

From Silos to Solutions: Integrating HIV and Substance Use Disorder Treatment and Prevention Services



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

Dr Springer reported receiving noncash provisions of study drugs or testing equipment from Cepheid, Roche, Alkermes, Inc, Indivior PLC, and Braeburn Pharmaceuticals, Inc; serving as consultant to Alkermes, Inc, Emergent BioSolutions, and Gilead Sciences, Inc; and serving on a data safety and monitoring board for Eli Lilly and Company. (Updated September 16, 2026)

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Learning Objectives

After attending this presentation, learners will be able to:

- Describe the epidemiology of substance use and HIV in the United States
- Explain how to screen for and diagnosis substance use disorders (SUDs)
- Initiate treatment for opioid, alcohol, and simulant use disorders when clinically indicated
- List plans to help patients with SUDs with or at risk for HIV initiate treatment and retain in care

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Outline

- Review epidemiology of Substance Use/ Substance Use Disorders (SUDs) and HIV
- Discuss the steps to integrate SUD and HIV prevention and treatment services
- Provide an overview of effective treatments of SUDs
- Review interventions to improve initiation and retention on SUD and HIV treatment/ prevention

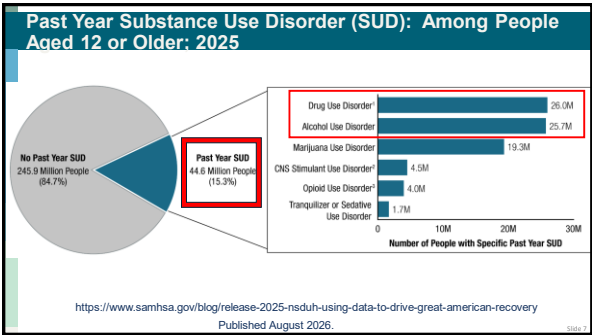
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Substance Use Disorders and Substance Use in the United States

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Self-Reported Opioid and Stimulant Use in 2025

1 in 4 people, **almost 70 million people**, reported illicit drug use in 2025

7.1 million people reported **opioid misuse**

780 K reported **fentanyl/ synthetic opioid use**

9.5 million reported **cocaine/ methamphetamine use**

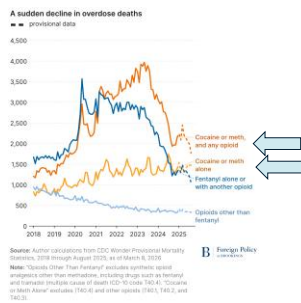
SABHSA 2026

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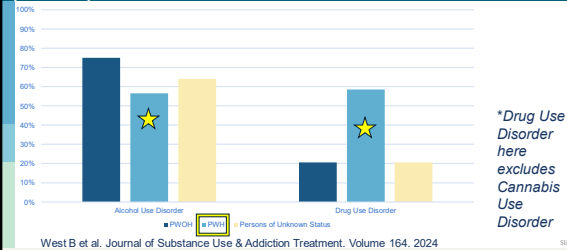
Drug Overdose Deaths Falling in U.S.

But Not for Everyone

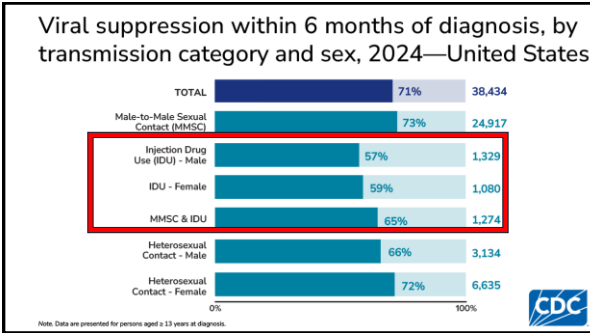


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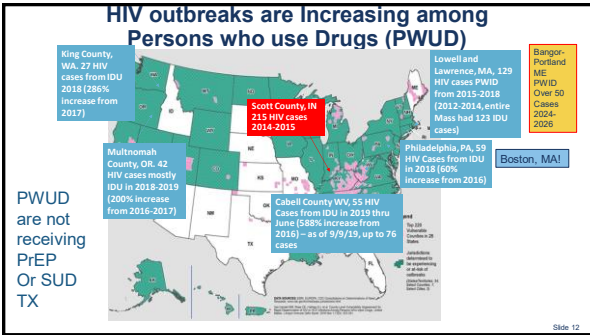
Persons with HIV (PWH) have a Higher Prevalence of Drug Use Disorders than Persons Without HIV (PWOH) or of Unknown Status



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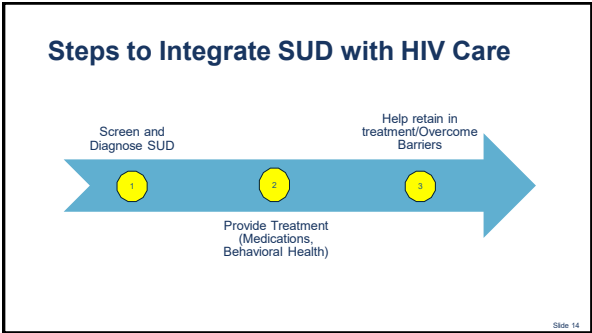
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How do you Diagnose a Substance Use Disorder?

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IDENTIFY: DSM-5 SUD Diagnostic Criteria

Diagnosed: 2-3 symptom criteria within a 12-month period	
Severity: Mild 2-3 symptoms; Moderate 4-5 symptoms; Severe 6 or more symptoms	
Category	Criteria
Loss of control	• "Opioids are often taken in larger amounts or over a longer period than was intended" • There is a persistent desire or unsuccessful efforts to cut down or control opioid use • A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects
Social problems	• Craving, or a strong desire or urge to use opioids • Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home • Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids • Important social, occupational, or recreational activities are given up or reduced because of opioid use
Risky use	• Recurrent opioid use in situations in which it is physically hazardous • Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
Pharmacologic problems	• Exhibits tolerance: need for a larger amount to achieve desired effect or diminished effect with same amount • Exhibits withdrawal: occurrence of a characteristic opioid withdrawal syndrome or continued use of opioids or closely related substances to avoid withdrawal symptoms

American Psychiatric Association. (2013). *Opioid Use Disorder*. In *Diagnostic and statistical manual of mental disorders (DSM-5)*. Arlington, VA: American Psychiatric Publishing.

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STEP 1

Start With a Simple Screening Question for Identifying Population

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EXAMPLE SCREENING

TAPS (Tobacco, Alcohol, Prescription medication, and other Substance use) Tool

- Created with support from NIDA
- REPLACED THE NIDA ASSIST (NM ASSIST) as of 2023
- The TAPS tool combines a quick initial screen (TAPS-1) with a brief assessment (TAPS-2) in a single, short questionnaire.

TAPS-1

- "In the PAST 12 MONTHS, have you used any tobacco product?"
- "In the PAST 12 MONTHS, have you had 5 or more drinks containing alcohol in one day?" (Men only)
- "In the PAST 12 MONTHS, have you had 4 or more drinks containing alcohol in one day?" (Women only)
- "In the PAST 12 MONTHS, have you used any illicit drugs (e.g. cocaine, meth (heroin, fentanyl)) or used prescription medications for non-medical reasons?"

- IF YES to ANY then Go to TAPS-2
- If the patient answers "never" to all, the screen is negative.
- Any other response triggers a brief follow-up assessment covering the past 3 months to determine the risk level*

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<https://nida.nih.gov/taps2>

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STEP 2

USE A DSM-5 DIAGNOSTIC TOOL TO IDENTIFY A TREATABLE SUD

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Screening/Diagnostic Tools For SUD			
1. The Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS) Tool	TAPS 1 is 4 item screener and if positive goes to TAPS 2 for DSM 5 SUD diagnosis	McElroy, J., Wu, L., Subramaniam, S., Torres, G., Kahraman, L.A., Soria, C., et al. Performance of the Tobacco Alcohol Prescription Medication and Other Substance Use (TAPS) Tool for Substance Use Screening in Primary Care. <i>Journal of General Internal Medicine</i> . 2017;32(10):950-955. doi: 10.7720/JGIM.16-0217. https://doi.org/10.7720/JGIM.16-0217	
2. Drug Abuse Screening Test (DAST)	10 items, no information about drug of concern	Babor, T.M. (1982). "The drug abuse screening test." <i>ADDICTION</i> , 77, 101-113.	
3. Substance Use Brief Screen (SUBS)	4 items, preliminary testing in primary care	McElroy, J., Srinivasan, S., Soria, C., Kahraman, L.A., et al. Brief Patient Self-administered Substance Use Screening Tool for Primary Care: Translation, Validation Study of the Substance Use Brief Screen. <i>Journal of General Internal Medicine</i> . 2017;32(10):950-955. doi: 10.7720/JGIM.16-0217	
4. Rapid Opioid Use Disorder (ROUDA) and Rapid Stimulant Use Disorder (RSUDA)	Both 8 items. Diagnose DSM-5 moderate to severe OUD and SUD. Can be administered by non-clinician. Validated to MINI.	O'Neil, A., Ford, D., and Springer, S.A. (2020). Validation of Two Diagnostic Assessments for Opioid and Stimulant Use Disorder for Use by Non-Clinicians. <i>Psych Res Clin Pract</i> , 9, 70-82.	
5. Michigan Alcohol Screening Test (MAST)	10 items, severity measure	Hogwood, G., Meehan, W., Grant, C. The validity of the Michigan Alcohol Screening Test (MAST). <i>Alcohol Alcohol</i> , 1989;24(5):523-527. PMID: 2631233	
6. Alcohol Use Disorders Identification Test (AUDIT) or AUDIT-C	10 items, well-validated for AUDIT; 3 items for AUDIT-C	Babor, T.M., et al. (2002). "Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Group on Early Detection of Persons with Harmful Alcohol Consumption—II." <i>ADDICTION</i> , 97(12), 791-804.	

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STEP 3

PROVIDE INTEGRATED SUD TREATMENT

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FDA-Approved Medications for Opioid Use Disorder (MOUD)			
	Metadone	Buprenorphine	Extended-release Naltrexone
Mechanism of Action	Full μ agonist	Partial μ agonist, Partial κ antagonist	Full μ antagonist
Delivery	Oral	Sublingual, film, injection*	Injection
Frequency	Daily	Daily oral; weekly/monthly injection	monthly
Setting	Licensed drug treatment program	PCC/HIV care setting	PCC/HIV care setting
Other	1. Highly structured due to safety concerns. 2. OUD potential 3. Interacts with some ARVs 4. Reduces HIV Risk Behaviors	1. No interactions with ARVs 2. Reduces HIV Risk Behaviors 3. Reduces OUD 4. Improves HIV Viral Suppression (VS)	1. Also treats Alcohol Use Disorders 2. No overdose or diversion concerns 3. Reduces HIV Risk Behaviors 4. Reduces Overdose 5. Improves VS**

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Form of LA Buprenorphine	Induction	How to Administer & Location	Dose	Frequency	Outcomes	Special Issues
Sublocade	Can do one dose of SL BUP or 4-8mg and then 300 mg injection same day and administer 2nd 300mg dose in 1 week	Sub-Cutaneous (SC) injection Upper Arm/ Thigh/Buttock/ Abdomen	300mg/ 100mg	Monthly	↓Use	• REMS • Refrigeration
Brixadi	Native of SL BUP or switch from SL BUP can be done same day	SC injection Upper Arm/ Thigh/Buttock/ Abdomen	8/16/24/32 mg weekly 4-8/16/32 mg monthly	Weekly or monthly	↓Use	• REMS

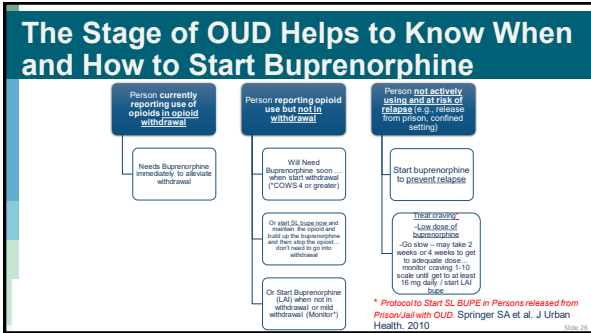
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Assess for Opioid Withdrawal Clinical Opioid Withdrawal Scale (COWS)	
Table 3. Clinical Opioid Withdrawal Scale (COWS) Awakening time from sleep per minute: 0 = pulse rate < 90; 1 = pulse rate 90-105; 2 = pulse rate 105-120; 3 = pulse rate > 120 Sweating (in past 1 hour): 0 = no report of sweating; 1 = subjective report of sweating; 2 = subjective report of sweating; 3 = subjective report of sweating; 4 = subjective report of sweating Restlessness: 0 = able to sit still; 1 = subjective difficulty sitting still; 2 = unable to sit still; 3 = frequent fidgeting; 4 = constant fidgeting Pupil Size: 0 = pupils pin-point or normal size for room light; 1 = pupils possibly larger than normal for room light; 2 = pupils moderately dilated; 3 = pupils dilated, only one of two visible Muscle/Bone/Joint Ache: 0 = not present; 1 = mild diffuse discomfort; 2 = patient reports severe diffuse aching of joints/muscles; 3 = patient reports severe diffuse aching of joints/muscles; 4 = patient reports severe diffuse aching of joints/muscles Muscle/Bone/Joint Ache: 0 = not present; 1 = mild diffuse discomfort; 2 = patient reports severe diffuse aching of joints/muscles; 3 = patient reports severe diffuse aching of joints/muscles; 4 = patient reports severe diffuse aching of joints/muscles Adapted from Hesson DR and Ling M. The Clinical Opioid Withdrawal Scale (COWS). J Psychoactive Drugs. 2003;35:233-9.	30-point (past 1 hour): 0 = no symptoms; 1 = stomach cramping; 2 = nausea/vomiting; 3 = vomiting/diarrhea; 4 = moderate/severe diarrhea Tremor: 0 = no tremor; 1 = tremor can be felt, but not observed; 2 = slight tremor observable; 3 = gross tremor/severe shivering yawning: 0 = no yawning; 1 = yawning once or twice during assessment; 2 = yawning 3 or more times during assessment; 3 = yawning several times or more Irritability/Anxiety: 0 = none; 1 = subjective increased irritability/anxiety; 2 = patient directly irritable/anxious; 3 = patient directly irritable/anxious Fluorescence: 0 = none; 1 = fluorescence; 2 = fluorescence of skin can be felt, arms hair standing up; 3 = prominent piloerection Total Score: 0-68 (0-24 = moderate; 25-36 = moderately severe; greater than 36 = severe)

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SLIDO Case Question. OUD and HIV
A patient with HIV is actively using fentanyl and is interested in treatment. They have had difficulty attending frequent appointments and taking daily medications consistently. The patient is willing to consider medication treatment for opioid use disorder (MOUD). Which approach is most appropriate? A. Offer daily transmucosal buprenorphine (e.g. Suboxone) with ART. B. Offer injectable buprenorphine with ART. C. Refer the patient to addiction medicine program. D. Provide overdose education only; defer MOUD because fentanyl use makes the treatment too complex and at risk of precipitating withdrawal

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Safe to Start High Dose LAI Buprenorphine In Persons With OUD Actively Using Fentanyl

- Buprenorphine in weekly and monthly LAI has been found to be **safe** to start in persons with OUD using fentanyl without precipitating withdrawal
- Shared decision making is essential to understand withdrawal potential and how to manage

1. D'Onofrio G et al. JAMA Network Open. 2023
2. D'Onofrio G et al. JAMA Network Open. 2024.
3. D'Onofrio G et al. JAMA. 2026
4. Sieval N. Springer S. JAMA Network Open 2025.
5. Shiwach R et al. JAMA Network Open. 2025 (x2)
6. Springer SA. JAMA Network Open 2025

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In a Multisite ED-Initiated LAI weekly Buprenorphine trial of 1200 patients with OUD and majority with fentanyl use- the incidence of **precipitated withdrawal** was less than 1% (N=9)

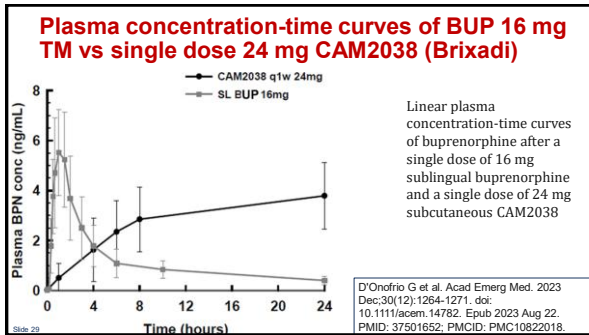
Table 2. Detailed Data From PIV Cases*

Enrollment date	Location	Age, decade	Race	Gender	Severity of use, days	Last use, h	Route	Other drug testing	BUP type	COWS scores, baseline/ mid/ end	Time elapsed, min†	Disposition	ED LOS, min
December 2020	Northeast	50s	Black	Woman	7	16	Injection	Opiates and fentanyl	SL	13/19	20	Discharged	83.40 min
January 2021	West	20s	White	Woman	7	8	Smoking	Fentanyl	XR	15/23	25	Discharged	23.50 min
February 2021	Northeast	40s	White	Man	7	8	Nasal	Fentanyl	XR	12/28	114	Observation†	73.50 min
												Discharged	
April 2021	Midwest	60s	Black	Woman	7	24	Nasal	Cocaine, opiates, marijuana	XR	8/16	60	Against medical advice	13.61 min
May 2021	Northeast	30s	Multiracial	Man	6	>24	Injection	Cocaine, marijuana, fentanyl	SL	13/23	54	Discharged	73.24 min
August 2021	South	30s	Multiracial	Man	6	24	Smoking	Cocaine, fentanyl	SL	13/32	55	Observation†	223.39 min
												Discharged	
September 2021	Midwest	40s	Black	Man	7	12	Nasal	Cocaine, marijuana, fentanyl	XR	13/20	30	Discharged	83.50 min
November 2021	Midwest	20s	American Indian/Alaskan Native	Man	7	16	Smoking	Cocaine, marijuana, fentanyl	SL	10/22	82	Discharged	83.43 min
December 2021	South	30s	Black	Man	7	15	Injection	Cocaine, fentanyl	SL	28/1-30†	116	Observation†	203.0 min
												Discharged	

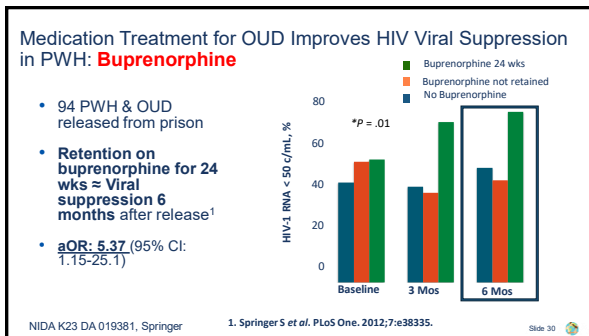
D'Onofrio G, et al. JAMA Netw Open. March 2023.

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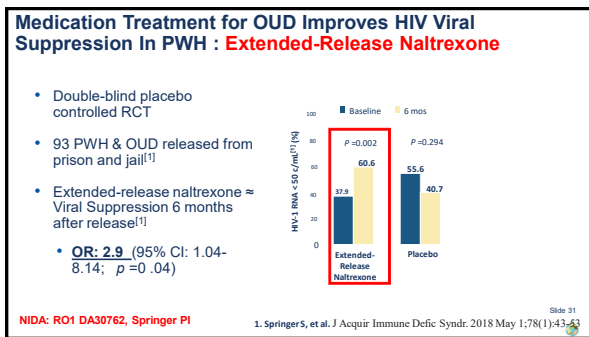
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Resources for Diagnosis and Treatment of OUD

The ASAM
NATIONAL PRACTICE GUIDELINE
For the Treatment of
Opioid Use Disorder
2020 Focused Update

PCSS Now

<https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline>

<https://pcssnow.org>

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Treatment of Alcohol Use Disorder

Medication Treatment:

- Goal is to reduce craving and amount of alcohol use
- Abstinence is not necessarily the goal
- Low risk Drinking

Alcohol Withdrawal Risk Assessment:

- Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA)-Ar
- *If history of prior withdrawal symptoms that include delirium/seizures, then refer to inpatient detoxification first!

Behavioral Treatment:

- Cognitive Behavioral Therapy
- 12-step programs (e.g. AA)
- Individual Counseling

1. Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). *British Journal of Addiction* 84:1353-1357, 1989.

2. The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management. *Journal of Addiction Medicine* 14(3):1-72, May/June 2020.

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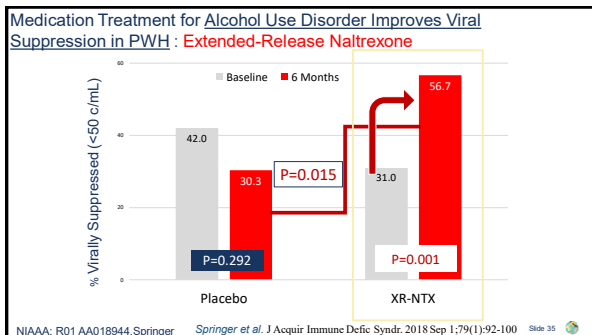
FDA-Approved Medication Treatments for Alcohol Use Disorders

	Naltrexone	Extended-Release Naltrexone (XR-NTX)	Acamprosate	Disulfiram
Mechanism of Action	Full μ antagonist	Full μ antagonist	Blocks N-methyl D-aspartate receptors	Inhibits acetaldehyde dehydrogenase
Delivery	Oral	IM	Oral	Oral
Frequency	50mg Daily	380 mg q4 weeks*	2 tablets, 3 times daily	Daily
Other	1. Poor adherence 2. Good efficacy;	1. Also treats OUD; no diversion; 2. no dependence or respiratory depression 4. increased adherence over oral naltrexone	1. Not proven to be better than NTX; 2. compliance issues; 3. can be used with buprenorphine or methadone	1. Poor compliance 2. poor efficacy 3. High level of monitoring needed for toxicity side effects (Vib etc)

* 1. Arora et al. COMBINE study. JAMA 2005; 293:2051-2060. 2. Glick et al. JAMA 2001; 286:1555-1560.

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Resources for Alcohol Withdrawal and Alcohol Use Disorder Management

American Society of Addiction Medicine (ASAM)

National Institutes of Alcohol Abuse and Alcoholism (NIAAA)

Substance Abuse and Mental Health Services Administration (SAMHSA)

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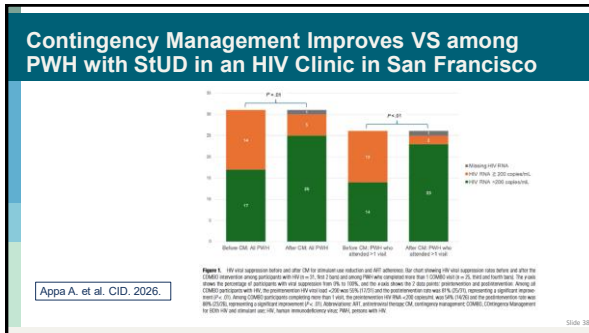
Stimulant Use Disorder Treatment

- Currently there are **no** FDA-approved medications for treatment of stimulant use disorder
- Behavioral treatments are the recommended treatment:
 - Most effective has been Contingency Management (CM) programs that can reduce stimulant use^{1,2}
 - Original voucher or incentive-based CM also has alternative "fishbowl method" to reduce stimulant use.

1. Petty NM. Psychiatrist. 2011; 35 (5) :161-163. 2. Brandon S et al. JAMA Open Network 2021 4(5)

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Resource for Treating Stimulant Use Disorders

The ASAM/AAP
CLINICAL PRACTICE GUIDELINE ON THE
**Management of
Stimulant Use
Disorder**

<https://www.asam.org/quality-care/clinical-guidelines/stimulant-use-disorders>

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Cocaine Use Disorder (CUD) Pharmacotherapies (not FDA approved)

Medication	Mechanism of Action	Results	ASAM	Can treat Co-occurring disorders
Bupropion	Dopamine & Norepinephrine Reuptake inhibitor	Mixed Evidence • Not superior to placebo on abstinence at end of treatment • 2 RCT's was superior to placebo w/ 3 or more weeks abstinence	Consider for use in those with cocaine use disorder and co-occurring disorders	Major Depression & Tobacco use Disorder
Topiramate	Anticonvulsant, Blocks Voltage-dependent Na channels, Increase GABA receptor activity, Antagonizes Na Glutamate receptors, etc	Mixed evidence • MA- Higher rate of continuous cocaine abstinence over 3 wks compared to placebo	Side effects cognitive & paresthesia, appetite suppression Consider for those with AUD and Cocaine use Disorder	FDA Approved for Epilepsy & migraine Can reduce alcohol use

<https://www.asam.org/quality-care/clinical-guidelines/stimulant-use-disorders>

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Amphetamine-Type Stimulant Use Disorder (ATS) Pharmacotherapies (<i>not FDA approved</i>)			
Medication	Results	ASAM Recs	Treats Co-occurring disorders
Bupropion	Not effective alone for Amphetamine-Type Stimulant Use Disorder (ATS) ¹	Could consider for those who use less than 18 days/month and have tobacco use	Major Depressive Disorder Tobacco Use Disorder
Bupropion and XR-Naltrexone	Reduced amphetamine-type stimulant use ¹ • 1 open label study • 1 RCT	Consider for those with ATS and Major Depressive Disorder / AUD / Tobacco use Disorder (TUD) high doses of naltrexone (450 mg XR formulation) used in the studies XR/ATS: FDA approved for 4 weeks in AUD and OUD but RCT used 13 weeks	XR/ATS: FDA approved for OUD and AUD
Topiramate	Mixed evidence ² • 2 RCTs showed reduction in ATS compared to placebo • 1 RCT did not improve abstinence	Side effects have to be monitored (see cocaine use disorder table) Can consider in those with ATS and AUD	Epilepsy - Migraine
Mirtazapine	Mixed • MA and SR showed no reduction in ATS use ¹ • 2 placebo controlled RCTs showed small reductions in ATS use also reduction in sexual risk behaviors (both studies in MSM) • 1 large phase 3, parallel-group, double-blind, placebo-controlled RCT for persons with Methamphetamine Use Disorder Randomized to Mirtazapine (30mg daily for 12 weeks) or equivalent placebo and there was a statistically significant reduction in stimulant use with Mirtazapine ²	Consider in those with co-occurring depression	Major Depressive Disorder

1. <https://www.asam.org/quality-care/clinical-guidelines/stimulant-use-disorders>
2. McKetin N et al. Mirtazapine for Methamphetamine Use Disorder A Randomized Clinical Trial. JAMA Psychiatry. 2020;83(6):581-589. (PubMed: 31999548) Slide 61

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Emerging Treatment for SUDs: GLP1 RAs

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GLP1 RAs As Potential Treatment for AUD

- Phase 2 double blind parallel-arm RCT of N=48 non-treatment seeking adults with AUD
- Semaglutide (0.25mg/ wk x 4 wks , 0.5mg/wk x 4 wks, 1.0mg x 1wk or placebo weekly
- Primary outcome was amount of alcohol consumed

Alcohol consumption (g)

Group	Alcohol consumption (g)
Semaglutide	~45
Placebo	~65

P=0.01

Changes in drinks per drinking day

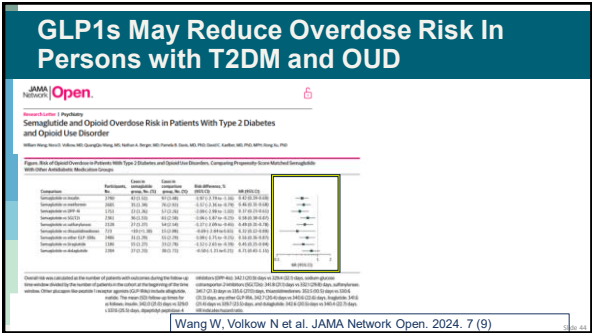
Week	Semaglutide (drinks/day)	Placebo (drinks/day)
Baseline	~1.5	~1.5
1	~1.2	~1.4
2	~1.1	~1.3
3	~1.0	~1.2
4	~0.9	~1.1
5	~0.8	~1.0
6	~0.7	~0.9
7	~0.6	~0.8
8	~0.5	~0.7

P=0.04

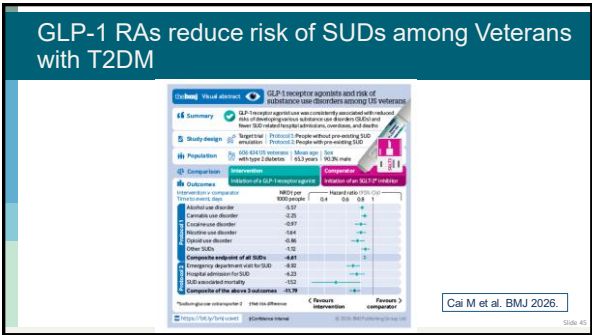
Hendershot C et al. JAMA Psychiatr. 2025

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ALWAYS PROVIDE HARM REDUCTION SUPPLIES & EDUCATION

- Overdose: Naloxone Prescriptions
- Provide training on how to recognize overdose & administer naloxone for patients and their loved ones/ friends/partners
- Drug Testing Strips (fentanyl and xylazine)
- Syringe Service Programs (SSPs)
- Safe injection education & supplies
- Safe injection sites

What You Can Do to Test for Fentanyl

TEST FOR

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STEP 4

Overcome Barriers to Help Patients Initiate Treatment & Retain in Care

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Patient Barriers to Accessing SUD and HIV Prevention and Treatment

1. Lack of transportation: URBAN and RURAL settings
2. Housing instability
3. Poverty
4. Lack of Insurance
5. Lack of communication (cell phones)
6. Lack of personal identification
7. Substance use that interferes with healthcare
8. Mental illness
9. Lack of ability to find pharmacy, pay for medications or pharmacy may not carry meds
10. Stigma
11. Difficulty identifying where to go or who to go to....



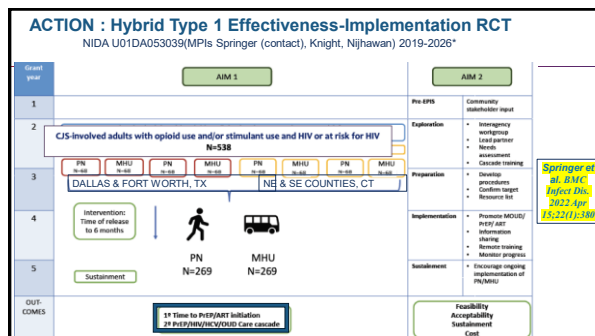
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How do we Overcome Barriers?



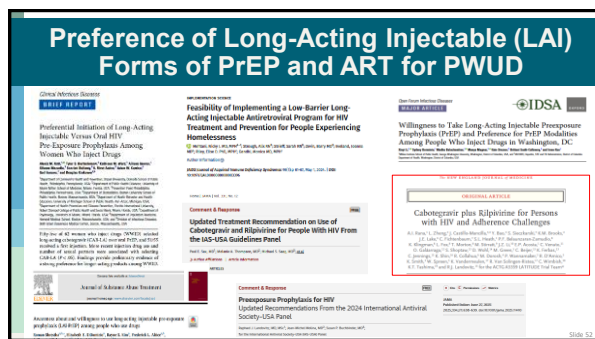
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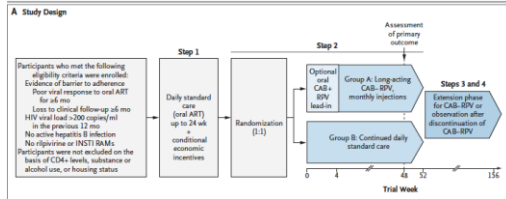
Mobile Health Unit participants were 3X more likely to start ART/PrEP than those assigned a Patient Navigator.

Of PrEP initiators: 45% on the Mobile Health Unit started **LAI PrEP** vs 0% in the Patient Navigator group

1. Springer et al. Abstract 1071. Conference on Retroviruses and Opportunistic Infections (CROI). Denver, CO. February 22-25, 2026.
2. Springer et al. Abstract 247. **IdWeek**. Washington, DC. October 21-24, 2026



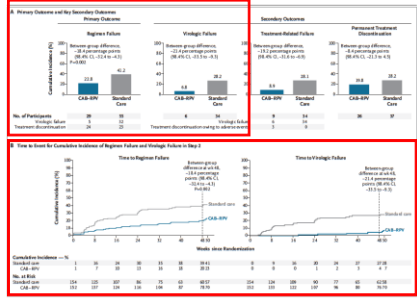
LATITUDE Trial (ACTG A5359): LAI CAB-RPV vs Daily oral ART for PWH with Adherence Challenges



Rana A et al. NEJM 2026; 394:848-71. Slide 54

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LATITUDE Trial: Primary Outcome



Rana A et al. NEJM 2026; 394:848-71. Slide 55

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What about access to the medications?



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First Legalized Mobile Retail Pharmacy and Clinic In the United States to Provide ART, PrEP & SUD Treatment Where People Live

Mobile Health Clinic

- Primary Clinical care
- Screening for substance use disorders (alcohol, opioid, and stimulant)
- Mental health
- Rapid testing for HIV and Hepatitis C
- Social services



Mobile Retail Pharmacy

Over 400 Medications

- ART/PrEP (LAI & Oral)
- MOUD (Buprenorphine, LAI/TM)
- XR-NTX
- Psychiatric illness
- Antibiotics
- Diabetes
- Hypertension etc.
- Vaccinations

Mobile RETAIL Pharmacy and Clinic

1. Springer SA. J Gen Intern Med. 2023.
2. Tarifa A... Springer SA. OFID. 2025.
3. Springer SA et al. CROI Feb 2026.

NIDA Avant Garde Award:
2019-2020, 2022-2027
PI: Sandra Springer, MD

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Summary

- Substance use and SUDs are prevalent among PWH and those at risk for HIV
- Screening, Diagnosing and Treating SUD can improve SU & HIV outcomes
- Understanding and overcoming barriers to access HIV testing/ PrEP/ART & SUD tx is essential to end HIV.
- Provision of medications, including LAI formulations, to people where they want services is essential.

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Other Resources



IAS-USA

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The IAS-USA Annual Update on HIV Management in Chicago, Illinois (Offered In-Person and Virtually), October 15, 2026 Page 19

2025 Manuscript Mobile Pharmacy and Clinic Pilot Findings

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On the IAS-USA Website:

MATE ACT Free CME Webinars: HIV and SUD

*(MATE Act = Medication Access & Training Expansion)

A ONE TIME 8-HOUR TRAINING IS REQUIRED FOR ALL PRACTITIONERS WHO HAVE A DEA REGISTRATION (CONTROLLED SUBSTANCE LICENSE)



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National Substance Use Warmline

- Cost-free, confidential clinician-to-clinician tele-consultation
- Staffed by addiction medicine and HIV specialist physicians, clinical pharmacists, and advanced practice nurses

9:00 AM – 8:00 PM Eastern Time Monday – Friday
(855) 300-3595 | Submit cases online

<https://nccc.ucsf.edu/clinician-consultation/substance-use-management/>

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HIV Prevention and Treatment Guidelines that include SUD Management

DHHS

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IAS-USA

Gandhi RT, et al. JAMA. 2025. [Published online Dec 1, 2024]

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Q and A Session

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