2018 NATIONAL

RYAN WHITE

CONFERENCE ON HIV CARE & TREATMENT

NATIONAL RYAN WHITE 2018 CONFERENCE ON HIV CARE & TREATMENT

Toolkits for Tackling Pain Treatment, Opioid Management, and Medication Assisted Treatment in HIV Primary Care

Objectives for today

1. Improve HIV provider and clinic capacity to manage pain, opioid use, and opioid misuse.
2. Learn practical strategies, benefits, and best practices for integrating buprenorphine treatment into HIV care.
3. Identify tools to use or adapt to your clinical setting for managing pain, prescribing opioids, treating opioid use disorder, and responding to opioid overdose.

2018 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Northeast/Caribbean AETC Opioid Management Toolkit

NATIONAL 2018 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Why Do We Need an Opioid Toolkit?

Daria Boccher-Lattimore
Northeast/Caribbean AETC

Crisis

Is the Opioid Epidemic a Tech Problem?

Apr 18, 2018

We visit the Dark Web, where you can get heroin, fentanyl and oxycontin shipped right to your door. This week, the link between online drug markets and America's opioid crisis.

The New York Times
26 mins ·

Hundreds of pharmacies are required to sell an overdose antidote without a prescription. We called all of them. Only a third knew the rules.

NYTIMES.COM
Overdose Antidote Is Supposed to Be Easy to Get. It's Not.

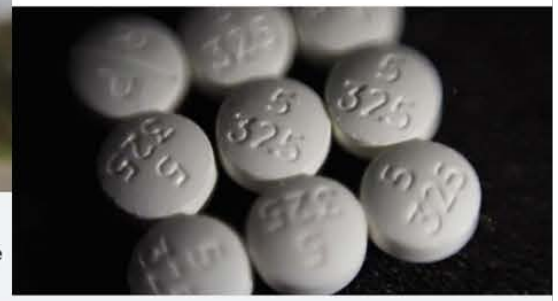
Washington Post
1 hr ·

"Only now, because those dying in this epidemic look like the children and grandchildren of those in power, are we finally applying some compassion and common sense to addiction."

WASHINGTONPOST.COM
Perspective | We hated addicts when they were black. It is different now that they are white.

Washington Post
1 hr ·

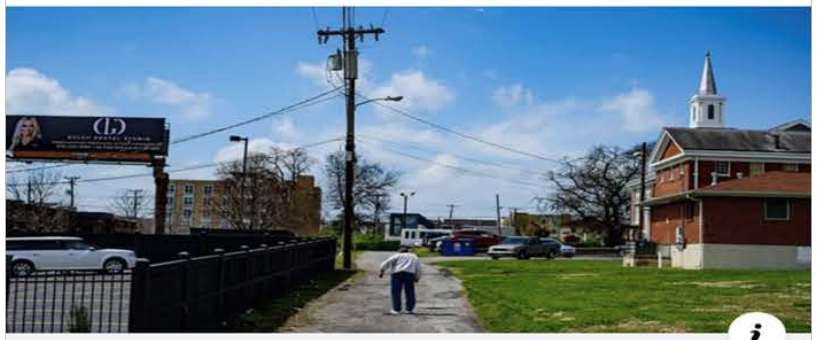
It did not appear that the effort targeted any of the drug distributors or manufacturers.



WASHINGTONPOST.COM
DEA's opioid crackdown brings arrests of prescribers, pharmacists

Washington Post
3 hrs ·

Across the country, in cities big and small, the hundreds of thousands of people who lack permanent shelter are facing elevated health risks as communities unsuccessfully search for solutions.



WASHINGTONPOST.COM
Surge in homeless deaths linked to opioids, extreme weather, soaring housing cost

Why NECA AETC embarked on this journey

Getting ahead of the curve

- Defining what we should and could do as a region

Our region is New Jersey, New York, Puerto Rico, and USVI

- Regions vary in
  - paths to opioid use and disorder
  - co-morbidities
  - available services for people with pain and/or opioid addiction
  - the laws and regulations that could effect access to buprenorphine and naloxone

The Need for Workforce Support

- Our region: 9.8% of the US population but 19% of PLWH
- Comprehensive Needs Assessment
  - Delphi Survey- panel of experts
  - challenges in workforce/system capacity
  - specific HIV-related needs that are important to address through training and technical assistance
  - Mental health and substance abuse service integration was the second highest ranked system capacity issue and the highest ranked urgent training need
  - NA: 1st place- Mental Health and Psychosocial issues, Tied for fourth Substance Use

“You do run into [health care] professionals that say ‘he’s a drug addict he’s not worthy of 100 percent treatment because he’s gonna go back and self destruct, he doesn’t care about his self so why should I care about him’.”

St. Marie, Pain Medicine 2014

NATIONAL 2018 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Toolkit Development

Karen McKinnon
Northeast/Caribbean AETC

Approach

- Utilizing a consensus process to identify realistic expectations
  - of the HIV provider (low volume through specialty HIV)
  - of the HIV primary care clinic
- Identifying resources, training, and support needed to get there
- Filling the gap: develop/modify tools, support, training infrastructure to address the above

Training Audience Continuum

- Novice (screening) to experienced providers (MAT implementation)
- What all should know v. what specialists should know
- Roles of different team members
- Stigma from front desk to exam room

Patient Continuum

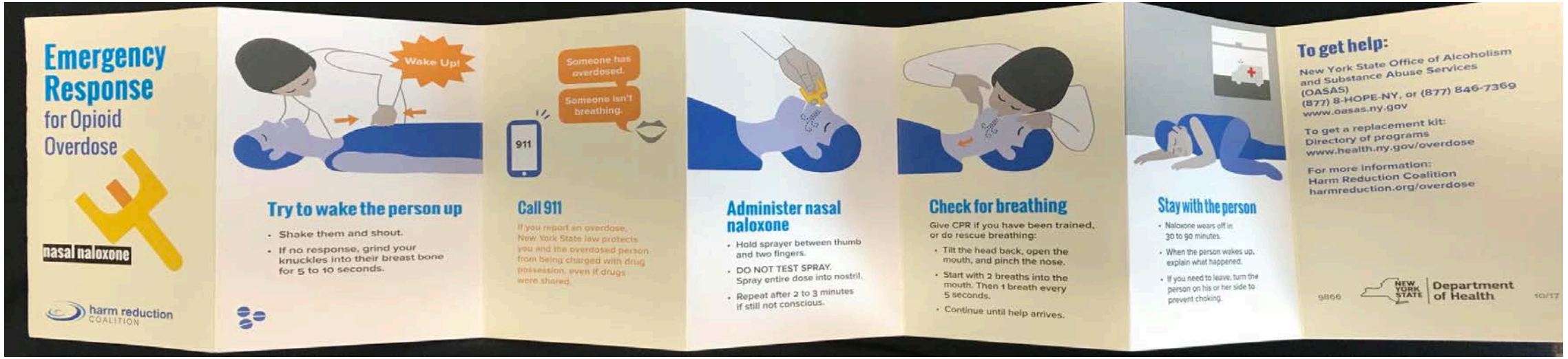
- PLWH presenting *with* pain *without* opioid use disorder
- PLWH presenting with *both* pain and opioid use disorder
- PLWH with opioid use disorder (*not* in treatment for pain)

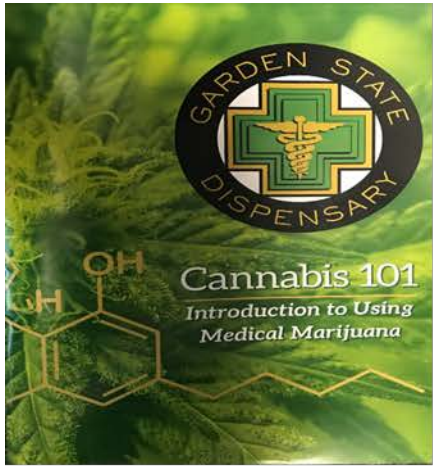
NECA AETC Opioid Toolkit

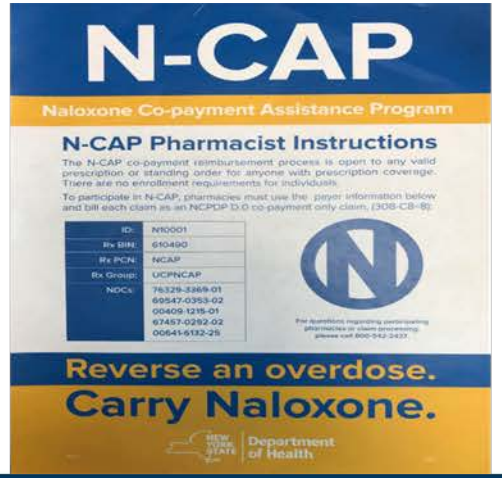
PowerPoint	▪ 10-15 slides + regional epidemiology (each region can plug in theirs)
	▪ 5 things we can train on
	  ▪ Manage pain effectively and use opioids judiciously
	  ▪ Integrate MAT into primary care for PLWH
	  ▪ Co-prescribe naloxone (e.g., when prescribing buprenorphine or any other opioid)
	  ▪ Improve diagnosis of opioid misuse/opioid use disorder
	  ▪ Acknowledge suffering/pain (“reframe pain”)

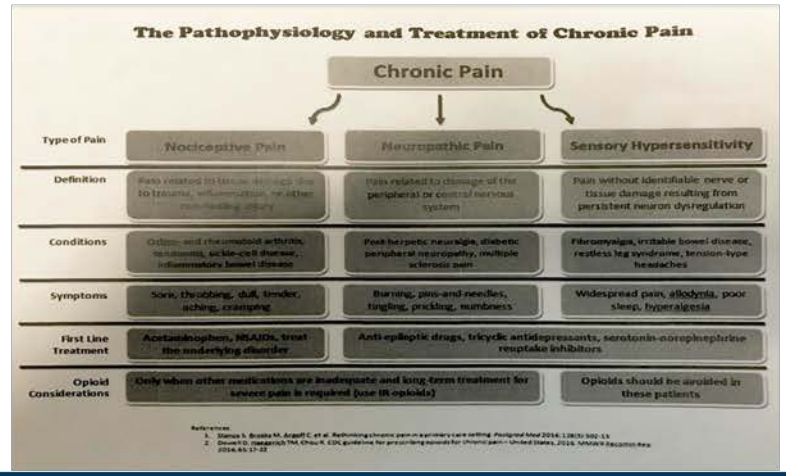
Pocket guides	▪ Screening—pain/functioning ▪ Screening—opioid use disorder/SBIRT ▪ MAT ▪ Non-pharmacologic therapies ▪ Opioid overdose prevention ▪ What HIV patients need to know
Graphics	▪ Infographics for Powerpoint presentations and pocket guides ▪ Waiting/consultation room posters ▪ Stigma reduction (provider, self)
Resources	▪ Local treatment locations ▪ Local buprenorphine prescribers ▪ Local regulations about treatment/overdose prevention ▪ Regional NECA AETC contact info

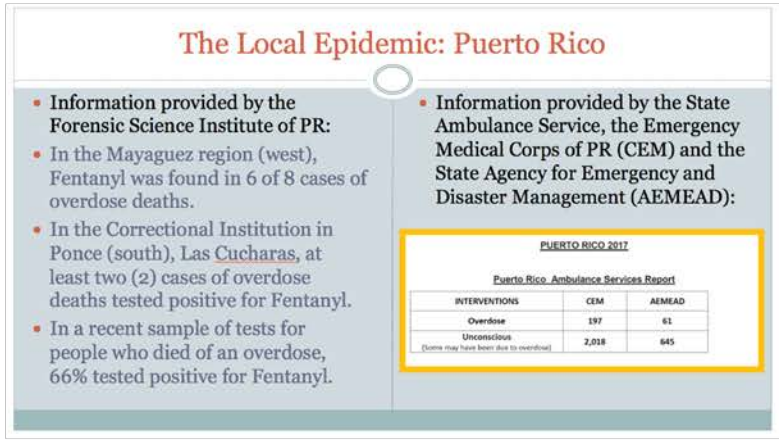
Sample toolkit materials











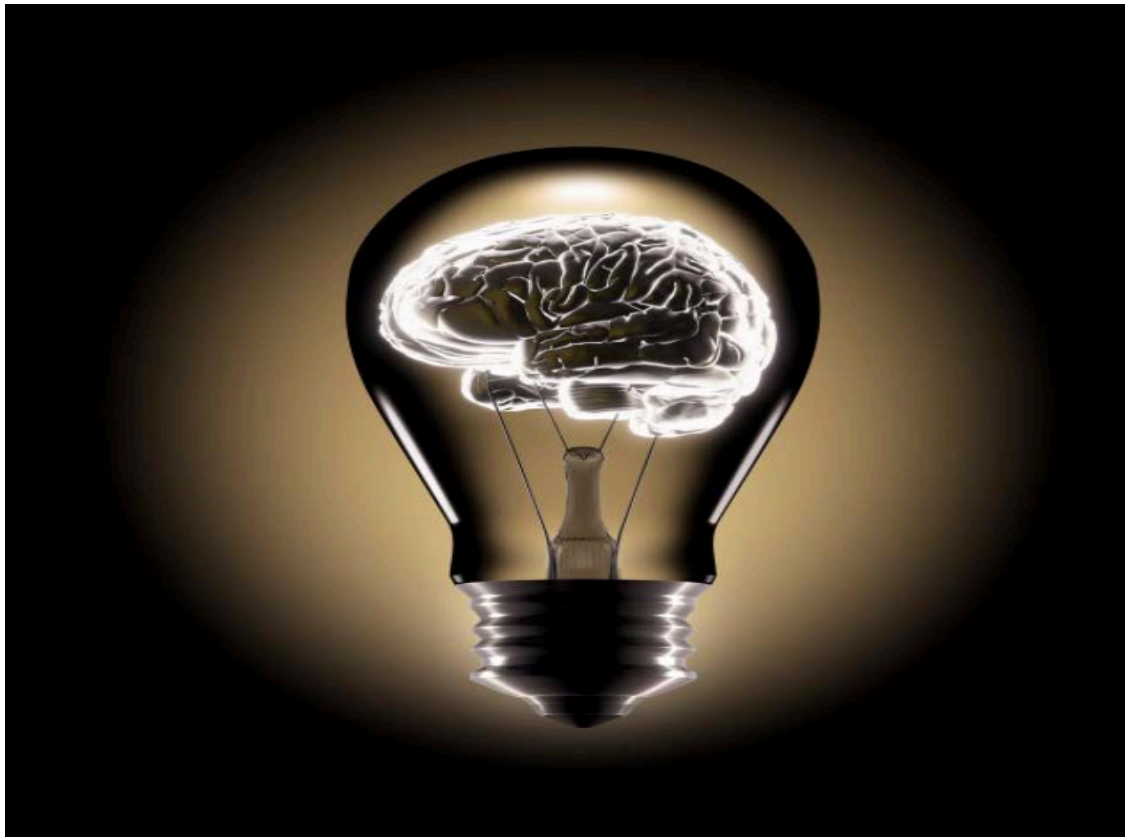
NATIONAL 2018 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Managing Pain and Opioid Use Disorder with People Living With HIV

Francine Cournos
Northeast/Caribbean AETC

Overview

- Pain and its management with PLWH should be addressed holistically.
- If Opioid Use Disorder is part of the picture, MAT is the standard of care.
- This toolkit was developed to facilitate pain assessment, treatment, and management of opioid use problems seen in HIV care.



Approaching Pain with PLWH

- Between 30% and 90% of PLWH experience pain.
- Multisite pain is common.
- Chronic pain affects:
  - Retention in care
  - Functioning
  - Healthcare utilization, including opioid use
  - ART adherence
- A holistic approach to pain management for PLWH will improve care and outcomes.

Jaio JM, Pain, 2015; Miaskowksi C, J Pain, 2011; Edelman EJ, JGIM, 2013; Merlin JS, JAIDS, 2012; Merlin JS, Pain Med, 2013; Surratt, AIDS Pt Care STDs, 2015; Knowlton AR, J Palliat Care, 2015; Ellis RJ, Arch Neurol, 2010; Jaio JM, Pain, 2015; Johnson A, J Opioid Manag, 2012; Perry B, J Pallliat Med, 2012.

Managing pain with non-opioids

Other medications and non-pharmacologic therapies should be considered prior to prescribing opioids for most pain.

- For chronic pain, psychosocial interventions have produced modest improvements
  - Cognitive restructuring
  - Relaxation
- Other considerations may play a role (such as insurance coverage, provider time commitment, and patient buy-in when choosing realistic alternatives to opioids).

Parker et al., J of Intl AIDS Soc, 2014; CDC report, March 2017

Managing pain with opioids

Opioids are a class of drugs including both prescription pain medications and illicit drugs:

- Morphine, codeine (natural opioids)
- Oxycodone, oxymorphone, hydrocodone, hydromorphone (semi-synthetic opioids)
- Methadone, fentanyl, tramadol (synthetic opioids)
- Heroin (derived from morphine; illegal in U.S.)
  - 4/5 of new heroin users started by misusing prescription opioid pain medications

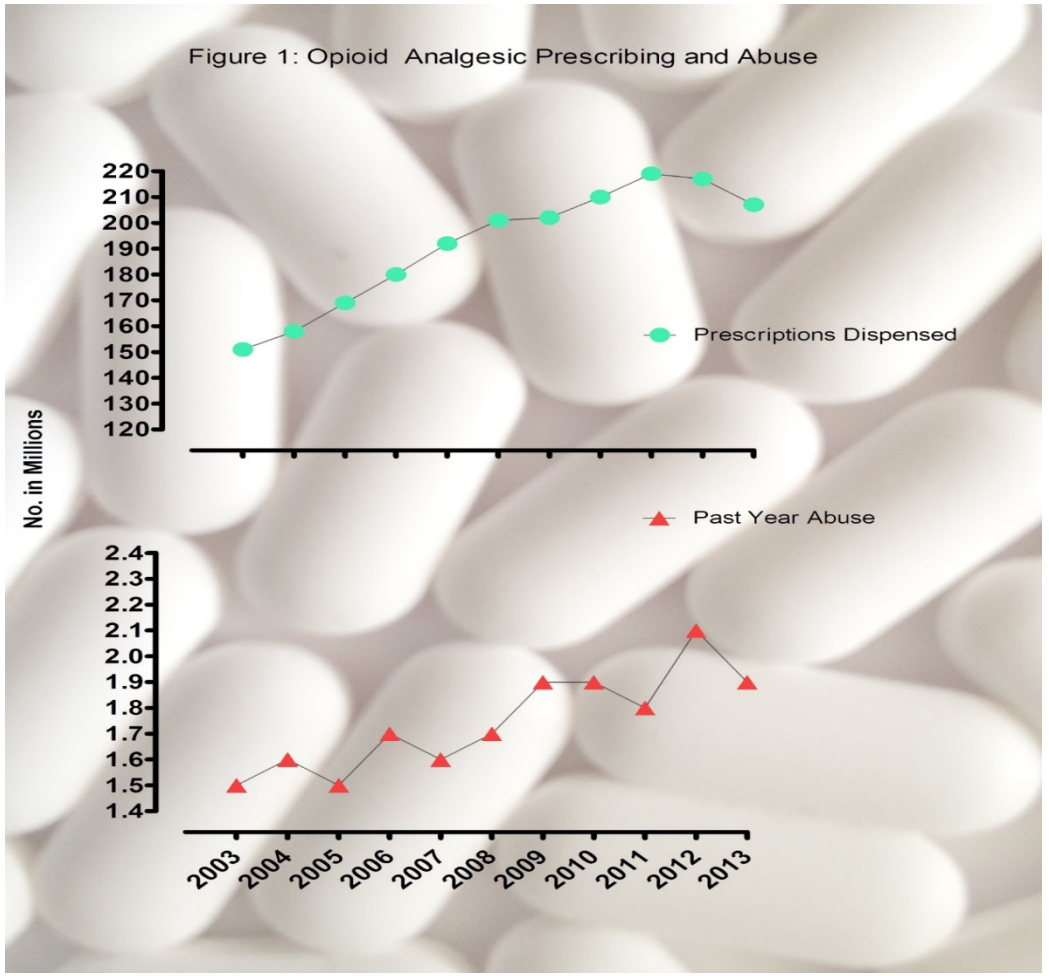
Opioid dosing

- Opioids are most appropriate for severe, acute pain.
- The probability of chronic opioid use rises rapidly **after just 3 days of dosing**.
- Receiving a refill or being prescribed a longer-acting opioid also increases chances of long-term use.
- Short-term prescribing of opioids (study tested < 7 days) could reduce the chances of unintended chronic use by half.
- Appropriate opioid prescriptions:
  - Less often
  - Shorter duration (3 days for acute pain)
  - Lowest effective dose
  - Not with benzodiazepines

Overuse of opioids

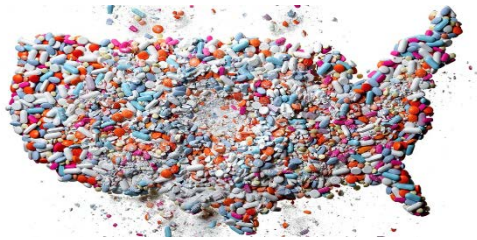
Opioid prescribing

- Opioid prescriptions increased dramatically, peaking in 2011, now leveling off.
- Greater availability of opioids was accompanied by increases in misuse and overdose.
- Outside of the US and Canada, developed countries manage pain with much less opioid use.



This figure shows the steep rise, in green, in the millions of opioid prescriptions dispensed between 2003 and 2013 which corresponds to the steep rise, in red, of past year opioid abuse.

Opioid Crisis and HIV Care

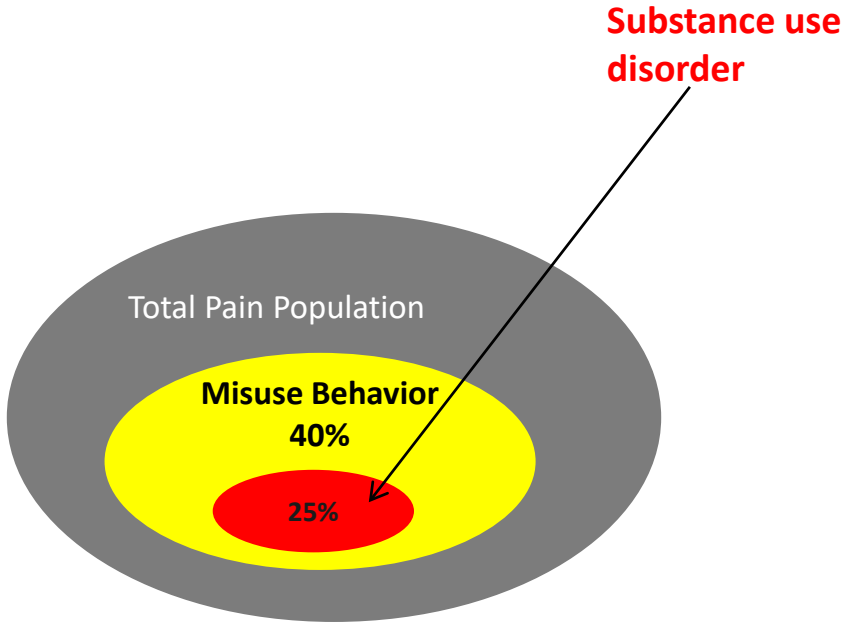


- The opioid prescribing/overdose crisis is the context in which we are treating PLWH for
  - pain
  - substance misuse
- Since 2000, overdose deaths involving opioids have nearly quadrupled.
- Drug overdose deaths are now
  - the leading cause of accidental death in the US (ahead of motor vehicle and firearms-related deaths)
  - the leading cause of death among people under 50
- The crisis is characterized by a sharp increase in deaths from heroin and synthetic opioids, such as fentanyl and carfentanil.

Opioid Misuse

Opioid misuse = Intentional use of a drug product in an inappropriate way:

- Using more than prescribed
- Non-medical route of administration
- Obtaining opioids without a prescription
- Doctor shopping



This figure of concentric circles shows that of the total population with pain, 40% have opioid misuse behavior and of those 25% have a substance use disorder.

Approaching Opioid Misuse with PLWH

- MAT is the standard of care for opioid use disorder.
- In conjunction with MAT, non-pharmacologic therapies improve outcomes.
- Substance use disorders are chronic brain diseases that need appropriate treatment.
- Reducing stigma increases treatment access and acceptability:
  - ↓ Pejorative terms
  - ↓ Punitive language and policies
  - ↓ Negative assumptions

Medication-Assisted Treatment (MAT)

MAT is a treatment approach that combines counseling and behavioral therapy with medication to block the impact of opioids on the brain.

This image of a person filled with puzzle pieces shows that MAT for Opioid Use Disorder is one part of the person's behavioral health needs for addressing the whole person.

Integrate MAT into primary care for PLWH

Medication-Assisted Treatment Options

- Buprenorphine with co-prescribed naloxone
- XR-Naltrexone/Extended Release-Vivitrol
- Methadone referral

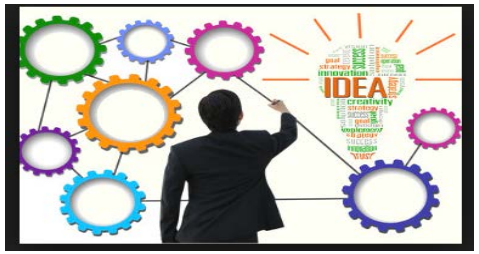
Counseling, Therapies & Structured Environments

- Individual and group counseling
- Inpatient, residential, intensive outpatient treatment

Other support/services

- Case or care management
- Recovery and peer support services
- 12-step fellowship

MAT Integration: What's Needed



- Engaging the clinic
- Using a collaborative care model—physicians may feel overwhelmed trying to do this on their own
- Utilizing specific work flows, assessments, and treatment protocols
- Practice facilitation and technical assistance can facilitate all of the above

Opioid Overdose

Opioids

- Potent pain medications that produce profound euphoria that can lead to misuse

Lack of oxygen

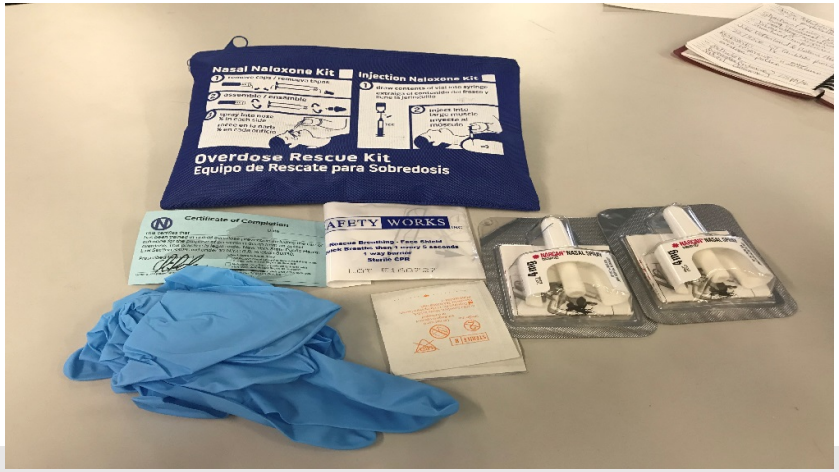
- Opioids decrease breathing
- Primary mechanism of fatal opioid overdose
- Causes the heart to stop

Risk factors for overdose

- Re-initiating use after a period of detox (e.g., post-incarceration)
- Street drugs of unknown purity
- Snorting or injecting
- Mixing with other drugs/alcohol
  - Most people who overdose have 3+ substances on board
- Using alone

Opioid Overdose Prevention

Naloxone (NLX) is an opioid antagonist/blocker commonly used by medical and emergency personnel to reverse opioid overdoses.



This picture shows an overdose rescue kit containing Naloxone spray, latex gloves, a certificate of training completion, and instructions for administering the spray.

Overdose education and naloxone distribution (OEND) programs are increasing as an overdose harm reduction tool.

OEND programs typically:

- allow for non-medical persons to easily obtain NLX
- teach individuals how recognize and respond to opioid overdose
- provide immunity if NLX is used in good-faith (e.g., Good Samaritan laws)

Acknowledge suffering/reframe pain

- Care teams can't eliminate all pain.
- The primary goal of treatment is not only to improve pain but also to improve physical and emotional functioning.
- PLWH may get relief from pain with cognitive behavioral therapy, physical therapy, hypnosis or medical marijuana.
- "Reframing" how one thinks about pain.
  - "While it doesn't take the pain away, it does make my situation feel workable."
  - Reframing can enhance wellbeing: agency, sanity, self-preservation, and the potential for joy in this lifetime.

NATIONAL 2018 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Implementation of MAT

Jameela J. Yusuff
Northeast/Caribbean AETC

STAR Health Center, Brooklyn NY

- Established in 1991, RW Part C funding
- PCMH Level 3, one-stop shop for all medical/behavioral health needs
- HIV primary care and prevention (PReP/PEP)
- HCV services including Fibroscan
- LGBTQ care (HRA), Hormone therapy
- Women's health—Colposcopy and Prenatal
- Integrated MH/SA counselors, trauma informed Care, Seeking Safety
- Medical CM, clinical pharmacist, outreach, CAG, social media, and nutrition services
- Opioid Prevention Program, AETC site, SBIRT trained staff
- Buprenorphine services since 2008 via a SAMHSA grant

Getting Started

- Grant Funding (SAMHSA grant): provided funding medication/visit/training 2008-2013
- Cross Collaborated: Site Visit and In-services from experienced MAT providers
- Workforce Developed: Online/in-person trainings for providers and care team
- Use of Data to understand population eligible for MAT
  - Low doses of methadone, opioid using, heroin using
- Community partnerships: referrals and treatment as needed
- Staff Education and Buy-in: on MAT options, clinic flow, and cultural sensitivity
- Linking with pharmacies who stock buprenorphine who can deliver to clinic
- Other Administrative adjustments:
  - New policies developed and disseminated
  - Double locked box in nursing
  - Toxicology screens include buprenorphine
  - Literature on overdose prevention & MAT in the waiting room

How are patients referred?

- Clinic identified patients who were eligible (EMR search for methadone, heroin user, narcotic medications) and discussed MAT options
- Providers are listed on the OASAS website
- Social Media: Website, Facebook, Twitter
- Linkage agreements with CBO, treatment centers, syringe exchange programs
- Opioid Grand Rounds –Promoted referrals to our clinic
- Inpatient linkage and transition to our clinic
- Word of mouth

Eligibility

- Opioid Dependent
  - Methadone <30mg/day
  - Using illegal or non-prescribed opioids to avoid withdrawal
  - On buprenorphine elsewhere (transfer)
  - Recently released from (jail, prison, residential treatment)
- Exclusions
  - Not opioid dependent
  - Methadone 31mg or higher
  - Actively receiving pain medication
  - Actively receiving benzodiapezines, and unwilling to sign release
  - Psychiatrically unstable
  - Determined to be at risk of fatal interactions (alcohol/other drugs)
  - Pregnant (case by case)

Patient is Pre-Screened by Nursing

- New Referrals are directed to Nursing
- Phone Assessment by nursing
  - Current opioid use/withdrawal symptoms
  - Psychiatrically stable
  - Pain management
  - Other substance: alcohol, benzodiazepines, other sedatives
  - Insurance? (need to enroll in coverage, check on Prior Authorizations)
  - Buprenorphine maintenance vs detox
  - Initial appointment is for evaluation
  - If approved for treatment—attendance requirement

Initial appointment

- Register and enroll in clinic, counseling program
- Referred to case management if patient needs to apply for insurance
- Sign treatment agreements
- Complete initial office visit examinations (history/physical)
- Eligibility is reviewed
- Baseline drug screen (oral swab or urine)
- Complete and review lab testing per order set (hepatic panel, hepatitis, HIV)
- Check prescription drug monitoring program (I-Stop)
- Pt is scheduled to return to clinic for induction

Induction

- Timing of initial evaluation and buprenorphine induction depends of longest acting opioid being used by the patient
    - Heroin/short acting: 24hr;intermediate activing 48hours, Methadone 72hrs
- Clinical Opiate Withdrawal Scale (COWS) is assessed by nursing staff
- Patient must meet moderate withdrawal to receive first induction dose, if not in active withdrawal—must come back later the same day or next day
- Patient is given 4mg—wait 1 hour, and reassess with COWS—target dose 8mg for day 1 and 16mg for day 2; Patients do not typically require more than 16mg per day (32mg is the max dose)
- Patient is scheduled to return in a week and then given enough medication till the next appointment.

Follow up

- Patients within the induction phase may require closer followup
- Routine followups for patients on maintenance may be from 30 days to 90 days
- Patients are expected to pick up buprenorphine 28-30days
- Urine toxicology screens are done at each visit, liver function tests are scheduled at least every 6months
- Cold urine specimens are not acceptable—patient will need to resubmit
- All patients receive a narcan kit and followed by MH counselors for individual or group sessions.

Discharge

- Patients could be tapered off if they choose (not recommended b/c relapse risk)
- Urine toxicology negative for BUP on 2 occasions within 6months
- Urine toxicology is positive for opioids on 2 occasions within 6months
- Clinic offers referrals and assists with linkage to another provider

Resources

Becoming an Opioid Overdose Prevention program

www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/become_a_program.htm

SAMHSA Guidelines for Medication Assisted treatment in Primary Care

www.integration.samhsa.gov/clinical-practice/mat/RAND_MAT_guidebook_for_health_centers.pdf

ECHO for Opioid Addiction Treatment (online learning community for FQHCs)

https://echo.unm.edu/nm-teleecho-clinics/opioid/

Provider's Clinical Support System for Medication Assisted Treatment

http://pcssmat.org/

“I [have] really great doctors that I’m working with now that understand my addiction and understand that I do need to control my pain.”

St. Marie, Pain Medicine 2014

2018 NATIONAL

RYAN WHITE

CONFERENCE ON HIV CARE & TREATMENT

NATIONAL RYAN WHITE 2018 CONFERENCE ON HIV CARE & TREATMENT

Pain Treatment, Opioid Management, and Medication Assisted Treatment into HIV Primary Care: Toolkits and Lessons Learned

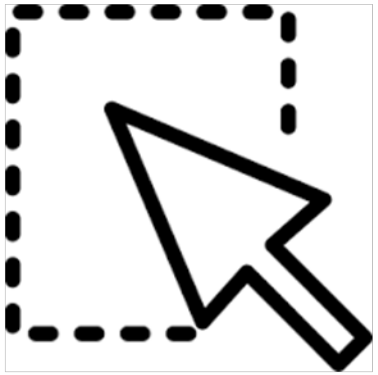
Alexis Marbach, Abt Associates; Hannah Bryant, AIDS United, Alice Thornton, Bluegrass Care Clinic; Maribel Acevedo Quiñones, Centro Ararat; Ann Avery, The MetroHealth System

Project Background

- Four-year Cooperative Agreement with HRSA's Special Projects of National Significance (SPNS)
- Funding amount of $3 million/year for the ITAC, with $2.4 million going to implementing sites
- Replicates four previously-implemented SPNS initiatives

Interventions

AIDS United: Implementation and Technical Assistance Center (ITAC)



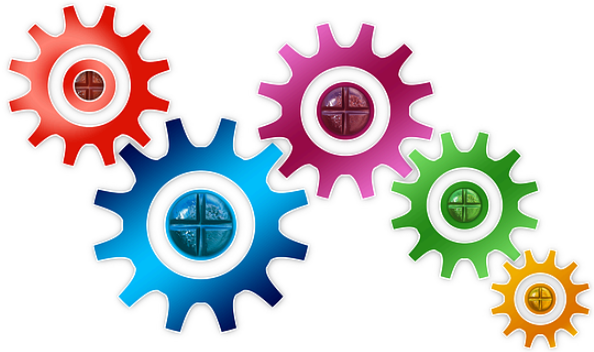
Select & Fund 12 Sites

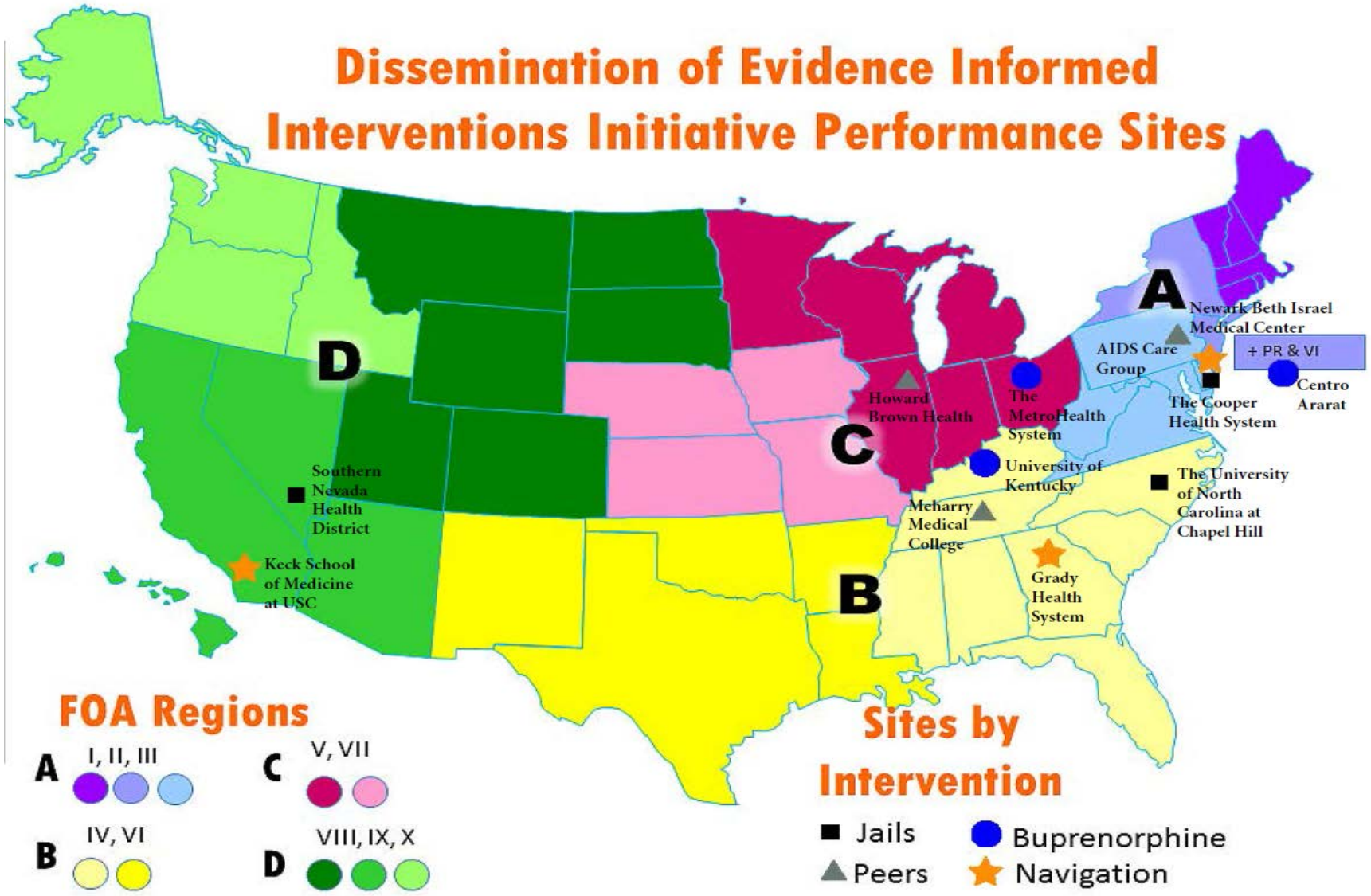
Provide TA

Coordinate Experts

Boston University: Dissemination and Evaluation Center (DEC)

- Adapt and design 4 intervention models for replication.
- Design and implement multi-site evaluation
- Studying both patient outcomes (including retention in care and viral suppression) and implementation findings (what works in practice and what facilitates/hinders implementation)
- Publish and disseminate final adapted interventions and study findings




Dissemination of Evidence Informed Interventions Initiative Performance Sites
A
B
C
D
Newark Beth Israel Medical Center
AIDS Care Group
+ PR & VI
Centro Ararat
The Cooper Health System
Howard Brown Health
The MetroHealth System
University of Kentucky
The University of North Carolina at Chapel Hill
Meharry Medical College
Grady Health System
Southern Nevada Health District
Keck School of Medicine at USC
FOA Regions
A I, II, III
B IV, VI
C V, VII
D VIII, IX, X
Sites by Intervention
Jails
Peers
Buprenorphine
Navigation

Integrating Buprenorphine Treatment for Opioid Use Disorder in HIV Primary Care

Audience: HIV primary care settings that do not already provide on-site buprenorphine treatment services.

Target population: People living with HIV and opiate use disorder.

Time frame of the intervention: No predetermined time frame as the time from induction to stabilization to maintenance will vary for each patient.

Core Elements of Buprenorphine Intervention

- Clinic buy-in
- Introduce the intervention to client
- Initiating treatment
- Monitoring treatment
- Integration of treatment into the clinical setting

Lessons Learned – Pre-Implementation

Facilitators of successful implementation:

- Overwhelming need for this service due to the epidemic
- Commitment and engagement from all intervention team members and clinic leadership

Barriers to implementation:

- Issues with prior authorizations persist
- Barriers to creating collaborative relationships (historical RW funding cuts)
- Stigma of accessing substance abuse treatment in smaller communities, geographic barriers (urban clinic treating patients from rural areas)

Lessons Learned – Year 1 of Implementation

- Enrollment is dependent on provider and clinical coordinator capacity.
    - Patients with high acuity and substance use disorder need more time and engagement with the clinic staff and often do not have a linear path to recovery, making it hard to take on additional clients and offer high quality care.

- The landscape of MAT is consistently changing, and it is important for sites to have a champion/advocate to make sure they are “at the table” for conversations about expanding MAT within their clinic/local area.

Lessons Learned – Year 1 of Implementation

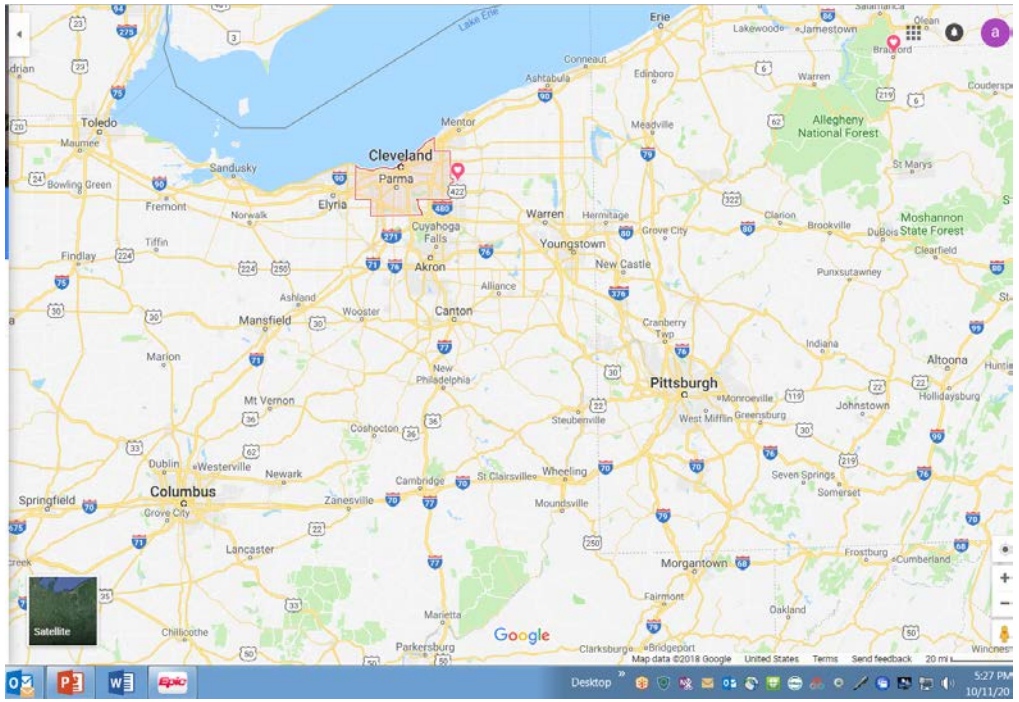
- Providers and clinical coordinators are addressing patients with high acuity, co-occurring substance use disorders, mental health concerns, and high levels of experienced stigma, impacting the level of care they need to receive.

- The role of the clinical coordinator needs to have it's own implementation materials/manuals.
    - Clinical coordinators have coordinated group therapy sessions, in addition to individual counseling, which can support patients in establishing sober support systems.

MetroHealth: Background

The MetroHealth System is in Cleveland, Ohio and is the public hospital system for Cuyahoga County.

It is comprised of the main hospital complex and clinics, 2 mini hospitals, 4 emergency depts, a skilled nursing facility, an acute rehab facility and > 30 community health centers.



MetroHealth: Implementation

Facilitators

- Strong team based care
- Dedicated staff
- Integrated EMR
- Institutional buy-in

Barriers

- The biggest challenge is pt readiness.
- Work schedules, child care and transportation have been barriers to both initiation and retention.
- Untreated mental illness and reluctance to address underlying MH issues

MetroHealth: Lessons Learned

- "It's the hardest thing I have ever done! It's not as easy as just prescribing a pill. I have learned a ton and wouldn't trade the experience and learning opportunities. I have gained general skills in managing pts with addiction." – Ann Avery, lead prescribing provider

- Patients appreciate low-barrier access to care and inclusion of MAT in their HIV clinic: "They like that it is part of our clinic and not elsewhere".

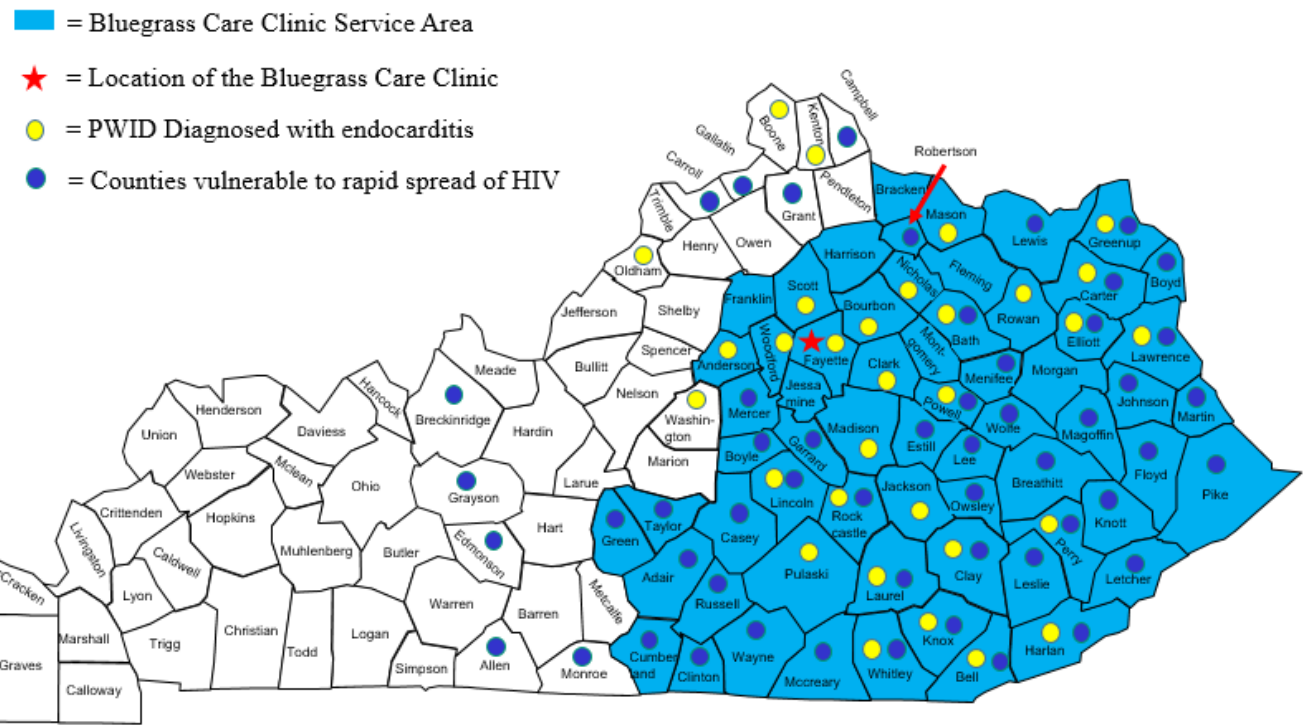
- Identifying someone to engage with the patient for the behavioral changes needed is essential; this person also did the leg work for prior authorizations which can be very time consuming.

University of Kentucky – Bluegrass Care Clinic: Background

The Bluegrass Care Clinic (BCC) is a Ryan-White funded HIV primary care clinic within the University of Kentucky Healthcare system.

The BCC is located in central Kentucky and serves 63 out of Kentucky's 120 counties.

In 2017, the BCC served just over 1600 patients with HIV and primary care, medical case management, mental health, nutrition services and specialty referrals.



University of Kentucky – Bluegrass Care Clinic: Implementation

Facilitators:

- Existing relationships with multidisciplinary team.
- Internal champions.
- Many patients feel accepted and know their health status is protected.
- Wrap-around services provided by RW part B allow patients to maintain access to MAT.

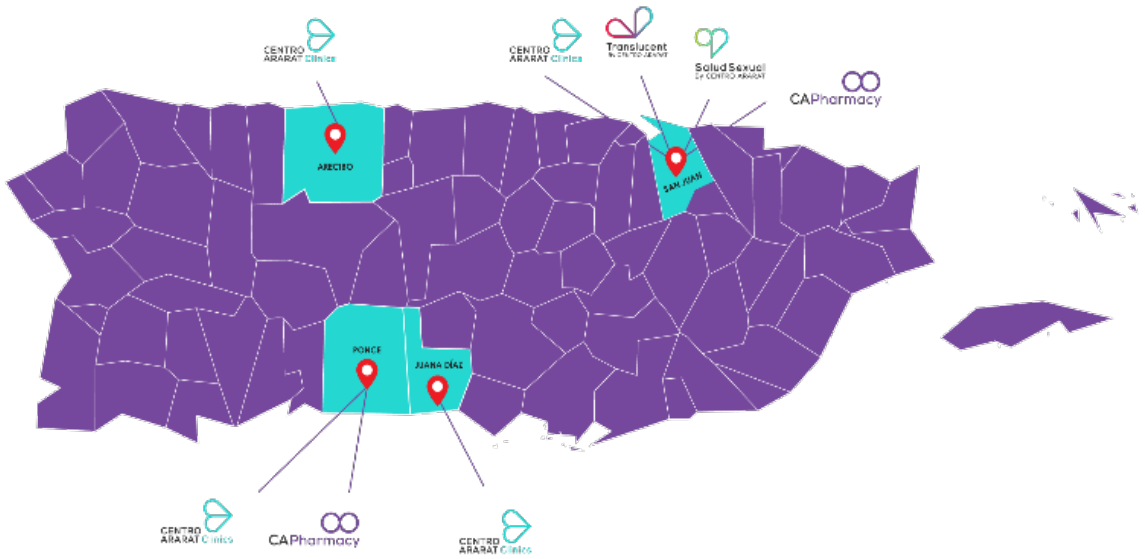
Barriers:

- Stigma (both HIV, substance use & MAT related stigma)
- Life chaos
  - Poverty
  - Transportation
  - Phone access
  - Lack of social support

University of Kentucky – Bluegrass Care Clinic: Lessons Learned

- Many of patients have histories of significant trauma, comorbid mental illness and additional substance use disorders.
- The BCC aims to provide **low-barrier treatment**, recognizing that patients who are struggling need more help, not less.
- It is very helpful for the provider(s) to have dedicated clinical time to providing OUD treatment because patients often need to be seen much more frequently than they would for HIV primary care.
- Be patient. Keep a trauma-informed perspective when working with these clients. Celebrate victories with clients, no matter how small.

Centro Ararat: Clinic Background



- The Buprenorphine Initiative was implemented at CENTRO ARARAT Juana Díaz.
- Juana Diaz is one of 15 municipalities collectively known by the Puerto Rico Health Department as the Ponce Health Region (PHR).
- Except for Ponce, the municipalities in the PHR are considered "rural" by USDA programs operating in Puerto Rico.
- Ponce is the second largest city in Puerto Rico. It is an industrial, governmental and commercial center for the region.
- In 2010, The entire region had a combined population of over 565,000.

Centro Ararat: Implementation

Facilitators:

- Team received immediate buy-in from administration and management (supported by a clinic and community champion)
- Alignment with the CA mission to be inclusive and have respect for liberty and diversity of all human kind.

Barriers

- Hard to reach community
  - Working with an outreach team to find/engage clients
- Building relationships and establishing the clinic as a viable option for MAT
- Loss of funding at other local agencies

Centro Ararat: Lessons Learned

- Everyone has different expectations about treatment.
- Assessment of patient's treatment expectation is crucial prior to initializing treatment.
- Integration of OUD treatment in HIV primary care enabled us as providers to improve overall treatment adherence.
- Having an experienced addiction counselor has been an asset since it has helped clients identify relapse prevention strategies and has provided internal guidance for providers and the rest of the multi-disciplinary team to better understand and work with the cyclical nature of recurrence in this population.
- This intervention takes a lot of time and effort, there must be a dedicated staff to work directly with this population. This staff must be trained in the needs of substance use disorder population and mental health pathologies.

Resources Currently Available

Implementation resources are available for download on the TargetHIV website

- https://nextlevel.targethiv.org/

Training Manuals Coming Soon

- Anticipated release, Fall of 2018
- Will also be posted on TargetHIV website

Looking Ahead: Care & Treatment Interventions

- Continue monitoring implementation at sites and multi-site outcomes evaluation.
- Analyze and summarize interim findings
- Update adapted interventions
- Release final interventions as CATIs

Questions?