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Center for Health Care Strategies

Integrating Harm Reduction into Health Care Settings Serving Medicaid Members

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TAKEAWAYS

- Harm reduction, an evidence-based prevention strategy aimed at reducing the negative effects of drug and alcohol use, remains underutilized and underfunded within mainstream health care settings, mainly due to pervasive stigma toward people who use drugs or alcohol.
- Medicaid plays a major role in covering health care for people with substance use disorder (SUD), those who use drugs or alcohol, or are in recovery, and is uniquely positioned to expand access to culturally and linguistically appropriate, evidence-based SUD services, including harm reduction.
- This brief explores how health care organizations and states can integrate and sustain harm reduction into settings that serve Medicaid beneficiaries and other populations, aiming to improve health outcomes while reducing health care costs.

Over the past 25 years, the U.S. has faced a worsening opioid epidemic, with overdose deaths rising sharply due to prescription opioids, heroin, and more recently, synthetic opioids like fentanyl. Between 1999 and 2023, approximately 806,000 people died from an opioid overdose. The crisis has grown more complex, as many overdose deaths now involve combinations of opioids and other substances, such as stimulants. At the same time, excessive alcohol use remains a leading preventable cause of death across the country.

In 2024, the U.S. saw its first decrease in opioid overdose deaths in recent years. Notably, some states still saw increases in overdose deaths, and marginalized communities continue to experience disproportionately high mortality rates. Experts credit several factors to this overall decline, most notably increased access to naloxone, a lifesaving medication that reverses the effects of an opioid overdose.

A Brief History of Harm Reduction

The modern harm reduction movement began in the 1980s as a grassroots response to HIV transmission among people who inject drugs. Communities disproportionately affected — particularly Black and LGBTQ+ groups — led syringe exchanges and public education campaigns about safer practices. These harm reduction strategies have proven effective, contributing to a 44-58 percent drop in HIV transmission.

Harm reduction has proliferated in response to the opioid epidemic, helping to reverse or reduce the effects of opioids and transmission of infectious diseases. While often associated with drug use, harm reduction is a secondary prevention strategy, much like those used for other diseases, equipping people with tools and information to stay safer and healthier.

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Naloxone is one key component of harm reduction — a philosophy and set of services aimed at reducing the negative effects of drug and alcohol use. In practice, harm reduction not only saves lives by reducing drug and alcohol-related deaths, but it also keeps people who use drugs or alcohol engaged in care and helps prevent the spread of infectious diseases such as HIV and hepatitis C virus (HCV). For a more comprehensive look at the evidence base for harm reduction, please see the resource list on page 12.

Despite its proven successes, harm reduction remains underutilized and underfunded (and often misunderstood) within mainstream health care settings, such as hospitals, emergency departments, and safety net health centers like federally qualified health centers. Community-based harm reduction programs, such as syringe access programs, are leaders in providing harm reduction services, often innovating in response to the real-world needs and preferences of people who use drugs or alcohol in their communities. To better meet the needs of people who use drugs or alcohol and improve health outcomes, harm reduction can be better integrated into mainstream health care — not only as sustainable practices and services, but also as policies and as a guiding philosophy for how health care providers serve their patients.

Federal Health Policy Changes and Harm Reduction

Interviews to inform this brief were conducted in Spring 2025. In July 2025, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a Dear Colleague letter clarifying which "harm reduction" supplies and services are eligible for funding. Health care organizations interested in using SAMHSA funds for harm reduction should review this guidance. For example, SAMHSA funds can be used to support opioid overdose reversal supplies (e.g., naloxone), substance test kits (e.g., fentanyl test strips), wound care supplies, and education and activities to reduce the risk of sexually transmitted infections. However, federal funds cannot be used to purchase safer-use supplies, such as pipes or needles.

In addition, recent changes to Medicaid eligibility and redeterminations included in the 2025 budget reconciliation act (OBBBA) will directly impact people at risk who use drugs or alcohol and those with SUD. People in a qualifying drug or alcohol treatment program are exempt from new federal Medicaid work requirements, but many others may lose Medicaid coverage and access to health care — including harm reduction services and SUD treatment. As states implement these new requirements, they should consider the impact the policy change will have on people with SUD and how they can mitigate harm to ensure people can maintain their Medicaid coverage and access the care they need.

An estimated 21 percent of nonelderly adult Medicaid members have SUD, and Medicaid plays a major role in providing care to this group, those who use drugs or alcohol, and those in recovery. While Medicaid covers a large proportion of people with SUD in the U.S., significant treatment gaps remain: only about one in four people who need SUD treatment receive it. As the nation's largest payer for SUD treatment, Medicaid has a critical opportunity to expand access to a full continuum of evidence-based and culturally and linguistically appropriate SUD services, including harm reduction services, that meet people where they are in their use and/or recovery.

To better understand how harm reduction can be integrated and sustained in health care settings serving Medicaid beneficiaries, Anka Consulting and the Center for Health Care Strategies (CHCS) conducted a literature review and interviews with stakeholders nationwide, including health care providers who embrace harm reduction, state Medicaid and managed care organization (MCO) representatives, and state public health leaders. The findings informed this brief, made possible by support from Vital Strategies.

What is harm reduction?

Harm reduction is both a philosophy and a practice, shaping *how* care is provided and *what* services are offered to people who use drugs or alcohol. The National Harm Reduction Coalition defines harm reduction as "a set of practical strategies and ideas aimed at reducing the negative consequences associated with drug use." It also defines harm reduction as a social justice movement that underscores respect for and the rights of people who use drugs or alcohol. Harm reduction affirms that practices and policies should be rooted in the needs of people and communities and developed in partnership with those who will use services. For this reason, there is no universal definition for harm reduction.

To guide harm reduction, the National Harm Reduction Coalition outlines eight core principles. These principles address the realities of drug use with compassion and pragmatism, focusing on reducing harm, promoting dignity, and improving quality of life. The principles emphasize non-judgmental support, inclusion of people who use drugs or alcohol in decision-making, and recognition of the broader social factors that influence drug-related harm.

What does harm reduction look like outside of substance use?

Many health care providers already apply harm reduction principles to behaviors and conditions beyond substance use. They may call it something different — such as secondary prevention — or not label their approach to care. For example, primary care providers often treat people with type 2 diabetes. Patient education is typically the first step after diagnosis, offering information about the disease; guidance on diet, exercise, and necessary lifestyle changes; explanations of common medications and their side effects; and discussion of the risks of not controlling the disease, which can lead to serious health conditions such as heart disease, neuropathy, and vision loss.

Making the necessary lifestyle changes to control diabetes and maintain good health can be a difficult and overwhelming experience. Disease management for diabetes — as with most chronic conditions — is not often linear. For example, patients may stray from their nutrition plans and eat food that causes their blood sugar to rise, putting them at risk for adverse health outcomes. When patients experience a setback or challenge, providers may work with the patient to help them get their blood sugar back into a safe range, such as providing further guidance on diet, making a referral to a nutritionist, or prescribing medication. The same approach — meeting people where they are — should be employed when treating someone who uses drugs or alcohol, but too often, it is not.

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What does harm reduction look like for substance use?

For health care providers and organizations serving people who use drugs or alcohol, using harm reduction could include:

- **Creating safe, non-judgmental care environments.** People who use drugs and alcohol should be able to receive health care services without stigma. Providers often lack training on substance use or may hold biases. Organizations can support non-punitive, respectful care, even if the person is currently using drugs and/or alcohol.
- **Reducing risk of infection and other comorbidities.** Offering supplies like clean needles, syringes, and test strips to check for fentanyl or xylazine helps prevent infections, including endocarditis, and infectious diseases, such as HCV and HIV. Making these resources available in clinics, emergency departments, and other health care settings also reduces stigma related to substance use.
- **Providing naloxone.** Health care organizations can offer free naloxone in public spaces for people to take at their convenience, and providers can co-prescribe naloxone when prescribing any opioid (for pain or otherwise).
- **Ensuring access to low-barrier, evidence-based addiction services.** Harm reduction includes providing low-barrier access to evidence-based treatments like medications for opioid use disorder, such as buprenorphine and methadone. This means that access to these medications is available in settings where people may need them and barriers to access are low (e.g., no counseling requirements). For example, emergency departments might provide buprenorphine inductions or employ peer support workers to engage and counsel people admitted for drug or alcohol use. Health care clinics might partner with a mobile methadone unit to bring services to clients who have difficulty traveling to an opioid treatment program. Health care settings seeking to provide harm reduction services should be equipped to screen, treat, and manage substance use.
- **Offering comprehensive care regardless of a person's substance use and/or interest in changing or stopping use**. Removing exclusion criteria for accessing services, such as not seeing people who are currently under the influence of substances, increases the likelihood of engagement and reflects a non-judgmental, person-centered approach.

Challenges for Health Care Organizations

Interviews identified several challenges inside health care and provider settings. The following summarizes the key challenges that health care organizations might encounter when integrating harm reduction into clinical and organizational practices:

Cultural and Philosophical Barriers

- **Stigma and bias toward people who use drugs or alcohol.** Stigma around drug use is deeply woven into society, and this includes the health care sector. Bias can consciously and unconsciously seep into treatment, creating barriers to trust and effective care. It can also impact policies set by health care organizations, and intentionally and unintentionally reinforce stigma and create barriers for people who use drugs or alcohol.
- **Philosophical differences about drug use, addiction, and recovery.** Health care providers and leaders may have different beliefs about drug use, addiction, and recovery. They may believe in abstinence-only or punitive approaches to working with people who use drugs or alcohol or who are in recovery. This can be particularly apparent in hospital-based settings but is also a notable part of culture in health care settings more broadly. Within the addiction field, there is tension between those who believe in using medications for addiction treatment (MAT), an evidence-based practice for treating SUD, and those who are skeptical of their use.
- **Mainstream medical culture.** Harm reduction emphasizes *accompaniment* and *partnership,* which can contrast with medicine's traditional focus on *fixing* or *changing.* Many health care providers lack training on drug use and addiction and may not have the tools or knowledge to help patients struggling with SUD, even if they want to help them. In some cases, providers may not recognize their own limitations and, as a result, may label patients who are struggling as "bad," "non-compliant," or "not willing to change."

Knowledge and Training Gaps

- **Limited provider understanding of harm reduction and its value.** Health care providers may not understand harm reduction, what it looks like in practice, or how it may be helpful for their work as providers and to their patients. Many health care providers may also see harm reduction as enabling drug use rather than the evidence-based reality of harm reduction practices meeting people where they are in their use and minimizing the negative consequences of drug use.

- **Insufficient training and education on substance use and addiction.** Health care providers may not have the training or education on the continuum of substance use and addiction, limiting their ability to effectively care for people who use drugs or alcohol. Historically, addiction medicine has been siloed from physical and even mental health care, and providers may see substance use as a problem they are not responsible for or equipped to address.

Organizational and Leadership Challenges

- **Lack of leadership buy-in.** Health care leaders may have a narrow or incomplete understanding of harm reduction. For example, they may think of harm reduction as solely naloxone distribution or syringe exchange. They may also not understand the value of harm reduction in improving health outcomes and generating cost savings, which can lead to a lack of investment. See the resource list on page 12 for more information on the value of harm reduction.

- **Lack of experience partnering with harm reduction organizations.** Health care organizations and systems may be new to partnering with harm reduction organizations. Navigating these new relationships may be a challenge for both kinds of organizations as they operate with different principles and cultures, as well as regulations, which can make partnership challenging at first. Furthermore, many staff at harm reduction facilities have histories of drug use. It is possible that these same people have had experiences at the health care organization seeking to partner with them. This can help health care organizations understand how people who use drugs or alcohol may experience care at their facility, but if those experiences are poor, it can also impact the relationship-building process.

Operational and Structural Barriers

- **Lack of understanding of coding and billing for harm reduction.** Some health care providers may not be aware that they can seek reimbursement for the harm reduction services they already provide. Furthermore, health system leaders and providers may not be aware of how they can bill for harm reduction services. This leads to an inability to collect data on the financial and health impacts of harm reduction interventions.

- **Limited access to evidence-based and culturally and linguistically appropriate SUD treatment.** A key aspect of harm reduction is connecting people seeking care to evidence-based SUD treatments. This can be challenging in communities where there are limited options for SUD treatment, or if there are no providers who can provide care that is culturally, racially, and ethnically appropriate and in a patient's preferred language. This can lead to delays in accessing care, people leaving treatment early, as well as racial and ethnic disparities in treatment.

Legal and Policy Constraints

- **Legal and regulatory barriers.** State laws and regulations governing some provisions of harm reduction services, particularly around syringe distribution, vary widely. Some states prohibit the distribution of syringes entirely. Others restrict the types of organizations authorized to operate harm reduction programs and the physical locations where harm reduction programs can operate. In addition, provider "scopes of practice" included in state provider licensing regulations may prohibit certain providers from offering some forms of harm reduction services.

- **Lack of understanding about Title 42 Code of Federal Regulations Part 2 (42 CFR Part 2).** This regulation protects the privacy and confidentiality of SUD patient records. However, many health care providers do not fully understand how these regulations apply to working with people with SUD and cite it as a barrier to providing care.

Opportunities to Integrate Harm Reduction into Health Care Settings Serving Medicaid Populations

Successfully integrating harm reduction into mainstream health care settings serving Medicaid populations requires buy-in and coordination across different sectors and stakeholders. The following strategies, distilled from interviews and a literature review, can help health care organizations and states incorporate harm reduction into their policies and practices to improve care for people who use drugs or alcohol and decrease health care costs.

Opportunities for Health Care Organizations

Key opportunities for health care organizations to adopt harm reduction in settings serving Medicaid populations include:

- **Train and educate health care professionals on harm reduction and SUD.** For harm reduction to take root and flourish within health care, organizations can prioritize training clinical and non-clinical staff on harm reduction and SUD. Training and educational materials will be more effective if they are developed in partnership with people who currently use or formerly used drugs or alcohol, grounding them in real-world experience.

  Foundational education — "harm reduction 101" — can help destigmatize the concept and clarify its role in care. Ongoing training, informed by patient feedback from qualitative surveys and accountability metrics, can foster organization-wide culture change and reduce stigma and bias in policies and practice. Health care organizations committed to long-term systemic change may also consider 360-degree assessments of their care continuum and clinical redesigns that center harm reduction principles throughout service delivery.

Training can also include practical skills on coding and billing for harm reduction services (e.g., screening, brief intervention, and referral to treatment, using relevant place of service codes). This includes helping providers chart accurately to ensure codes are recognized and reimbursed, which is essential for financial sustainability. Training should also include robust technology support, including user-friendly resources, such as reference "cheat sheets," integrated into electronic health records to support effective billing.

Additionally, health care organizations can offer trainings and educational materials on federal privacy regulations (such as 42 CFR Part 2) to alleviate provider concerns about patient confidentiality in SUD treatment.

- **Develop leadership and staff buy-in for harm reduction.** Integrating harm reduction into health care organizations requires both education and buy-in from leadership and staff. This includes ensuring all staff, including health care providers, administrators, and payers, understand the science and medicine behind SUD, the scope of the opioid epidemic within their community, and the impact of past drug policies, including on communities of color and low-income populations.

  Organizations may consider diversifying and expanding the workforce and recruiting individuals who can serve and be supported as internal champions (including those with lived experience, e.g., peer support specialists) for organizational culture change around harm reduction. Interviewees noted that this includes acknowledging that for some staff, harm reduction can be a driver of staff wellness. Approaches that are person-centered (even if a person is still using drugs/alcohol) and align with patient preferences can improve staff satisfaction and lower staff burnout and turnover.

- **Underscore the value case for harm reduction.** In addition to building cultural buy-in, champions for harm reduction should underscore to leadership the value case for harm reduction. Expanding access to harm reduction interventions and supplies is a cost-effective public health strategy that prevents costly infections such as HIV and HCV, infectious endocarditis, significant wound care needs, bacterial sepsis, and complications such as overdose-related hypoxia — all of which lead to higher health care costs and diminished quality of life.

  By implementing harm reduction effectively, hospitals may reduce uncompensated high-cost care. For example, treating uninsured patients with bacterial endocarditis is expensive due to lengthy hospital stays with intense treatment. If patient infections are caught early and treated with wound care, hospitals can reduce the use of beds and lower costs. Ultimately, harm reduction interventions ease the economic burden on the health care system and potentially generate savings for taxpayers and Medicaid programs. See additional resources on page 12 on the value of harm reduction.

- **Partner with community-based harm reduction organizations.** Effective harm reduction requires close collaboration between health care organizations, community-based harm reduction organizations, and people with lived experience.* Community-based harm reduction organizations can help health care organizations gain a deeper understanding of harm reduction methodologies, particularly approaches that build trust through proactive, non-judgmental engagement.

  Co-locating community-based harm reduction staff within health care settings can help connect patients to additional services, such as food and housing, while also cultivating trust with patients who may be distrustful of the health care sector. This approach supports a "no wrong door" model, while enabling seamless referrals between organizations. Health care services can also be integrated into community-based harm reduction facilities, offering low-barrier access to medications for opioid use disorder, wound care, preventive screenings, vaccinations, and, when appropriate, linkages to health care providers.

- **Strengthen the capacity of harm reduction partners.** Health care organizations can also support community-based harm reduction organizations in navigating Medicaid and other payer systems, while respecting the mission and vision of the harm reduction organization. This could include assistance with obtaining a Medicaid ID, building administrative infrastructure to submit claims, generating clinical encounter notes that meet documentation requirements, understanding relevant billing codes, and managing claim submission and resubmission procedures.

- **Engage people with lived experience.** In addition to partnering with harm reduction organizations, health care organizations can employ people with lived experience to support outreach and care delivery. These individuals can help build rapport and trust with patients, as well as collaborate with traditional health care providers to develop a shared plan and vision for positive outcomes. People with lived experience can also help health care organizations develop meaningful quality metrics to assess progress toward individual goals and continuous quality improvement. Through participation in workgroups and steering committees, they can provide data and personal stories to inform more effective and responsive programs. Providers can engage people with lived experience routinely and compensate them for their participation to avoid tokenism and address power dynamics.

  Cultivating meaningful partnerships between health care organizations and communities is a gradual process, with success reflected in the quality of care and respect provided to individuals seeking SUD services.

* For this brief, the term 'people with lived experience' refers to people impacted by drug or alcohol use — including those in recovery as well as people who currently use substances or have an SUD.

Opportunities for States

Key opportunities for states to advance the use of harm reduction for Medicaid populations include:

- **Partner with health system leaders.** Health system leaders can be valuable partners for state Medicaid agencies in designing and implementing comprehensive SUD care continuums. Based on their own clinical expertise, as well as that of providers serving people with SUD in their care settings, system leaders have critical insights into patient needs, the effectiveness and cost efficiency of current SUD services, and care delivery implementation challenges. Their input can help inform agency strategic planning, regulatory efforts, and managed care contracting.

- **Leverage State Plan Amendments and Section 1115 Demonstration Waivers.** States can use State Plan Amendments (SPAs) to expand access to harm reduction services. For example, in 2023, **New York State**'s Medicaid agency received federal approval for a SPA that expanded reimbursable harm reduction benefits to better serve people with SUD. The SPA expanded coverage and reimbursement for new services and defined which types of organizations are eligible to provide Medicaid harm reduction services.

  Through authority in Section 1115 of the Social Security Act, the federal government can waive certain Medicaid requirements to allow states to pilot new services and care models, as long as they support Medicaid's core objectives. Many states have used 1115 waivers to pilot broad SUD system reforms. For example, **West Virginia** received approval for a waiver in 2017 that served as the foundation for reimagining the state's SUD care continuum, largely in response to the impact of the opioid epidemic on the state. West Virginia's waiver has significantly expanded access to evidence-based care, including MAT. Additionally, a number of states have taken advantage of a recent 1115 waiver opportunity aimed at better meeting the needs of soon-to-be-released justice-involved individuals with SUD. Through this opportunity, states were invited to propose approaches for improving care transitions and coordination from justice settings to community providers following release. SPAs and 1115 waivers provide opportunities for states to integrate harm reduction services into broader SUD system reform efforts.

- **Analyze current state laws and regulations governing the provision of harm reduction services.** It is important for state Medicaid leaders to understand related laws and regulations — including any potential restrictions on offering harm reduction services, such as syringe distribution, whether in the community or in health care settings. This includes evaluating provider scopes of practice to determine if they restrict providers' ability to offer harm reduction and SUD services. If restrictions exist, states can consider broadening scopes of practices to support these critical services.

States can also assess policies limiting access to MAT. While MAT is a leading evidence-based best practice in the treatment of people who use drugs, many states have outdated laws and regulations that restrict how and when providers can offer this form of care. More specifically, many states have policies that restrict access to buprenorphine and methadone, two of the most effective forms of MAT.

- **Collect, analyze, share, and operationalize data.** States can capture meaningful data across the continuum of care to identify gaps in services and understand individual and community needs. Examples include Medicaid claims data on treatment engagement, hospital-based data on emergency department visits related to SUD, and geospatial state data on overdose incidence by ZIP code. Linking and analyzing these data across agencies and systems enables states and health systems to assess patient engagement and identify trends — such as increasing overdose rates in particular regions or among specific demographic groups. Based on these insights, providers and community partners can implement specific outreach and engagement strategies. This approach is critical for people with SUD who may have had poor provider experiences and may be more likely to engage in care through outreach from a harm reduction services provider.

- **Partner with Medicaid members.** State Medicaid agencies can engage Medicaid members living with SUD through Medicaid Beneficiary Advisory Councils and other mechanisms, such as focus groups and steering committees. These engagement activities provide valuable input for designing effective care models. People living with SUD or who use drugs and alcohol often experience longstanding stigma and discrimination in health care settings and may distrust providers. Meaningful community engagement can rebuild trust, strengthen harm reduction services, and ensure care is aligned with the needs of people who use drugs or alcohol or have SUD.

- **Incorporate harm reduction benefits into managed care contracting.** States can expand access to harm reduction services by incorporating them into the broader suite of SUD services included in Medicaid managed care contracts. With 85 percent of Medicaid members receiving care through MCOs and 52 percent of all Medicaid spending flowing through MCOs, managed care contracting presents a significant opportunity to scale harm reduction services. States can highlight the cost-saving potential of harm reduction services to MCOs using Medicaid claims and public health data. States can also seek input from health system leaders — particularly those with clinical backgrounds — who bring unique perspectives on which services improve patient outcomes and decrease system costs, given their blend of both clinical and executive experience.

Moving Forward

Substance use and its related health consequences are major public health issues, with a particular impact on the Medicaid population. Despite the growing availability of treatments, people with SUD and those who use drugs or alcohol still face barriers to care. These often stem from persistent stigma and bias, uncoordinated care, limited provider training, and restrictions on providing effective evidence-based treatment. Harm reduction is an evidence-based approach that supports improved health outcomes for people who use drugs or alcohol and those with SUD. Advancing harm reduction efforts requires collaboration across sectors — including health care systems, providers, policymakers, and, most importantly, people with lived experience — to shape harm reduction policies and programs and integrate them into systems of care.

Additional Resources for Integrating Harm Reduction into Health Care Settings

Following is a non-exhaustive list of resources to help health care stakeholders make the case for integrating harm reduction into care settings, including evidence on its effectiveness and tools to support adoption.

Evidence on Economic Efficiency

These resources highlight the cost-effectiveness and financial impact of integrating harm reduction into health care, showing it can decrease the economic burden on payers and providers while generating cost savings.

- The Cost-Effectiveness of Harm Reduction (*International Journal of Drug Policy, 2015)*
- Harm Reduction is Healthcare: Sustainable Funding for Harm Reduction Programs *(National Harm Reduction Coalition, 2025)*
- Population-Based Trends in Hospitalizations Due to Injection Drug Use-Related Serious Bacterial Infections, Oregon, 2008 To 2018 (*PLoS One, 2020)*

Evidence on Compassionate and Effective Care

These studies outline the evidence on care outcomes for harm reduction for patients and providers, including improved patient outcomes by reducing morbidity and mortality associated with substance use and decreased provider burnout through more compassionate, effective, and sustainable care practices.

- Integration of a Community-Based Harm Reduction Program into a Safety Net Hospital: A Qualitative Study *(Harm Reduction Journal, 2022)*
- Meeting People Where They Are: Implementing Hospital-Based Substance Use Harm Reduction (*Harm Reduction Journal, 2022)*
- Patient and Staff Perspectives on the Impacts and Challenges of Hospital-Based Harm Reduction (*JAMA Network Open, 2024)*
- Exploring the Healthcare Environment and Associations with Clinical Outcomes of People Living with HIV/AIDS *(AIDS Patient Care and STDs, 2017)*

General Tools and Resources

These resources provide evidence-based guidance, practical tools, and educational materials that support safer practices, enhance service delivery, and promote health and dignity for people who use drugs or alcohol.

- Hospital Adoption of Harm Reduction and Risk Education Strategies to Address Substance Use Disorders *(American Journal of Drug and Alcohol Abuse, 2023)*
- Harm Reduction Resource Center *(National Harm Reduction Coalition)*
- Supporting People Who Use Drugs Across the Spectrum of Care (*National Health Care for the Homeless Council, 2023)*
- The ABCs of Harm Reduction: A Toolkit for Hospitals *(Mosaic Group, 2024)*
- Addictionary (*Recovery Research Institute, 2021)*
- The Other 99: Using Harm Reduction Strategies to Drive Connections and Save Lives *(CHCS, 2023)*
- Integrating Harm Reduction into Health Care Facilities Serving Medicaid Members *(CHCS, 2025)*
- Harm Reduction Principles for Healthcare Settings. *(Harm Reduction Journal, 2017)*

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ABOUT ANKA CONSULTING

Anka Consulting, a health care consulting firm founded by Kimá Joy Taylor, MD, MPH, supports programs that enhance patient care, improve population health outcomes, and increase equitable access to and outcomes from high-quality, affordable health care, with a particular focus on substance use services.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation.

ABOUT VITAL STRATEGIES

Vital Strategies is a global health organization that believes every person should be protected by a strong public health system. Our overdose prevention program works to strengthen and scale evidence-based, data-driven policies and interventions to create equitable and sustainable reductions in overdose deaths, working in several states and local jurisdictions and supporting national technical guidance.