients, seven of whom have reported results (4 testing positive).

What specific factors led to the success of this practice? The specific factors leading to the success of ASAS include 1) community partnerships, 2) street outreach, 3) Naloxone training and provision, 4) referrals, and 5) fentanyl testing. First, the partnership with HRAC eliminates additional paperwork if participants already registered with HRAC (Paperwork is challenging with PWID because of stigma and mistrust with authorities). Second, the street outreach with AuMHC has been effective in locating new participants and addressing transportation barriers. Third, a fixed site is offered through ITAV, where participants already feel safe and helps with the neighborhood relations. Fourth, services have helped developed trust with our staff, supporting our long-range goal of getting our clients into substance use treatment. Finally, ASAS seeks to innovatively adopt new practices over time, such as the recent introduction of fentanyl test strips.

Public Health impact of practice. ASAS's public health impacts include 1) reducing the risk of spreading infections by distributing sterile syringes, 2) addressing barriers and hard-to-reach population by finding and enrolling new SSP participants, which further reduces the risk of HIV and HCV transmission, and 3) saving lives by distributing Naloxone kits.

Website for your program. http://www.tchd.org/689/Syringe-Access-Service

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[1] Tri-County Health Department Opioids: Prescription Drug & Heroin Crisis Data and Resource Web Maps

https://tchdgis.maps.arcgis.com/apps/MapSeries/index.html?appid=0fa0cfda70ca4848b4238be48c6396e1

[2] Colorado Department of Public Health and Environment. "Viral Hepatitis in Colorado: 2016 Surveillance Report," September 2017. Available at: https://www.colorado.gov/pacific/cdphe/hepatitis

[3] https://www.cdc.gov/hiv/risk/idu.html

[4] Colorado Department of Public Health and Environment data

[5] https://www.cdc.gov/hiv/pdf/risk/cdchiv-fs-syringe-services.pdf

Responsiveness and Innovation

A Model Practice must be responsive to a particular local public health problem or concern. An innovative practice must be -

1. new to the field of public health (and not just new to your health department) OR
2. a creative use of an existing tool or practice, including but not limited to use of an Advanced Practice Centers (APC) development tool, The Guide to Community Preventive Services, Healthy People 2020 (HP 2020), Mobilizing for Action through Planning and Partnerships (MAPP), Protocol for Assessing Community Excellence in Environmental Health (PACE EH). Examples of an inventive use of an existing tool or practice are: tailoring to meet the needs of a specific population, adapting from a different discipline, or improving the content.

- Statement of the problem/public health issue.
- What target population is affected by problem? (please include relevant demographics)
  - What is the target population size?
  - What percentage did you reach? What has been done in the past to address the problem?
- Why is the current/proposed practice better? Is current practice innovative? How so/explain?
  - Is it new to the field of public health?
  - Is it a creative use of existing tool or practice?

What tool or practice did you use in an original way to create your practice? (e.g., APC development tool, The Guide to Community Preventive Services, HP 2020, MAPP, PACE EH, a tool from NACCHO's Toolbox etc.)

Is the current practice evidence-based? If yes, provide references (Examples of evidence-based guidelines include the Guide to Community Preventive Services, MMWR Recommendations and Reports, National Guideline Clearinghouses, and the USPSTF Recommendations.)

Please state the Responsiveness and Innovation of your practice : *

Statement of the problem/public health issue. The Aurora Syringe Access Services (ASAS) utilized an innovative approach to address Metro Denver's need for comprehensive syringe services program (SSP) for people who inject drugs (PWID) through community partnership. In addition to the mortality and morbidity from opioid overdose[1], PWID are at higher risk of acquiring HIV and Hepatitis C (HCV) infection through sharing injection equipment and high-risk sexual behaviors. In 2016, 46.3% of Colorado's acute HCV cases were attributed to injection drug use (IDU). The TCHD area represented 13.4% of Colorado's acute HCV cases in 2016. The TCHD area had 128 new HIV cases (8.6 per 100,000)[2] and 17 cases (13.3%) were associated with IDU in 2017.

What target population is affected by problem? (please include relevant demographics) What is the target population size? Comprehensive SSPs reduce the risk of HIV and HCV infection transmission and prevent opioid overdose deaths. Between 2012-2015, the Harm Reduction Action Center (HRAC, a large downtown Denver SSP) had experienced a high volume of TCHD residents (921 participants) accessing their services. Of these, 31% of them were traveling from Aurora, experiencing transportation barriers. Although the actual HIV and HCV prevalence among PWID living in TCHD jurisdiction is unknown, according to the HRAC's intake questionnaire, TCHD participants disclosed current HIV infection (2%) and HCV infection (18%). They also reported reusing syringes (87%) and borrowing syringes (35%) in the last 30 days at the time of SSP enrolment. Using a national estimate,[3] the ASAS's target population is about 3,000 PWID currently live in the TCHD area (0.3% of 1 million adults living in Adams, Arapahoe, and Douglas Counties).

What percentage did you reach? What has been done in the past to address the problem? Between 10/5/16 and 9/30/18, ASAS served 328 participants; provided 1,174 interactions; enrolled 148 new participants; distributed 78,590 sterile syringes; and collected 67,956 used syringes. ASAS distributed 364 Naloxone kits (opioid antagonist). 15.3% of Naloxone-trained participants reported the recent use of Naloxone to save someone's lives. Therefore, ASAS has reached about 11% of its target population in two years. Prior to the ASAS implementation, four SSPs existed in the Metro Denver area including HRAC (downtown), Boulder County (north), Jefferson County (west), Colorado Health Network (downtown). Transportation was a challenge for PWID population who live far from fixed SSP sites. In 2017, Colorado Health Network SSP moved to the east side of downtown.

Why is the current/proposed practice better? Is current practice innovative? How so/explain? Is it new to the field of public health? Is it a creative use of existing tool or practice? ASAS delivers innovative and comprehensive health services and syringe access services to PWID. ASAS uses a new, flexible, and systematic approach to address the public health problems (HIV and Hepatitis C infection morbidity and mortality, overdose deaths) in the communities.

The first innovative approach ASAS uses is the strong collaboration with community-based organizations (CBO). ASAS currently partners with three CBOs (HRAC [http://harmreductionactioncenter.org/], It Takes a Village [ITAV], Aurora Mental Health Center's Homeless Services Program [AuMHC, https://www.aumhc.org/programs-services/specialized-services/homeless-services/]) to navigate neighbor relations and offer services where PWID already access other services. Initially, HRAC provided an outreach worker to help with the implementation of the ASAS program. HRAC continues to provide technical assistance, data management, ordering of supplies, and Naloxone standing order and logistics. Besides the day-to-day operational collaboration, HRAC utilize their credibility and trust in the PWID community in spreading the word about the ASAS during their SSP services and via their social media and informing the ASAS staff and participants about the current harm reduction best practices and policy advocacy initiatives in Colorado. ITAV provides services to African American communities, transgender communities, and people with history of incarceration. AuMHC provides homeless outreach and long term case management services for the homeless population. Both CBOs support ASAS with

behavioral health navigation services.

The second innovative approach is a combined fixed site and outreach model. The fixed site is more efficient for large exchanges, convenient for housed participants, and offers HIV, HCV, and STI testing services. Additionally, the street outreach is more effective in finding new participants who have never accessed SSP at HRAC or elsewhere and addressing the transportation barriers among the homeless population.

The third innovative approach is harm reduction outreach activities outside of the Aurora area. ASAS staff provide the same quality harm reduction services (risk reduction education, wound care education, referrals, and the distribution of risk reduction materials) but does not include syringe exchange. Harm reduction outreach activities have been successful in building trust with PWID, reducing stigma about IDU in the communities, as well as providing active community resources referrals.

The fourth innovative approach is the provision of Naloxone training and the distribution of Naloxone kits. ASAS's Naloxone program is comprehensive, including the distribution of Naloxone kits at the fixed site, during the street outreach, during the harm reduction outreach, through community Naloxone training (at the homeless shelters and the drug problem solving court), as well as the train-the-trainer training opportunities at CBOs and local law enforcement. ASAS assisted in training the Aurora Police Department dispatch officers to administer Narcan.

The fifth innovative approach is the implementation of fentanyl testing training, partnering with HRAC. Fentanyl testing strips detect the presence of Fentanyl in the substance therefore mitigating the adverse consequences from unintended use of fentanyl. During the syringe access service visits, participants are trained to use fentanyl strips and they are encouraged to report back the results at the subsequent visits.

Is the current practice evidence-based? If yes, provide references. Comprehensive syringe service programs (SSP) are effective in reducing harms (HIV and HCV infection, opioid overdose deaths[4]). It also promotes the resource and treatment services utilization. SSPs do not increase drug use or crime (https://www.cdc.gov/hiv/pdf/risk/cdchiv-fs-syringe-services.pdf).

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[1] Tri-County Health Department Opioids: Prescription Drug & Heroin Crisis Data and Resource Web Maps

https://tchdgis.maps.arcgis.com/apps/MapSeries/index.html?appid=0fa0cfda70ca4848b4238be48c6396e1

[2] Colorado Public Health and Environment data

[3] Lansky A, Finlayson T, Johnson C, Holtzman D, Wejnert C, Mitsch A, et al. Estimating the

number of persons who inject drugs in the United States by meta-analysis to calculate national

rates of HIV and hepatitis C virus infections. PLoS One. 2014;9(5).

[4] https://www.cdc.gov/hiv/pdf/risk/cdchiv-fs-syringe-services.pdf

LHD and Community Collaboration

The LHD should have a role in the practice's development and/or implementation. Additionally, the practice should demonstrate broadbased involvement and participation of community partners (e.g., government, local residents, business, healthcare, and academia). If the practice is internal to the LHD, it should demonstrate cooperation and participation within the agency (i.e., other LHD staff) and other outside entities, if relevant. An effective implementation strategy includes outlined, actionable steps that are taken to complete the goals and objectives and put the practice into action within the community.

- Goal(s) and objectives of practice
- What did you do to achieve the goals and objectives?
  - Steps taken to implement the program
- Any criteria for who was selected to receive the practice (if applicable)?
- What was the timeframe for the practice were other stakeholders involved?
- What was their role in the planning and implementation process?
  - What does the LHD do to foster collaboration with community stakeholders? Describe the relationship(s) and how it furthers the practice goal(s)
- Any start up or in-kind costs and funding services associated with this practice? Please provide actual data, if possible. Otherwise, provide an estimate of start-up costs/ budget breakdown.

Enter the LHD and Community Collaboration related to your practice : *

Goal(s) and objectives of practice. Comprehensive harm reduction and syringe service programs (SSP) are effective in reducing harms from injection drug use and opioid overdose deaths[1]. SSPs reduce community needle stick injuries, reduce HIV and/or Hepatitis C infection, and prevent opioid overdose deaths. Other benefits include increased utilization of substance use treatment services and referrals to other needed medical and/or social services. On October 5, 2016, Tri-County Health Department (TCHD) implemented Aurora Syringe Access Services (ASAS) to provide comprehensive harm reduction and SSP in the Aurora area. The City of Aurora encompasses all three TCHD Counties (Adams, Arapahoe, and Douglas Counties) in the Metro Denver area. Its delivery model is a combination of a fixed site (fixed location) and street outreach. The objectives are: 1) to distribute 6,666 sterile syringes monthly, 2) to distribute 300 Naloxone kits yearly, 3) to enroll 10 new participants monthly, and 4) to make active referrals (10% of participants) monthly.

What did you do to achieve the goals and objectives? Steps taken to implement the program? In 2015, the Harm Reduction Action Center (HRAC) (a downtown Denver SSP) approached TCHD to offer SSP in Aurora to address the service gap and the opioid deaths epidemic. Between 2012-2015, HRAC had been experiencing high volume of TCHD residents (921 participants) accessing their services. Of these, 31% of them were traveling from Aurora. Many encountered transportation barriers. Guided by the Clean Syringe Exchange Program Approval law (C.R.S. 25-1-520), in 2016, TCHD conducted an extensive community stakeholder engagement process, including local law enforcement agencies, district attorneys, substance use treatment providers, persons in recovery, community based organizations, HCV and HIV advocacy organizations, and members of the community. The community town hall meeting was conducted on April 5, 2016. ASAS initially partnered with five community based organizations (CBOs) (HRAC, It Takes a Village [ITAV], Colfax Community Network [CCN], Comitis Crisis Center, Aurora Mental Health Center's Homeless Services Program [AuMHC]) to navigate neighbor relations and offer services where PWID already access other services. ASAS currently partners with HRAC for data management and technical assistance, with ITAV to offer the fixed site services, and with AuMHC to conduct joint street outreach.

Any criteria for who was selected to receive the practice (if applicable)? Any people who inject drugs (PWID) living in the Denver Metro area.

What was the timeframe for the practice were other stakeholders involved? What was their role in the planning and implementation process? Guided by the Clean Syringe Exchange Program Approval law (C.R.S. 25-1-520), in 2016, TCHD conducted an extensive community stakeholder engagement process. Key stakeholders defined by the law include local law enforcement agencies, district attorneys, substance use treatment providers, persons in recovery, community based organizations, Hepatitis C and HIV advocacy organizations, and members of the community. First, TCHD leadership met extensively with local key stakeholders including sheriffs, district attorneys, local police departments, the Colorado State Public Health Department, and Aurora City leadership to communicate the needs of PWID in the Aurora area and to introduce the idea of syringe access services as an evidence-based program. The community town hall meeting was hosted on April 5, 2016, to invite all the key stakeholders defined by the law and anyone who may be interested to hear about the program and ask questions. Additionally, initially, ASAS actively engaged five CBOs (HRAC, ITAV, CCN, Comitis Crisis Center, AuMHC) to strategize the neighbor relations, assess the needs of PWID, and promote the concept of harm reduction and SSP in the community.

What does the LHD do to foster collaboration with community stakeholders? Describe the relationship(s) and how it furthers the practice goal(s) Initially, in addition to partnering with HRAC, ASAS partnered with four CBOs to strategically strengthen the neighbor relations and meet PWID folks where they already access other services. For example, ITAV provides services to the African American community, transgender populations, and people who have history of incarceration. CCN provides motel outreach, prioritizing transitionally housed and transactional sex workers. Comitis Crisis Center provides shelter services and homeless outreach services in Aurora. AuMHC provides homeless outreach and long term case management services. ASAS currently partners with HRAC for data management and technical assistance, with ITAV to offer the fixed site services, and with AuMHC to conduct joint street outreach. The success of our partnerships and the ASAS greatly relies on the frequent communication and the continuous quality improvement attitude. We respect each other's expertise and services that we provide in the community and rely on each other to educate clients and the community about each other's services and to reduce stigma about injection drug use. ITAV supplies a behavioral health navigator/certified addiction counselor during the fixed site hours for seamless referrals to substance use treatment or other behavioral health services. Also, ITAV staff provides HIV, Hepatitis C, and/or STI testing services on site to ASAS participants. Additionally, during the outreach, ASAS staff are able to directly refer participants to the AuMHC's case worker for a long-term case management services for the homeless.

Any start up or in-kind costs and funding services associated with this practice? Please provide actual data, if possible. Otherwise, provide an estimate of start-up costs/ budget breakdown. State funds provided by the Colorado Department of Public Health and Environment were instrumental in starting and maintaining our program. In 2016, $63,066 was awarded from Colorado Department of Public Health and Environment (Hepatitis Biomedical Prevention Services funds) to plan and implement Aurora Syringe Access Services. Over the subsequent two years, CDPHE has continued to support the program with annual grants of Hepatitis Biomedical Prevention Service and Colorado HIV and AIDS Prevention Program of approximately $270,000/year, which supports staff, clean injection and naloxone supplies, and a contract for behavioral health navigation support.

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[1] https://www.cdc.gov/hiv/pdf/risk/cdchiv-fs-syringe-services.pdf

Evaluation

Evaluation assesses the value of the practice and the potential worth it has to other LHDs and the populations they serve. It is also an effective means to assess the credibility of the practice. Evaluation helps public health practice maintain standards and improve practice. Two types of evaluation are process and outcome. Process evaluation assesses the effectiveness of the steps taken to achieve the desired practice outcomes. Outcome evaluation summarizes the results of the practice efforts. Results may be long-term, such as an improvement in health status, or short-term, such as an improvement in knowledge/awareness, a policy change, an increase in numbers reached, etc. Results may be quantitative (empirical data such as percentages or numerical counts) and/or qualitative (e.g., focus group results, in-depth interviews, or anecdotal evidence).

- What did you find out? To what extent were your objectives achieved? Please re-state your objectives.
- Did you evaluate your practice?
  - List any primary data sources, who collected the data, and how? (if applicable)
  - List any secondary data sources used. (if applicable)
  - List performance measures used. Include process and outcome measures as appropriate.
  - Describe how results were analyzed.
  - Were any modifications made to the practice as a result of the data findings?

Please enter the evaluation results of your practice : *

What did you find out? To what extent were your objectives achieved? Please re-state your objectives. The objectives of Aurora Syringe Access Services (ASAS) program are 1) to distribute sterile syringes, 2) to train and distribute Naloxone kits, 3) to enroll new participants, and 4) to actively refer clients to substance use treatment services and other community resources. The street outreach has been successful in locating new participants who had never accessed SSP elsewhere. Between 10/5/16 and 9/30/2018, ASAS serviced 328 unduplicated participants and provided 1174 interactions; enrolled 148 new clients who never accessed syringe access services at HRAC; distributed 78,590 sterile syringes and collected 67,956 used syringes, a relatively high return rate of 86%. ASAS staff also trained and distributed 364 Naloxone kits (opioid antagonist). 15.3% of participants who accessed Naloxone training reported recently using Naloxone to save someone's lives. ASAS workers were able to actively refer 13 participants to substance use treatment services and 36 participants to the long term case management services with Aurora Mental Health Center's Homeless Services Program.

At the request of our law enforcement partners, to assess potential unintended consequences of the program, we have also remained in close dialogue with local law enforcement agencies, particularly the Aurora Police Department (APD), to understand any emerging concerns; thus far, the only issue that has arisen has been their concern about ASAS staff safety in working with clients in homeless encampments, which has been addressed by following the outreach safety protocol (at least two staff to do outreach, checking APD twitter feed for safety updates). We have supplemented this assessment by carrying out annual reviews of crimes possibly related to drug use/sales in the census tracts in the area of our program, and thus far have seen no evidence of increased crime.

Did you evaluate your practice? List any primary data sources, who collected the data, and how? (if applicable) List any secondary data sources used. (if applicable) List performance measures used. Include process and outcome measures as appropriate. Describe how results were analyzed. Were any modifications made to the practice as a result of the data findings???????? ASAS has completed two annual program evaluations (6/2017 and 6/2018), with the help of our internal evaluation team and Masters in Public Health (MPH) practicum students. The annual program evaluation consisted of the program data review (primary data and descriptive analysis), stakeholder feedback (qualitative data), and participant feedback (qualitative data). MPH students reached out to community partners and key stakeholders to seek open-ended feedback and suggestions for improvement. ASAS participants were asked to fill out survey to answer some demographic and injection practice questions, the needs, and suggestions for improvement. Some barriers identified were lack of transportation, fear of police, lack of time, and lack of trust. Some needs identified were transportation assistance, housing assistance, and hygiene kits. Many voiced the need for more accessible service hours at the fixed site. The data was used to improve the service delivery (distribution of more hygiene kits, warm and active referrals to homeless services for housing assistance, and adding another days at the fixed site). We also reached out to the APD to provide feedback about our services. They were receptive and supportive of our services in our communities. We will continue to work closely with the APD and assist in Naloxone training for their patrol officers in future. We also seek participant feedback periodically. With the suggestion of participants, ASAS established a website and use social media to promote awareness of the services. The performance measures we routinely monitor are 1) the number of syringes distributed, 2) the number of encounters, 3) the number of Naloxone kits distributed, 4) % of self-reported reversal, and the first three are included in our newly developed TCHD Substance Abuse Dashboard (http://substanceabuse-tchdgis.opendata.arcgis.com/).

Sustainability

Sustainability is determined by the availability of adequate resources. In addition, the practice should be designed so that the stakeholders are invested in its maintenance and to ensure it is sustained after initial development (NACCHO acknowledges that fiscal challenges may limit the feasibility of a practice's continuation.)

- Lessons learned in relation to practice.

- Lessons learned in relation to partner collaboration. (if applicable)
- Did you do a cost/benefit analysis? If so, describe.
- Is there sufficient stakeholder commitment to sustain the practice?
    - Describe sustainability plans.

Please enter the sustainability of your practice : *

Lessons learned in relation to practice. During the first year of the ASAS implementation, we offered the fixed site services twice a week. It was challenging for many participants to keep track of time (e.g., remembering day or time or when ASAS's fixed site is opened). In October 2018, with the adequate staffing and responding to the feedback from the participants, we approached our partner organization (It Takes a Village [ITAV]) to add another day of service, offering three days a week. With further support of our partner and to reduce the barrier to access services, we will be offering four days a week starting in January 2019.

Lessons learned in relation to partner collaboration. Our partnerships with three community partners (Harm Reduction Action Center (HRAC), ITAV, Aurora Mental Health Center's Homeless Services Program [AuMHC]) have been going smoothly and strengthening. We also have a good relationship with the local law enforcement. We regularly communicate and seek feedback from the community partners to improve our practice. For example, HRAC continues to provide data management services including sharing the participant database, to offer the logistics of Naloxone standing order and protocol, and to provide technical assistance (e.g., marketing, fentanyl testing strips, outreach safety, staff coverage, and identifying potential stakeholders in other communities). ASAS staff worked closely with Aurora Police Department in training their patrol officers to administer Narcan. They have asked us to provide a refresher training early next year. Additionally, we have been reaching out to other parts of our community partners outside Aurora to assess the need for the expansion of syringe access services. We have been collaborating with Veterans' Administration homeless outreach workers in providing harm reduction outreach outside of Aurora. Three other community partners are in the process of joint harm reduction outreach collaboration outside of Aurora in the near future.

Did you do a cost/benefit analysis? If so, describe. No, we have not done a cost/benefit analysis.

Is there sufficient stakeholder commitment to sustain the practice? Yes, our partnerships with three community partners (HRAC, ITAV, AuMHC) have been going smoothly and strengthening. We regularly communicate and seek feedback to improve our practice. For example, as we are planning to expand syringe access and harm reduction outreach services outside of the Aurora area, AuMHC is willing to partner with us in conducting more street outreach. Additionally, ITAV is willing to offer their space to offer ASAS more regularly (Monday through Thursday) with a reasonable fee. Their staff members are willing to support ASAS participants any time and offer free meals/clothes to ASAS participants as they have enough supplies. Other partners, particularly the Aurora Police Department, have been supportive of the program, particularly with the growth of persons experiencing homelessness (many of whom have substance use disorder problems) in their jurisdiction. As an ancillary benefit, the ASAS has emerged as an important point of contact for TCHD with populations using drugs and/or experiencing homelessness in recent hepatitis A outbreaks in urban locations in Colorado.

Describe sustainability plans. TCHD expects the same or increased budget from Colorado Department of Public Health and Environment's HIV and Hepatitis prevention fund as a part of HIV and Hepatitis C prevention (fixed annual contract). TCHD will reapply for Colorado HIV/AIDS Prevention Grant Program's syringe access service competitive grant in spring of 2020 for another 3-year award (2020-2022).

Additional Information

How did you hear about the Model Practices Program:: *

- ☐ I am a previous Model Practices applicant
- ☐ At a NACCHO conference
- ☐ Colleague in my LHD
- ☐ Colleague from another public health agency
- ☑ E-Mail from NACCHO
- ☐ Model Practices Brochure
- ☐ NACCHO Connect
- ☐ NACCHO Exchange
- ☐ NACCHO Exhibit Booth
- ☐ NACCHO Website
- ☐ Public Health Dispatch

Have you applied for Model Practices before?: *

- ☑ No, this is my first time applying.
- ☐ Yes, I have applied in the past.

If you answered yes to the question above, please let us know the year and award type. :