

## Substance Use Disorder

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### Financial Relationships With Ineligible Companies (Formerly Described as Commercial Interests by the ACCME) Within the Last 2 Years:

Dr Eaton has received grants paid to her institution from Bristol Myers Squibb, and has received consulting fees from Gilead Sciences, Inc. (Updated 12/14/22)

Dr Springer has received consulting fees from Alkermes Inc, and has received in-kind drug donations from Alkermes Inc (Vivitrol) and Indivior (Sublocade) for NIH-sponsored research. (Updated 12/14/22)

Slide 2

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### Learning Objectives

After attending this presentation, learners will be able to:

- Screen for substance use disorders in HIV prevention and treatment settings
- Initiate treatment for opioid use disorder with HIV treatment
- Consider alternative plans to help patients with substance use disorders and HIV stay retained in care

Slide 3

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### CASE 1.

- 46 yo M admitted to hospital for acute left sided weakness and slurred speech and found to have acute right corona radiata ischemic stroke. HIV + on admission screening test with a CD4 127 and VL 18,000 copies/mL.
- During H&P, reports 7-year history of HIV
- He never sought care as his wife was sick and now is deceased
- Seen by ID consults and agreeable to start BIC/TAF/FTC
- Discharged to Inpatient Rehab for PT/OT
  
- Day 7, returns from smoking & developed somnolence, decreased RR, AMS
- MET Team called: delivered naloxone, returned to USOH
- Patient reports insufflating fentanyl he received from a friend at bus stop on campus

Slide 4

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### ARS Question 1: CASE 1 (cont)

Which of the following is a substance use related outcome that could be prevented by integrating substance use screening and treatment into routine care?

- A. Ischemic CVA
- B. Delay in ART initiation
- C. Failure to engage in HIV treatment
- D. Advanced HIV
- E. All of the above

Slide 5

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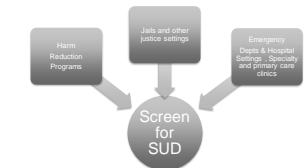
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### SBIRT: Screening and Brief Intervention and Initiation/ Referral of Medication Treatment for SUD



Initiate Rapid Screening for SUD In high prevalence areas

Slide 6

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### ARS Question 3: Case 3

46 yo M with HIV, OUD and recent CVA arrives at your HIV clinic for hospital follow up. You note that he was started on buprenorphine/naloxone (8mg/2mg) during his admission and is now taking 3 tabs daily. He is doing well and has not taken any non-medical opioids; reports occasional crack cocaine usage. Which of the following is associated with continued buprenorphine/naloxone or other MOUD?

- A. Improved Viral Load Suppression
- B. Improved Quality of Life
- C. Reduction in Overdose Risk
- D. All of the above

Slide 13

13

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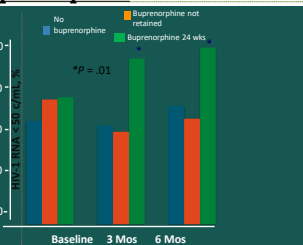
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### Medication for OUD Improves HIV Viral Suppression Rates: Buprenorphine

94 PWH & OUD released from prison  
Retention on buprenorphine for 24 wks ≈ Viral suppression (<50c/mL) 6 months after release  
aOR: 5.37 (95% CI: 1.15-25.1)



Springer. PLoS One. 2012;7:e38335.

Slide 14

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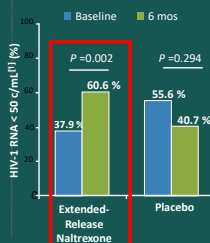
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### Medication Treatment for OUD Improves HIV Viral Suppression Rates: Extended-Release Naltrexone

93 PWH & OUD released from incarceration<sup>(1)</sup>  
Extended-release naltrexone ≈ Viral Suppression 6 mos after release<sup>(1)</sup>  
OR: 2.9 (95% CI: 1.04-8.14; P=0.04)



1. Springer S, et al. J Acquir Immune Defic Syndr. 2018;78:43.

Slide 15

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**Stimulant Use Disorder Treatment**

- Unfortunately, there are no FDA approved effective medications for treatment of cocaine and methamphetamine use disorder
- Behavioral treatments are the recommended treatment
  - Most effective has been Contingency Management programs that can reduce stimulant use
- Offer other harm reduction tools for persons who use stimulants SSPs, safe injection kits, drug testing (contamination of stimulant supply with fentanyl and xylazine)
- Offer naloxone to reduce risk of death from fentanyl / opioids contaminating stimulant supply
- Educate about xylazine contamination and risk of overdose from stimulants alone

Slide 19

19

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**What else do PWUD need?**

- Low-barrier access to HIV & SUD prevention and treatment services
- Bringing services to people in need, rather than expecting them to come to us in traditional clinics
- Low-cost/ Rapid scale-up approaches
- Community health workers
- Patient/ Peer navigators
- Pharmacists
- Telehealth with specialists
- Visiting Nurses- home care model
- Mobile health units, non-traditional clinic settings
- Long-acting injectable PrEP, ART, & MOUD & combinations of these treatments

Slide 20

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**Key Recommendations for Substance Use and HIV**

- Provide screening and treatment for substance use disorders to all persons at risk for and living with HIV (evidence rating: A1a)
- Substance use treatment should be integrated into HIV prevention and treatment services (evidence rating: A1a)
- Persons with substance use disorders and HIV infection or risk for HIV should receive integrated addiction treatment with:
  - Pharmacotherapy for opioid and alcohol use disorders (evidence rating: A1a)
  - Contingency management for stimulant use disorders (evidence rating: A1II)

Slide 21

21

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**Key Recommendations for Substance Use and HIV**

- Persons with opioid use and alcohol use disorders should be offered timely initiation of medications for substance use disorder regardless of HIV and HCV treatment plans (evidence rating: A1a)
- Peer/patient support staff, telehealth, extended hours, mobile clinics, and walk-in clinic options should be available to persons with substance use disorders who are receiving HIV treatment or prevention (evidence rating: A11b)
- Peer/patient support staff, mobile health units, and pharmacy delivery services should be available to persons with substance use disorders who are receiving HIV treatment or prevention (evidence rating: A11b)

Slide 22

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**Question-and-Answer Session**



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