



Presenting



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Objectives

- Highlight findings from CDC report on HIV-related substance use surveillance
- Share key principles regarding substance use disorder (SUD) treatment
- Recognize why SUD treatment is important for the care of people with HIV, and brainstorm ways to increase capacity to address substance use among your clients



Each of you play a critical role in addressing substance use

MEDICATIONS FOR OPIOID USE DISORDER SAVE LIVES

To learn more, visit nationalacademies.org/OUOTreatment

Hepatitis C and HIV are often-overlooked consequences of America's opioid crisis.

EIGHT IN TEN new Hepatitis C infections in the U.S. are transmitted through injection drug use.

Nearly **ONE IN TEN** new HIV infections in 2015 were due to injection drug use.

CONSENSUS STUDY REPORT

Opportunities to Improve Opioid Use Disorder and Infectious Disease Services

INTEGRATING RESPONSES TO A DUAL EPIDEMIC

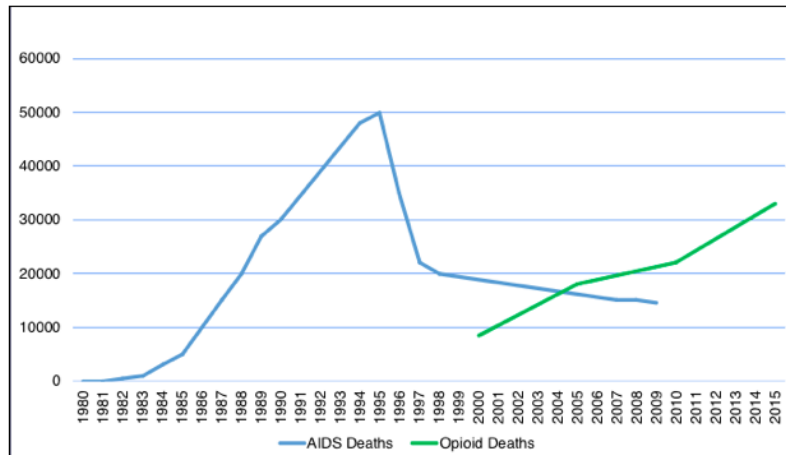
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“Call to action”: Substance use disorder treatment is effective, and HIV providers are critical – can address not only HIV prevention, but improve overall health for PLWH, a population that has been highly marginalized for years. Can also help improve HCV-related health outcomes. Strong evidence base that indicates **treatment of substance use disorders improves HIV and HCV-related health outcomes**¹⁻².

Infographic from <https://hepvu.org/resources/opioids/> (HepVu is presented by Emory University's Rollins School of Public Health in partnership with Gilead Sciences, Inc.)

Recent pubs from National Academies of Sciences Engineering Medicine

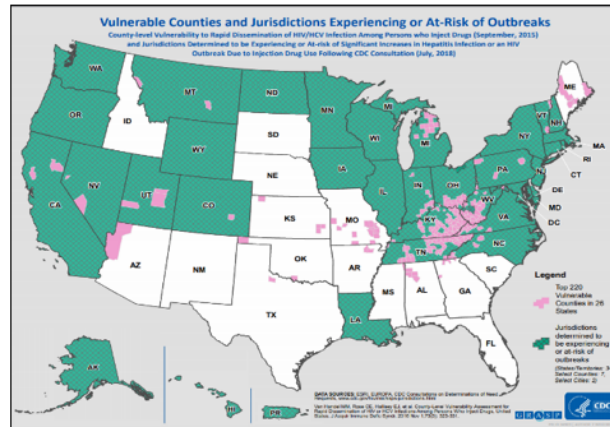
HIV, opioid-associated mortality



We shouldn't need to see much more than this, as our "call to action". What I haven't been able to incorporate this is 2016-current trends, but most of you may already be aware that overdose deaths are still occurring at very high rates, especially those where synthetic opioids (e.g. fentanyl) have been implicated

To give an idea of the comparison, the scale of the epidemics are very similar. We don't know how high the green line is going to get.

Is your area a “vulnerable” one?



<https://www.cdc.gov/pwld/vulnerable-counties-data.html>

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Many have prob seen this, released in 2016 (citation viewable via link).

The map describes projected county-level vulnerability to rapid dissemination of HIV/HCV infections among persons who inject drugs a well as jurisdictions determined to be experiencing or at-risk of significant increases in hepatitis infection or an HIV outbreak due to IDU. CDC was involved with this analysis. [Map highlights the top 220 vulnerable counties in 26 states and jurisdictions determined to be experiencing or at-risk of outbreaks (States/Territories: 34, Select Counties: 7)]

Since Scott County, clusters of diagnoses have been described

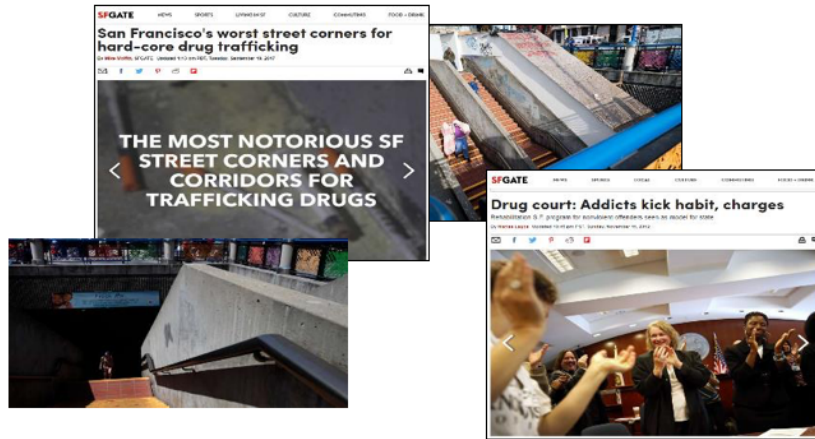
(primarily among networks of PWID)

in: Seattle, Montana, Northern Massachusetts, and Florida. As recently as September of 2019, a new HCV outbreak was identified in Cabell County, West Virginia

([https://www.politico.com/story/2019/09/02/hiv-opioids-cabell-west-](https://www.politico.com/story/2019/09/02/hiv-opioids-cabell-west-virginia-1668389)

[virginia-1668389](https://www.politico.com/story/2019/09/02/hiv-opioids-cabell-west-virginia-1668389)). It is important to note that as of early 2018, only 18 of the 220 “vulnerable” counties had syringe exchange programs in place, highlighting an area of critically unmet need.

My story as an HIV provider: Ms. E



CDC REPORT RELEASE: HIV infection Risk, Prevention, and Testing behaviors among persons who inject drugs – National HIV Behavioral Surveillance Injection Drug Use (23 U.S. Cities, 2018)

Table 13. Additional outcomes among persons who inject drugs—National HIV Behavioral Surveillance, 23 U.S. cities, 2018 (cont.)

	Sexual behaviors				Substance use behaviors			
	Number of episodes in prior 12 mo	%	95% CI	Total	Substance use behavior	Self-injury (episodes)	Years since last episode	Total
Wife/partner	153	30	27.4	201				
Other	153	16	13.1	18				
Friends	218	8	4.2	3				
Temporary	--	--	--	--				
Age at interview (yr)								
18-24	37 (5)	1	1.6	1				
25-29	31 (5)	2	3.2	11				
30-34	154	8	4.2	14				
35-39	154	0	0	0				
40-44	153	14	12.1	47				
Race/ethnicity								
Latino/Hispanic/Latino	19 (3)	1	4.1	1				
White	31 (5)	1	1.1	1				
Black/African American	154	13	8.4	42				
Hispanic/Latino	153	6	3.9	1				
Non-Hispanic/Other Pacific Islander	1 (1)	1	1.1	1				
Hispanic/Latino	153 (5)	0	0	0				
Hispanic/Latino	153	1	1.1	1				
Hispanic/Latino	154	0	0	0				
No valid NHBS HIV test result	154	0	0	0				
Total	214	218	27.8	180				

Table 14. Noninjection drug use in the 12 months before interview and binge drinking in the 30 days before interview among persons who inject drugs—National HIV Behavioral Surveillance, 23 U.S. cities, 2018

	Used drug	No.	%
HIV negative*			
Binge drinking (past 30 days)†		2,875	27.1
Any noninjection drug (includes binge drinking)		5,505	79.0
Cocaine		3,072	34.9
Heroin		4,662	44.1
Oxycodone		4,455	42.0
Heroin		2,827	12.1
Marijuana		6,332	66.1
Multimorphine		1,208	33.4
Prescription opiates‡		3,502	33.5
HIV positive*			
Binge drinking (past 30 days)†		164	23.4
Any noninjection drug (includes binge drinking)		519	72.4
Cocaine		274	26.4
Oxycodone		319	43.6
Heroin		224	36.8
Marijuana		72	5.8
Multimorphine		245	34.2
Marijuana		364	45.8
Multimorphine		215	25.4
Prescription opiates‡		175	23.9
No valid NHBS HIV test result†		28	22.5
Binge drinking (past 30 days)†		43	76.8
Any noninjection drug (includes binge drinking)		28	31.5
Cocaine		25	25.0
Oxycodone		32	36.0
Heroin		9	10.1
Marijuana		37	34.9
Multimorphine		41	45.1
Marijuana		29	32.6
Prescription opiates‡		17	36.3

Table 15. Lifetime testing for and diagnosis of hepatitis C among persons who inject drugs—National HIV Behavioral Surveillance, 23 U.S. cities, 2018

	HCV testing		HCV diagnosis*		Total No.
	No.	%	No.	%	
HIV negative†	4,438	79.7	4,512	43.4	10,017
Gender					
Male	5,178	79.9	5,147	43.0	7,206
Female	2,023	81.4	1,428	44.8	3,021
Transgender	180	82.8	237	35.6	351
Age at interview (yr)					
18-24	391	64.9	36	14.3	463
25-29	683	77.6	203	24.1	1,352
30-34	2,339	82.7	1,222	42.0	2,821
35-39	1,847	85.1	1,033	43.9	2,439
40-44	3,990	80.8	1,863	45.9	5,271
Race/ethnicity					
American Indian/Alaska Native	110	67.3	61	46.4	128
Asian	27	73.9	15	43.8	37
Black/African American	2,020	74.9	1,252	39.0	3,415
Hispanic/Latino	1,718	74.1	949	49.0	2,319
Native Hawaiian/Other Pacific Islander	9	64.3	2	14.3	14
White	3,287	83.7	2,075	48.4	4,287
Multiple races	470	83.0	234	49.8	568
HIV positive†	391	80.8	382	53.6	771
Gender					
Male	406	81.0	286	53.2	500
Female	194	85.4	172	54.8	224
Transgender	22	81.8	14	31.8	27
Age at interview (yr)					
18-24	8	69.8	6	66.7	9
25-29	48	80.2	28	48.1	54
30-34	113	80.8	64	48.4	138
35-39	161	80.5	103	51.7	201
40-44	263	79.3	153	38.7	333
Race/ethnicity					
American Indian/Alaska Native	6	50.0	5	83.3	6
Asian	3	75.0	1	25.0	4
Black/African American	249	74.9	155	48.0	335
Hispanic/Latino	194	71.8	100	40.0	268
Native Hawaiian/Other Pacific Islander	2	100	1	50.0	2
White	162	81.0	109	38.1	197
Multiple races	21	84.0	12	48.0	25
No valid NHBS HIV test result†	67	75.3	39	43.0	89
Total	5,117	79.7	5,040	46.1	10,427



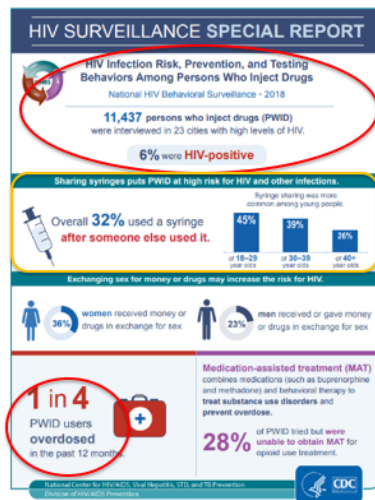
<https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-24.pdf>

The Centers for Disease Control and Prevention’s (CDC’s) National HIV Behavioral Surveillance (NHBS) serves as a key component of its high-impact prevention (HIP) approach to reducing the spread of HIV in the United States [2]. NHBS provides data for monitoring behaviors among populations at risk of acquiring or transmitting HIV infection and identifies the populations for whom scientifically proven, cost-effective, and scalable interventions are most appropriate.

This report summarizes findings from the fifth NHBS data collection among PWID, which was conducted in 2018. Data from previous years of data collection among PWID have been published elsewhere [6–9]. This report provides descriptive, unweighted data that can be used to describe HIV infection among PWID and the percentages of PWID reporting specific risk behaviors, HIV testing, and participation in prevention programs. Monitoring these outcomes is useful for assessing risk behaviors and the use of prevention efforts over time and for identifying new HIV prevention opportunities for this

population.

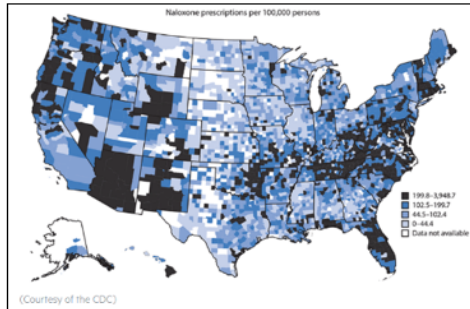
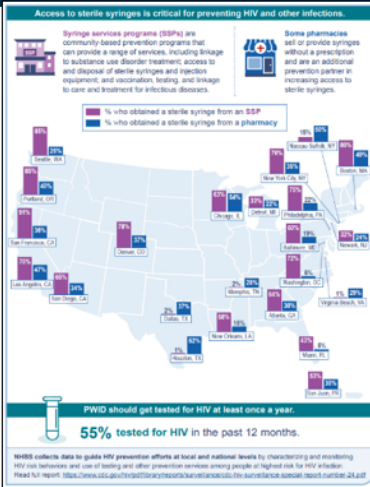
"HIV Surveillance: Special Report"



Medication-assisted treatment (MAT) combines medications (such as buprenorphine and methadone) and behavioral therapy to treat substance use disorders and prevent overdose.

28% of PWID tried but were unable to obtain MAT for opioid use treatment.

Access remains critically limited not only for medications, but also for important harm reduction interventions that have been proven effective



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https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-24-infographic.pdf?deliveryName=USCDC_1046_DM21674

Importance of Identifying and Treating Substance Use Disorders in People Living with HIV



Links between HIV and substance use are clear

- Substance use increases risk of HIV acquisition: *this is not only about injection drug use*
- Among people with HIV, many studies have described elevated rates of opioid use, as well as other substances (prescribed and non-prescribed)
 - Chronic pain, co-occurring psychiatric disorders common
 - For some patients, substance use may affect adherence to ARVs/other medications, engagement in care, etc.

Pain syndromes and OUD both common among PLWH... HIV primary care providers are well-positioned to *screen* for substance use disorders and *offer medications* for OUD treatment, however this is not an area that many HIV providers feel comfortable with. Don't really know, for example, how many HIV providers are waived to prescribe buprenorphine but am pretty confident in guessing that it's well < 1/4 (if even that? ... mention NP/PA – recent allowances with DATA 2000 eligibility?)

Acute and chronic pain syndromes are commonly reported among PLWH, and treatments have had limited/uneven “success”. PLWH have reported persistent pain, fatigue, myalgias, and poor concentration even after successful immune reconstitution on long-term ART. Greater pain severity also has been observed in patients with co-morbid HIV/AIDS and mental health disorders. Opioid analgesics frequently are prescribed to treat pain in persons with HIV/AIDS and were a mainstay of palliative AIDS care in the pre-cART years. Many PLWH, however, are

affected by opioid-use disorders. Also, abuse of prescription opioids in the general US population has climbed steadily over the last decade, with an estimated 11.4 million persons reporting nonmedical use of a prescription opioid in the past year. Thus, although opioids may have a limited role in treating some types of pain syndromes, prescribers must consider the potential adverse consequences of iatrogenic or missed addiction diagnoses.

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Challenges for HIV providers?

- Providers have indicated limited knowledge, comfort, and experience regarding management of chronic pain and substance use disorders among people with HIV
- HIV, substance use, and mental health have historically faced significant systems-level, provider-mediated, and community-based stigma and discrimination
 - Patients may be hesitant/scared to disclose, and providers may be reluctant to bring up or explore in depth



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Lum PJ, Little S, Botsko M, et. al. Opioid-prescribing practices and provider confidence recognizing opioid analgesic abuse in HIV primary care settings. *J Acquir Immune Defic Syndr.* 2011 Mar 1; 56 Suppl 1: S91-7.

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As provider, could be due to ?competing demands, feelings of helplessness/nothing can be done, hesitancy in bringing up something which pt may have experienced prior trauma/stigma around, etc.

*In an anonymous survey of 106 clinicians that provide prescription pain medications to their HIV-infected patients for the treatment of chronic pain, we detected infrequent use of guideline-recommended practices (eg, screening for substance use risk)¹⁷ and limited provider confidence in recognizing opioid analgesic abuse. Confidence was unexpectedly low, given providers' high estimates of the prevalence of chronic pain in their patients, the proportion of their patients receiving COT, and the proportion of their patients thought to be addicted to opioids.

Provider confidence recognizing opioid analgesic abuse also is associated in this study with caring for a higher number of patients per month; specifically, patients that are injection drug users, have chronic pain, or receive opioid analgesic prescriptions for pain. Although tempting at first to apply the old adage "practice makes perfect" to this association, we observe that few of the clinical guidelines recommended by professional pain organizations for prescribing

COT17,29 are practiced by HIV providers routinely (ie, “I do this with most or all my patients when I prescribe opioid analgesics”). When used routinely, however, clinical practices such as urine toxicology and prescribing longer acting opioids are associated with higher provider confidence in this study. Based on these findings, we suggest that the routine practice of clinical guidelines as recommended by pain experts may be applied to HIV care settings. In favor of a more standardized approach to pain management among HIV-infected patients are opportunities to reduce stigma that is reinforced by selective monitoring of misuse suspects in an already highly stigmatized patient population, and clear evidence that most providers are unable to predict with certainty which of their patients will develop problematic use, abuse, or dependence.^{39,40} Indeed, Katz et al⁴¹ have shown that reliance on aberrant behavior to trigger urine drug testing misses about half of COT patients using unprescribed or illicit drugs. In our study, urine drug testing was conducted selectively (ie, “I only do this when I suspect substance abuse”) by the majority (81%) of providers and routinely by only 9% of providers. We suggest that selective behavior is ineffective and contributes instead to a dynamic of “mutual mistrust” in provider–patient relationships, especially concerning opioid prescribing.⁴

BHIVES: 10 national sites developed and evaluated integrated models of office-based buprenorphine in HIV primary care settings

Old HIV Paradigm

- *“HIV was until recently a terminal illness, and largely affects marginalized populations...”*
- *“...the field has attracted providers who are committed to caring for [these] populations.”*

 **HHS Public Access**
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When HIV treatment goals conflict with guideline-based opioid prescribing: A qualitative study of HIV providers

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Abstract

Background—(1) HIV-infected patients have high prevalence of chronic pain and opioid use, making (2) care a critical setting for improving the safety of opioid prescribing. Little is known about (3) HIV treatment providers' perceptions about opioid prescribing to patients with chronic pain.

Methods—We interviewed 8 providers and conducted semi-structured telephone interviews with 18 HIV treatment providers (infectious disease specialists, general internists, family practitioners, nurse practitioners, and physician assistants) in Boston, NY. Open-ended interview questions focused on providers' experiences, beliefs, and attitudes about opioid prescribing and about use of guideline-based opioid prescribing practices (prescription prescribing and nonprescription Rx and injection in various). Transcripts were thematically analyzed using a modified grounded theory approach.

Results—Eighteen (32%) treatment providers included 13 physicians, 4 nurse practitioners, and 1 physician assistant. They were 47% female, 50% white, and practiced as (1) providers for a range of 1 to 40 years. Most reported therapy at doses above opioid treatment agreement (OTA) and were less likely (17%) with their patients on low-dose opioid therapy. (2) HIV treatment providers tended to view opioid prescribing for chronic pain within the "old paradigm" (use of prescription and pain pills) defined by three key themes: (1) primary of HIV goals, (2) flexibility with substance use, and (3) low discussion of risks. The (3) providers' perceptions, experiences, and concerns indicated that guideline-based opioid prescribing practices. The (3) treatment providers' perceived alignment with the (1) paradigm diminished whether and how guideline-based opioid prescribing practices were adopted. For example, the patients of (3) study

New HIV Paradigm

■ *“However, providers’ perception that [opioids for chronic pain] are the logical response to believing the verity of patients’ pain raises concerns that providers overestimated the benefits or underestimated the risks of opioids...”*

■ *...as HIV shifts toward being a chronic non-fatal disease, other competing risks need further attention.”*

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When HIV treatment goals conflict with guideline-based opioid prescribing: A qualitative study of HIV providers

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Abstract

Background—HIV-infected patients have high prevalence of chronic pain and opioid use, making HIV care a critical setting for improving the safety of opioid prescribing. Little is known about HIV treatment providers’ perceptions about opioid prescribing to patients with chronic pain.

Methods—We interviewed 8 providers and conducted semi-structured telephone interviews with 11 HIV treatment providers (infectious disease specialists, general internists, family practitioners, nurse practitioners, and physician assistants) in Boston, NYC, and a rural academic institution to assess providers’ experiences, beliefs, and attitudes about opioid prescribing and about use of guideline-based opioid prescribing practices (assessment, prescribing, and monitoring for and response to misuse). Transcripts were thematically analyzed using a modified grounded theory approach.

Results—Boston HIV treatment providers included 11 physicians, 4 nurse practitioners, and 3 physician assistants. They were 67% female, 34% white, and practiced as HIV providers for a mean of 16.4 years. Interviewed doctors in Boston always using opioid treatment agreements (OTAs) and never using written OATs with their patients on long-term opioid therapy. HIV treatment providers tended to view opioid prescribing for chronic pain within the “HIV paradigm,” a set of priorities and principles defined by three key themes: 1) primacy of HIV goals, 2) familiarity with substance use, and 3) the clinician as ally. A facility with substance use, and 2) the clinician as ally. The HIV paradigm sometimes supported, and sometimes conflicted with guideline-based opioid prescribing practices. For HIV treatment providers, perceived alignment with the HIV paradigm determined whether and how guideline-based opioid prescribing practices were adopted. For example, the primacy of HIV goals superseded conservative opioid prescribing when providers prescribed opioids with the goal of retaining patients in HIV care.



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HIV treatment providers tended to view opioid prescribing for chronic pain within the “HIV paradigm,” a set of priorities and principles defined by three key themes: 1) primacy of HIV goals, 2) familiarity with substance use, and 3) the clinician as ally. The HIV paradigm sometimes supported, and sometimes conflicted with guideline-based opioid prescribing practices. For HIV treatment providers, perceived alignment with the HIV paradigm determined whether and how guideline-based opioid prescribing practices were adopted. For example, the primacy of HIV goals superseded conservative opioid prescribing when providers prescribed opioids with the goal of retaining patients in HIV care.

Conclusion—Our findings highlight unique factors in HIV care that influence adoption of guideline-based opioid prescribing practices. These factors should be considered in future research and initiatives to address opioid prescribing in HIV care.

How do I know if someone might have a use disorder?

- You won't know unless you talk to your client/patient (person first language is critical)!
- The best screening tool is the one that works



Screen (S): Ask and Assess

STANDARD APPROACH
 About for screening when questions can be integrated into the EHR

Step 1: Ask about alcohol & drug use

ALCOHOL USE *A risk is higher at 12 or more of any 12 or more of the 12 items of the AUDIT-C (Table 1)*

AUDIT-C	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	None	Monthly or less	2-4 times a month	3-4 times a week	5 or more times a week	0-4
2. How many drinks containing alcohol do you have on a typical day when you drink?	1 or 2	3 or 4	5 or 6	7 or 8	9 or more	0-4
3. How often do you have five or more drinks on one occasion?	None	Less than monthly	Monthly	Weekly	Daily or almost daily	0-4

SCORING

0-3
 NONE
 4-6
 MILD
 POSITIVE

If positive, go to STEP 2A to assess with the full AUDIT on p. 6
 Your patient has at least 10% alcohol use.

If negative, reinforce their healthy decisions and continue with drug screening.

Drug Use

Single-item drug screen
 How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?
 (If asked what non-medical reasons means you can say because of the experience or feeling the drug causes)

SCORING

0
 NONE & NEW
 POSITIVE

If positive, go to STEP 2B to assess with the DAST-10 on p. 7
 Your patient has at least 10% alcohol use.

If negative, reinforce their healthy decisions.

Figure 1. AUDIT-C Screening System and Drug Questionnaire
 Abbreviations: AUDIT-C, Alcohol Use Disorders Identification Test - Consumption; DAST-10, Drug Abuse Screening Test - 10 questions; DSM, Diagnostic and Statistical Manual of Mental Disorders; NIAAA, National Institute on Alcohol Abuse and Alcoholism.



<https://www.managedhealthcareconnect.com/articles/use-screening-brief-intervention-and-referral-treatment-skilled-nursing-facilities>

“These are questions we ask everyone.... “

After screening: making a diagnosis

- Several resources available online to help walk through diagnostic criteria
- Framework largely the same for other substances

A Comparison Between DSM-IV and DSM-5

DSM-IV In the past year, have you:	DSM-5 In the past year, have you:	
Any 1 = ALCOHOL ABUSE Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems? More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving recklessly, using machinery, walking in a dangerous area, or having unsafe sex)? More than once arrested, been held at a police station, or had other legal problems because of your drinking? ***This is not included in DSM-5*** Continued to drink even though it was causing trouble with your family or friends?	1 Had times when you ended up drinking more, or longer, than you intended? 2 More than once wanted to cut down or stop drinking, or had to but couldn't? 3 Spent a lot of time drinking? Or being sick or getting over other aftereffects? 4 Wanted a drink so badly you couldn't think of anything else? ***This is new to DSM-5***	The presence of at least 2 of these symptoms indicates an Alcohol Use Disorder (AUD) . The severity of the AUD is defined as: Mild: The presence of 2 to 3 symptoms Moderate: The presence of 4 to 5 symptoms Severe: The presence of 6 or more symptoms
Any 3 = ALCOHOL DEPENDENCE Had to drink much more than you once did to get the effect you need? Or found that your usual number of drinks had much less effect than before? Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, nervousness, sweating, a racing heart, or a seizure? Or sensed things that were not there? Had times when you ended up drinking more, or longer, than you intended? More than once wanted to cut down or stop drinking, or tried to, but couldn't? Spent a lot of time drinking? Or being sick or getting over other aftereffects? Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink? Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?	5 Felt that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems? 6 Continued to drink even though it was causing trouble with your family or friends? 7 Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink? 8 More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)? 9 Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout? 10 Had to drink much more than you once did to get the effect you need? Or found that your usual number of drinks had much less effect than before? 11 Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, nervousness, sweating, a racing heart, or a seizure? Or sensed things that were not there?	



Source: National Institute on Alcohol Abuse and Alcoholism (NIAAA)

Especially important among PLWH given overlap with chronic pain

The DSM 5 criteria highlight pertinent areas of the history providers often want to know anyway, it's just a matter of reflecting on them objectively. Also notice that there's no distinction between dependence and addiction as described in the DSM4.

?reimbursed by both Medicare and CA Medicaid

<https://www.ihs.gov/california/index.cfm/news-events/program-directors-meetings/october-2016/substance-use-disorder-continuum-of-care-engaging-the-community-pdf/>

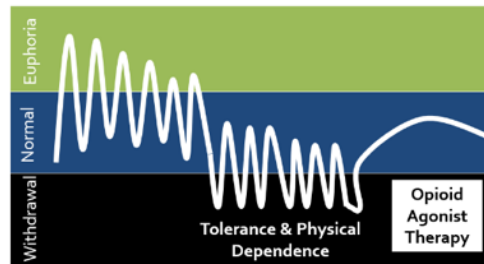
Another way to remember: "4 C's"

- Cravings
- Compulsion to use
- Loss of control (amount/frequency/behaviors)
- Continued use despite harms (consequences)

There's also a 5th "C" ...

Addiction is a Chronic Medical Condition

- Bio-psycho-social factors
 - Symptoms are relapsing and remitting
- Lifestyle changes may help
- Medications may be necessary for lifetime



<https://elearning.asam.org/buprenorphine-waiver-course>
The ASAM Treatment of Opioid Use Disorder Course: Includes Waiver Qualifying Requirements

Treatment for Opioid Use Disorder



- Decreases mortality: reduces injection and illicit drug use, HIV/HCV transmission, and bacterial infections (skin/soft tissue, endocarditis)
- Improves quality of life: supports return to employment, re-connection with loved ones
- Reduces criminal justice involvement

It is generally accepted that the best outcomes are typically achieved through a combination of pharmacological and behavioral therapies (NIDA, 2018), but there is evidence that some individuals may respond adequately to medications plus medical management alone (e.g., evaluation of medication safety and adherence, monitoring, or advice by the prescribing provider) (Gruber et al., 2008; McLellan et al., 1993; Schwartz et al., 2007, 2012; Weiss et al., 2011; Yancovitz et al., 1991). Given the resource limitations and the lack of empirical evidence about specific behavioral interventions to improve outcomes from medications for OUD, some have argued that clinicians should not be dissuaded from initiating medications for OUD simply because evidence-based behavioral therapies are not available (beyond medical management with monitoring) (Schwartz, 2016). At the same time, while medications to treat OUD prevent death and stabilize patients so that their comorbid psychiatric, medical, and social problems can be identified and addressed, these medications alone do not address the many complex problems that many individuals with OUD may have. Therefore, it is critical to take individual differences into account and select a treatment plan that is best suited to each patient's needs (Carroll and Onken, 2005). Provision of behavioral interventions can and often do occur in the medical management encounter with the prescriber.

The empirically supported behavioral therapies that have been evaluated in the context of medication-based treatment for OUD include (1) contingency management approaches, which provide tangible reinforcement for behaviors such as adherence and submission of drug-free urine specimens (Dugosh et al., 2016); (2) cognitive behavioral approaches, which teach skills and strategies intended to improve control over urges to use and to improve decision-making and problem-solving skills (Carroll and Weiss, 2017); and (3) structured family therapy approaches, which attempt to recruit family support for adherence and retention (Carroll and Onken, 2005). Behavioral therapies that have not yet been rigorously evaluated in the context of medication-based treatment for OUD include motivational interviewing (McHugh et al., 2010), which attempts to build the individual's own internal motivation for change; acceptance and commitment therapy (Ramsey et al., 2016; Stotts et al., 2009); 12-step facilitation to reduce cocaine use in individuals maintained on methadone (Carroll et al., 2012); mindfulness-based approaches (Zullig et al., 2018); dialectical behavioral therapy (Dimeff and Linehan, 2008); and other ancillary approaches such as yoga (Lander et al., 2017) and acupuncture (Baker and Chang, 2016). While evaluations of some of these approaches are ongoing, the number of studies is too small to draw firm conclusions.

Let's Talk About MOUD

Overall goals: reduce mortality risk, especially overdose-related risks, and support recovery

→ Prevent/address withdrawal, prevent intoxication, reduce cravings, avoid sedation

	METHADONE	BUPRENORPHINE
<i>Mechanism</i>	Full agonist	Partial agonist
<i>Location; frequency of Rx</i>	Specialty clinics; daily-weekly-monthly (individualized)	"Waivered" provider; weekly-monthly (individualized)
<i>Sedation risk</i>	Higher	Lower
<i>Pain control</i>	Doesn't last	Split doses (take multi times/day)
<i>Side effects</i>	Decreased libido, arrhythmia, constipation, sweating	Precipitated withdrawal if taken too early, headache, GI upset/constipation, insomnia/elev mood

1940s/early 2000s (2002)/1984 (oral) – 2010 (LAI)

Address concerns for diversion: both voluntary, and involuntary – often people are using street-obtained bup to prevent withdrawal

Want to emphasize: this is not “substituting one drug for another” (?ex nicotine patch)

<https://addictionmedicineupdates.org/2018/pcss-expert-explains-why-mat-isnt-substituting-one-drug-for-another/>

MOUD, continued

	BUPRENORPHINE	NALTREXONE
<i>Mechanism</i>	Partial agonist	Antagonist
<i>Location; frequency of Rx</i>	“Waivered” provider; weekly-monthly (individualized)	Any prescriber; monthly injections if being used for OUD
<i>Sedation risk</i>	Lower	None/minimal
<i>Pain control</i>	Split doses (take mult times/day)	None: will be difficult to use for individuals on chronic opioids
<i>Challenges</i>	Precipitated withdrawal if taken too early, side effects as noted previously	High rates of discontinuation; higher risk of overdose if return to use



Quick note about “detox”

Medically-supervised withdrawal, uses Rx to address symptoms, then slow taper



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High rates of drop out: 28% didn't get first dose vs 6% of bup

Ntx also can decrease cravings

May be equally effective to buprenorphine—after detox??

May be preferred by 12 step, criminal justice

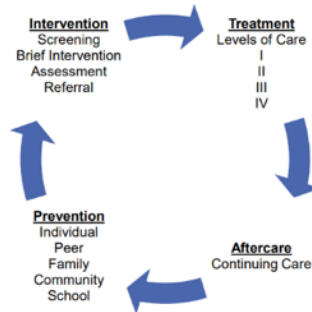
Risk of overdose, blocks opioid analgesics

Detox: medically-supervised withdrawal: typical approach is to offer doses of medications to treat withdrawal, then slow decrease (opioid agonists + adjunctive meds)

Chutuape, M et al. One-, three-, and six-month outcomes after brief inpatient opioid detoxification. The American Journal of Drug and Alcohol Abuse. Vol 27:1, 2001.

So which medication should my patient receive???

THE ONE THAT WORKS FOR THEM



There's no "wrong" way to support someone on their path to recovery – as HCP, best we can do is show patients that we are willing and able to support, and facilitate the steps in their process (quote we often state on perinatal HIV hotline– the best ARV combo is the one that the pt will take)

<https://www.ihs.gov/california/index.cfm/news-events/program-directors-meetings/october-2016/substance-use-disorder-continuum-of-care-engaging-the-community-pdf/>

Don't forget about alcohol use

MMWR | Screen and Intervene to Reduce Binge Drinking

Binge Drinking Can Cause Injury, Disease, Death | **More Intervention Is Needed** | **Primary Care Providers Can Make a Difference****

Binge drinking is defined as

     +

     +

on an occasion,
in about 2–3 hours



4 in 5 adults who binge drink were **not advised** to reduce drinking by a healthcare provider*

SCREEN all adults

PROVIDE FEEDBACK about health risks

WORK TOGETHER to reduce drinking if patient desires

*At most recent checkup within the past 2 years | **The US Preventive Services Task Force recommends alcohol screening for all adults and brief counseling for those who exceed recommended limits, which includes binge drinking. | 2017 data from the BRFSS, 13 states and the District of Columbia, as reported in Mokrysch-Cry et al., MMWR 2020. Learn more: bit.ly/3dA9v0u

WWW.CDC.GOV

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Routinized/EHR-triggered screening → RSR

Waiting/counseling/exam room signage

Standardized incorporation into intake and reassessment protocols

And if you're not yet assessing for stimulant use?

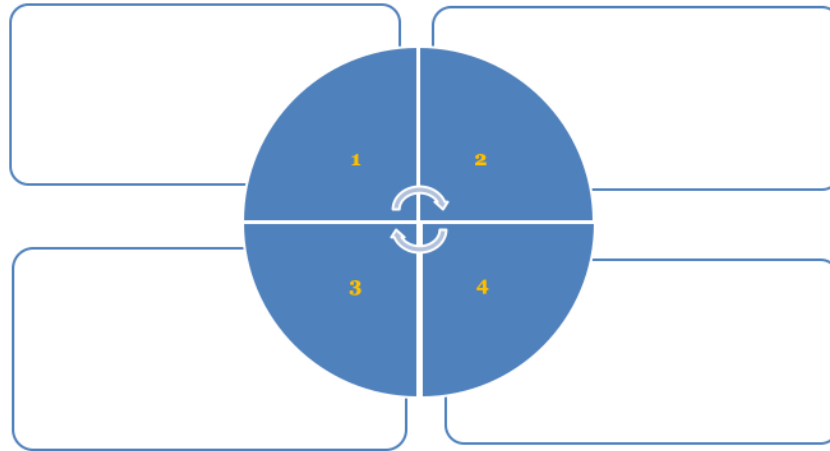
YOU PROBABLY SHOULD BE

Remember:

- Use is NOT limited to men who have sex with men
- Can lead to symptoms that are seen in other conditions which people with HIV are at risk for (i.e. neurosyphilis, HAND)
- In some areas, supply has been adulterated with opioids: **offer naloxone for ALL street use**
- Ongoing interest in medications for stimulant use treatment, but limited/mixed evidence to date

Linked to high risk sexual activities

Substance use care is not so different from HIV care: guiding principles



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Suggested speaker notes:

For those of you who might be thinking “I can’t be an HIV/HCV provider”, I’m hoping today’s short presentation can convince you otherwise. Substance use care and HIV/HCV care have fundamentally similar approaches and core principles that we have tried to depict here.

Substance use care is not so different from HIV care: guiding principles

- Person-centered care, emphasis on positive changes
- Focus on patient safety, well-being



Harm
reduction

Thing of primary importance is to always ensure the patient is at the center of any decision-making. For many patients, even engaging in care with a clinical professional can be a stigmatizing experience. Ambivalence towards treatment can be quite common, and we recommend that providers always strive to emphasize positive changes and “meet the patient where they’re at”. Message should be: No wrong door/Door is always open, and STAY ALIVE LONG ENOUGH TO ENTER TREATMENT

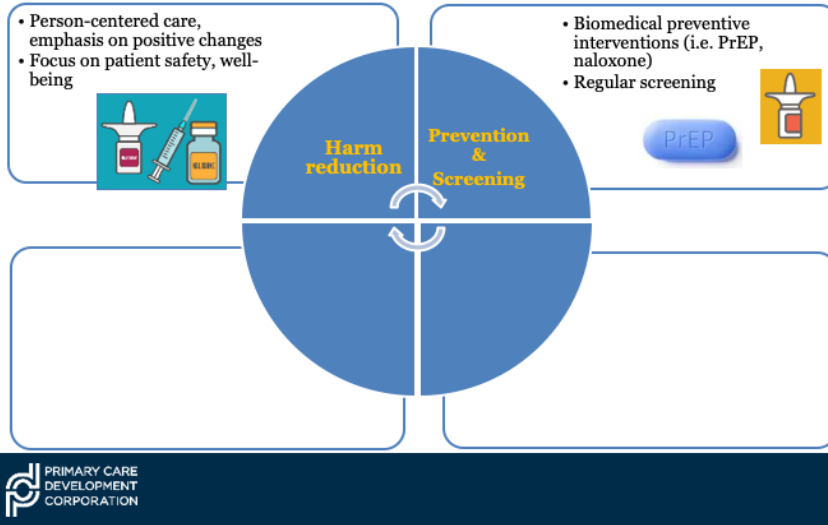
Harm reduction: evidence-based, client-centered approach seeking to reduce health and social harms associated with substance use/SUD without requiring people who use from abstaining/stopping. Provide individuals choice in how they’ll minimize harms through non-judgmental and non-coercive strategies to enhance skills, knowledge to live safer and healthier lives.

Pragmatism
Human values
Focus on harms

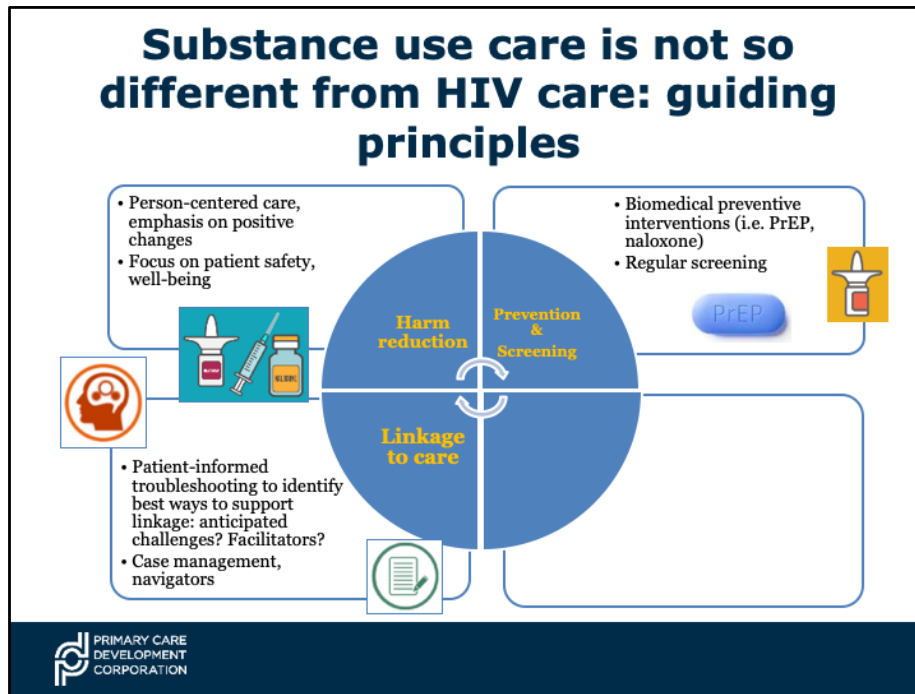
Overdose prevention sites/SIFs/SCSs

https://www.ippf.org/sites/default/files/positive_prevention_for_people_living_with_hiv.pdf

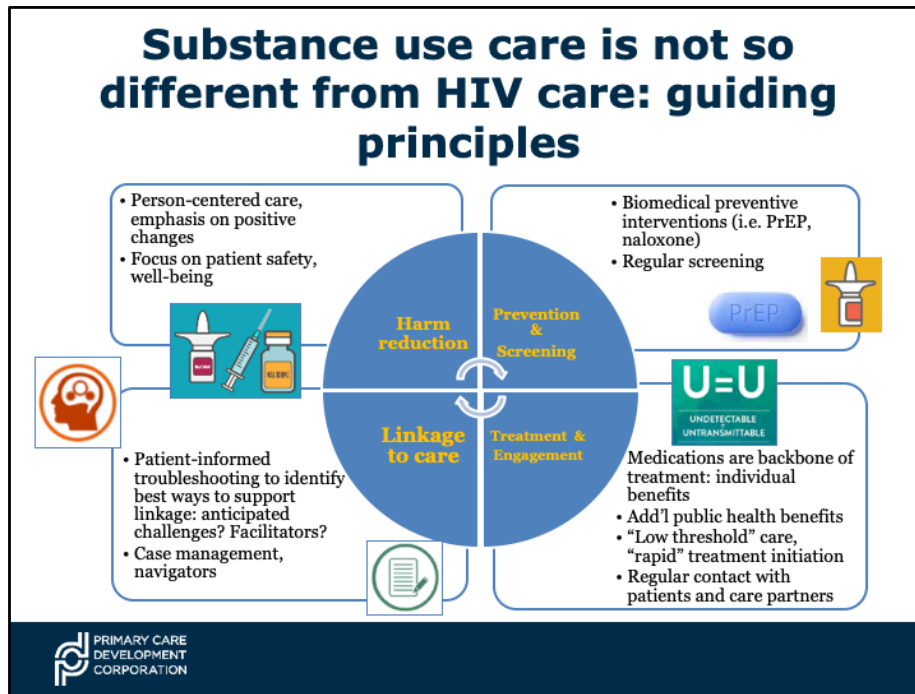
Substance use care is not so different from HIV care: guiding principles



For HIV, additional biomedical prevention interventions have proven effective—hopefully by now you have heard of pre-exposure prophylaxis, which is a medication that can be taken to prevent acquisition of HIV. There is substantial evidence on the effectiveness of PrEP, and now we need to ensure that more patients/communities are aware of PrEP, and have access to it if they are interested. Finally, linkage to care is crucial: ways to help improve and maintain engagement in care include early discussions with patients about any barriers and facilitators they are experiencing (or anticipate experiencing). Case managers and navigators can also be incredibly helpful.



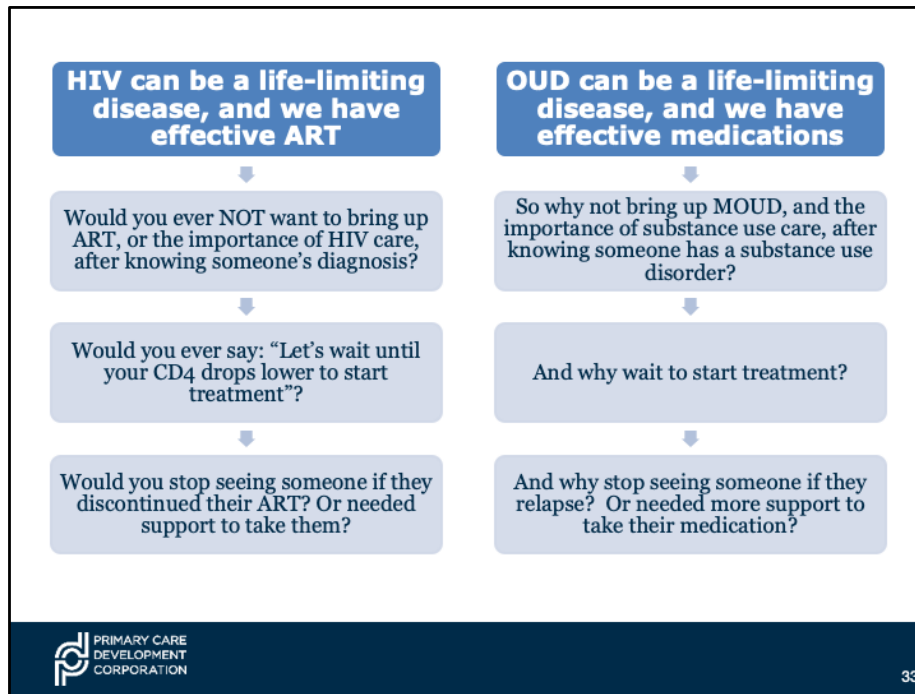
Importantly, we should try to minimize barriers to accessing care, be prepared to start treatment as soon as we have identified one of these conditions, and have reliable ways to stay in contact with our patients and other members of the care team, for example pharmacies. On the “prevention side”, it’s important to note we have effective means of preventing HIV, HCV, and substance use disorders. Regular screening is arguably one of the most important elements of prevention, and if you take home nothing else today, please remember to regularly screen for HIV and HCV.



In terms of treatment, although there are some differences in our specific approaches to HCV, HIV, and substance use disorders, the commonalities are probably more significant than any differences. Treatment of HCV is short-term and curative, compared to HIV treatment which is life-long and NOT currently curative, and treatment for substance use disorders is often over the long-term. Despite this, a core evidence-based tenet is that medications play a central role in improving health outcomes. Beyond the individual patient level, we know that treating HCV, HIV, and substance use leads to improved public health outcomes. For example, with HIV, we can now fully embrace “U=U”, or the fact that someone who is living with HIV and has an undetectable VL on ARVs does not transmit HIV to their sex partners.

HIV can be a life-limiting disease, and we have effective ART

- Would you ever NOT want to bring up ART, or the importance of HIV care, after knowing someone's diagnosis?
- Would you ever say: *"Let's wait until your CD4 drops lower to start treatment"*?
- Would you stop seeing someone if they discontinued their ART? Or needed support to take them?



Like saying: "Let's wait until your OUD is more severe, or wait until an overdose, to start treatment"

Understand that slips happen, set ground rules:

Use does not mean that treatment stops

Missed visits do not mean that treatment stops

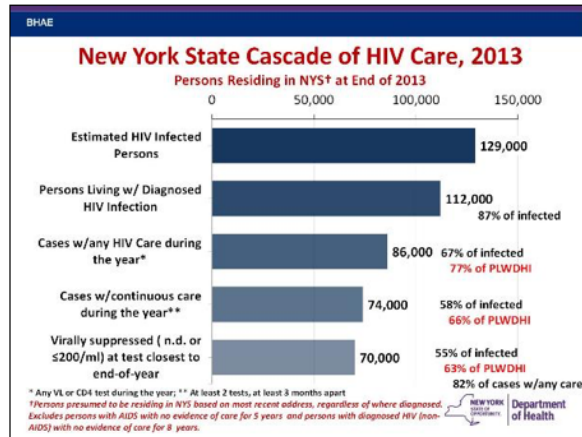
Diversion, threatening may → have discussion/explore, alternate treatment

Behavioral issues may be a symptom of the disease, trauma

Next Steps



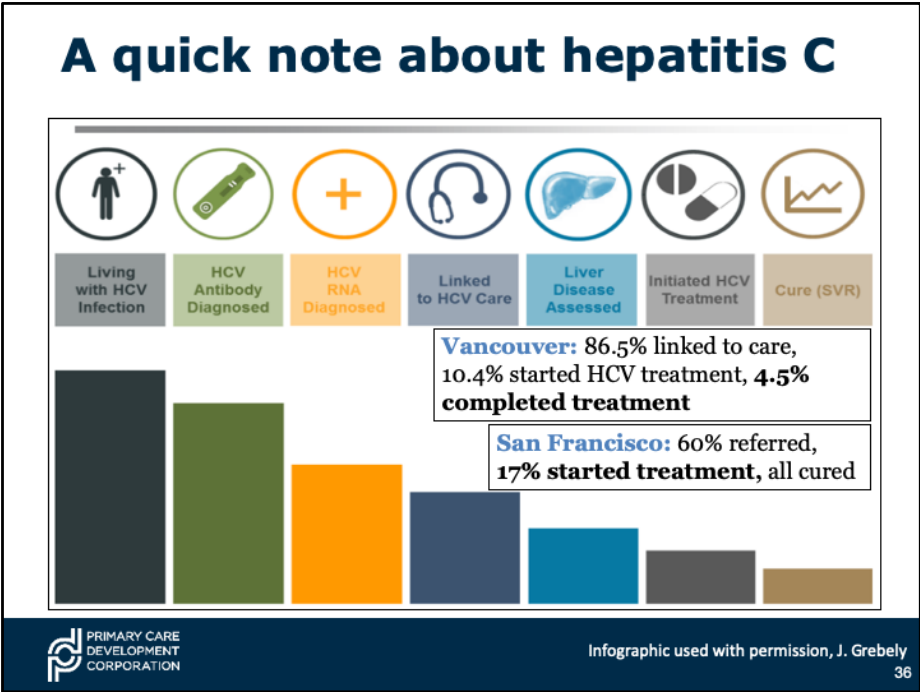
Take a look at your patient panel/clients



- Ask people how you can support/what do they need?
- Does everyone have naloxone?
- Ask yourself honestly: what support do I need/want to level up?**

CDC surveillance notes that, in general, rates of linkage to care, engagement/retention in care, and viral suppression were relatively low among females with infection attributed to injection drug use (77.1%), as well as males with infection attributed to injection drug use (76.4%), and males with infection attributed to male-to-male sexual contact and injection drug use (75.3%). There are many inter-related factors that appear to drive these outcomes, including provider-level issues (for example, lower rates of ART initiation/provision among PWID have been noted as well as provider-based stigma) as well as other factors such as medication adherence challenges and housing instability. The key point here is that we have much room to improve on linking to care, keeping people in care, and supporting consistent access to medications to remain virally suppressed.

?Reimbursement for testing services; new funding opportunities (e.g., federal EtE initiative, micro-elimination grants, substance use and HIV/HCV integration grants)



Suggested speaker notes:

Most of the preceding slides have highlighted outcomes along the HIV Care Cascade: this slide is just a quick acknowledgement that we are starting to look much more closely at HCV Care Cascade outcomes, especially as we strive to improve access to HCV care and treatment throughout the U.S. Although we don't have the same data and reporting systems in place for HCV at this time (compared to HIV), various studies have been published describing outcomes among specific cohorts of PWID/people with substance use disorders. Essentially all of them find HCV-specific health disparities affecting substance-involved populations.

Individuals with HIV-HCV coinfection are priority group for HCV treatment

- HCV treatment is a unique opportunity to engage with people who use drugs and help support them in making a significant, positive impact on their health
 - Many patients are highly motivated to address liver health: *HCV also has extrahepatic manifestations (glucose intolerance, some cancers, chronic joint pain, “brain fog”/mood)*
 - Don’t forget: reinfection education, risk reduction

HRSA HAB Hepatitis C initiatives

“HCV elimination”

Developing models using a jurisdictional approach

Identifying barriers to care (providers and patients)

Increasing capacity of HCV surveillance systems

Establishing practice model incorporating mental health/substance use treatment with HCV care

Defining HCV Care Continuum in the RWHAP

Outreach beyond jurisdictional approach: improved coordination with SAMHSA-funded SUD providers

Promising Practices

- Contingency management
- Motivational interviewing training
- Increased mental health, SUD services
- Peer navigation, case management
- “M-health” applications
- Decreased service agency stigma/bias
- Integrated HIV and addiction care: screening, treatment
- Quality improvement strategies, organizational change interventions

EDITORIAL

Open Access

Substance use and the HIV care continuum: important advances



P. Todd Korthuis^{1*} and E. Jennifer Edelman²



If you're providing HIV care, you are well-positioned to provide SUD care!

...already screening for opioid use?
SCREEN FOR OTHER SUBSTANCES

...already providing "warm hand-off" to local SUD providers?
PROVIDE ON-SITE SUD TREATMENT (MEDICATION INITIATION AND MONITORING)

...already providing HIV and HCV prevention counseling, condoms/syringes, and HIV/HCV testing?
GIVE NALOXONE, PERFORM REGULAR SUD SCREENING

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Wrap up: "friendly challenges" to chew on, in the hopes that we have at least piqued your interest at becoming a champion for PLWH affected by substance use.

?? Link back/forward to other sessions ??

Can't overstate the following: if you're already providing HIV care, incredibly well-positioned to help address the substance use (opioid/stimulant) epidemics. For ppl already deep into the HIV prevention/risk reduction space, consider incorporating naloxone + implementing regular SUD screening. If already universally screening for OUD, ask about other substances. If you're referring to local SUTP, consider integrating on-site SUD treatment into your program. Much evidence shows that integrated, co-located HIV/HCV care can vastly improve engagement in care and increase treatment success rates although not all individuals are comfortable with integrated care models..

Thank You!

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Interested in receiving a consultation from our team?

Substance Use Warmline 855-300-3595
Substance use evaluation and management

Perinatal HIV Hotline 888-448-8765
Pregnant women with HIV or at-risk for HIV & their infants

HIV/AIDS Warmline 800-933-3413
HIV testing, ARV decisions, complications, and co-morbidities

PrEPline 855-HIV-PrEP
Pre-exposure prophylaxis for persons at risk for HIV

Hepatitis C Warmline 844-HEP-INFO
844-437-4636
HCV testing, staging, monitoring, treatment

PEPline 888-448-4911
Occupational & non-occupational exposure management

Questions?

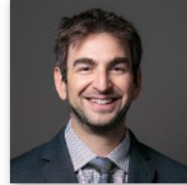
At this point we'd like to open the webinar to questions. You're welcome to raise your hand and you'll be unmuted to ask your question. You can also ask your question via the question or chat function. While the Q&A is going on, we will conduct a quick evaluation poll. Your feedback is critical to support our commitment to provide high quality content and resources, as well as improve our trainings for future participants. All responses will be kept confidential.

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Sustainable Strategies TargetHIV Link:
<https://targethiv.org/ta-org/sustainable-strategies-rwhap-community-organizations>



We appreciate the work you do in your communities and thank you for attending today's webinar. Please feel free to contact us if you have any questions or if we can be of assistance in any way.

Have a great day folks!!!