



The Intersection of HIV and Substance Use:

Enhancing the Care Continuum with Evidence-Based Practices

Training Series: Day 1
June 16, 2026

WELCOME!



Shea Grutemaro
(they/them)

*Program Officer | HIV Community Services
Unit*

Minnesota Department of Human Services

YOUR TRAINING TEAM



**Charles
Robbins, MBA**

(he/him/his)

Principal

Health
Management
Associates



**Helen
DuPlessis, MD,
MPH**

(she/her/hers)

*Physician
Principal*

Health
Management
Associates



**Anika Alvanzo,
MD, MS, FACP,
DFASAM**

(she/her/hers)

*Physician
Principal*

Health
Management
Associates



**Rachel
Johnson-Yates,
MA, LMHC, LAC**

(she/her/hers)

*Associate
Principal*

Health
Management
Associates

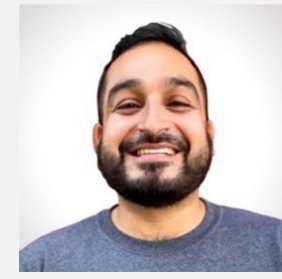


**Rob Muschler,
MPA**

(he/him/his)

*Senior
Consultant*

Health
Management
Associates



**Gabriel
Velazquez,
MPH**

(he/him/his)

Consultant

Health
Management
Associates

HOUSEKEEPING

Today is Session 1 and Session 2.

Please complete the evaluation for the training that will be sent out via email after each day.

You will be receiving a PDF of today's presentation.

Bio breaks at anytime. Lunch will be served between session 1 and 2.

Follow-up questions?

Contact Gabriel Velazquez:
gvelazquez@healthmanagement.com

CEUS ELIGIBILITY AND DISTRIBUTION

- » This series is eligible for CEUs
 - » These activities have been approved for CEUs by the Minnesota Board of Behavioral Health and Therapy for a total of 12 hours (if fully attended) for LADCs and LPC/LPCCs
- » To qualify for CEUs, you are required to
 1. Complete the pre-training quiz
 2. Be in attendance for the entire session
 3. Complete the accompanying evaluation survey for each session attended
 4. Complete the post-training quiz
- » CEU certificates will be issued approximately 1-2 weeks AFTER the completion of the training.
- » Any follow-up questions, please contact Gabriel Velazquez:
gvelazquez@healthmanagement.com

ACKNOWLEDGMENTS

We would also like to thank our community partners for their support in developing this curriculum.



Indigenous Peoples Task Force



LAND ACKNOWLEDGMENT



Every community owes its existence and vitality to generations from around the world who have contributed their hopes, dreams, and energy to making the history that led to this moment. Some were brought here against their will, some were drawn to leave their distant homes in hope of a better life, and some have lived on this land for more generations than can be counted. Truth and acknowledgment are critical to building mutual respect and connection across all barriers of heritage and difference.

We begin this effort to acknowledge what is buried by honoring the truth. We are standing on the ancestral lands of the Dakota people. **We want to acknowledge the Dakota, the Ojibwe (pronounced ow-jeeb-way), the Ho Chunk, and the other nations of people who also call this place home.** We pay respects to their elders past and present.

Please take a moment to consider the treaties made by the Tribal nations that entitle non-Native people to live and work on traditional Native lands. Consider the many legacies of violence, displacement, migration, and settlement that bring us together here today. Please join us in uncovering such truths at any and all public events.*

*This is the acknowledgment given in the USDAC Honor Native Land Guide – edited to reflect this space by Shannon Geshick, MTAG, Executive Director Minnesota Indian Affairs Council

DISCLOSURES

Faculty	Nature of Commercial Interest
Helen DuPlessis, MD, MPH	Dr. DuPlessis discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of health care clients. She is also a Board Member of Blue Shield of California Health Plan.

AGENDA FOR TRAINING SERIES

Session	Topics
#1 TUESDAY, JUNE 16 9:00 am to 12:00 pm	☐ Understanding HIV ☐ HIV Testing, Treatment and Prevention ☐ The Science of Addiction ☐ Screening and Assessment
#2 TUESDAY, JUNE 16 12:30 pm to 4:00 pm	☐ Ethical and Legal Issues ☐ Funding and Policy Considerations ☐ HIV Risk Reduction ☐ SUD Harm Reduction ☐ HIV and Stigma ☐ Pregnancy and HIV, SUD/ODU
#3 WEDNESDAY, JUNE 17 9:00 am to 12:00 pm	☐ Working with Justice Involved Persons ☐ Substance Use Disorder Treatment with Medications ☐ Mental Health Treatment and Counseling ☐ Stimulant Use ☐ Chem Sex
#4 WEDNESDAY, JUNE 17 12:30 pm to 4:00 pm	☐ Cultural, Racial and Sexual Identities ☐ Motivational Interviewing ☐ Accessing, Obtaining, and Integrating Services for Individuals with HIV and SUD in Minnesota

TIME FOR A POLL

Join at menti.com | use code 3549 3034

As we start today's training, what is one curiosity or question you're bringing with you about the topic?

Responses can be up to 200 characters and will appear here.

You can group responses if you get more than 10.

Turn on voting so people can flag their favorite responses.

 Mentimeter

GV ▾

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Topics

- Understanding HIV
- HIV Testing and Treatment
- The Science of Addiction
- Screening, and Assessment
- Ethical and Legal Issues
 - Funding and Policy Considerations
 - HIV Risk Reduction
- SUD Harm Reduction
 - HIV and Stigma
- Motivational Interviewing

SMALL BREAKOUT GROUPS

**GET TO KNOW YOUR TRAINING
COLLEAGUES**



BREAKOUT ACTIVITY

“GET TO KNOW YOUR COLLEAGUES”

INSTRUCTIONS

- >> Step 1: Turn to 3-4 people seated near you. No need to move – just group up with those within easy talking distance.
- >> Step 2: You’ll have 5 minutes. Each person will share the following:
 - >>Name
 - >>Your pronouns
 - >>One thing you’d like others to know about you that relates to this training
- >> Step 3: When the timer goes off, please wrap up your conversation and shift your attention back to the front

THE INTERSECTION OF HIV AND SUD

CONTEXT FOR THE INTERSECTION OF HIV & SUD

Substance use disorder (SUD) is frequently diagnosed among people with HIV.

SUD also increases risk for acquiring HIV infection.

The federal Health Resources and Service Administration (HRSA) recognizes the benefit of substance abuse treatment service for people with HIV and classifies outpatient treatment as a core medical service.



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CONTEXT FOR THE INTERSECTION OF HIV & SUD

Tremendous biomedical advancements in HIV prevention and treatment have led to aspirational efforts to end the HIV epidemic.

However, this goal will not be achieved without addressing the significant mental health and substance use problems among people living with HIV (PLWH) and people vulnerable to acquiring HIV.

These problems exacerbate the many social and economic barriers to accessing adequate and sustained healthcare.



GLOSSARY OF TERMS

- » Sexual orientation – a person’s identity in relation to the gender or genders to which they are sexually attracted (straight, gay, lesbian, asexual, bisexual, pansexual)
- » Gender identity and/or expression - internal perception of one’s gender; how one identifies or expresses oneself.
 - » Cisgender – a term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth
 - » Transgender – refers to an individual whose current gender identity and/or expression differs from the sex they were assigned at birth (may have transitioned or be transitioning in how they are living)
 - » Gender Expansive - refers to an individual who expresses identity along the gender spectrum (genderqueer, gender nonconforming, nonbinary, agender, two spirit)
- » Sexual Minority – refers to a group whose sexual identity orientation or practices differ from the majority of and are marginalized by the surrounding society.

GLOSSARY OF TERMS

- Race - is usually associated with inherited physical, social and biological characteristics. In this context that means race is associated with biology. Institutionalized in a way that has profound consequences (White, African American, American Indian Alaskan Native, Native Hawaiian or Pacific Islander)”
- Ethnicity - a term used to categorize a group of people with whom you share learned characteristics and identify according to common racial, national tribal, religious, linguistic, or cultural origin or background. (Hispanic, Non-Hispanic Black, etc.)

SOURCE: US Office of Management and Budget: Federal Register Vol. 62(210): 58782

GLOSSARY OF TERMS

- » Health Insurance Portability and Accountability Act (HIPAA) - required the creation of national standards to protect sensitive patient health information (PHI) from being disclosed without the patient's consent and includes a Privacy Rule addressing disclosure of and access to PHI; the Security Rule protects disclosure of and access to electronic PHI (e-PHI) a subset of information covered by the Privacy Rule
- » Code of Federal Regulations, Title 42, Part 2 (42 CFR Part 2) – a complicated set of regulations that strengthen the privacy protections afforded to persons receiving alcohol and substance use treatment (in addition to the more general privacy protections afforded in HIPAA). The regulations restrict the disclosure and use of alcohol and drug patient records which are maintained in connection with any individual or entity that is federally assisted and holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment (42 CFR § 2.11)
- » Family Education Rights Protection Act (FERPA) - protects the privacy of student education records in public or private elementary, secondary, or post-secondary school and any state or local education agency that receives funds under an applicable program of the US Department of Education.

SOURCE: Centers for Disease Control and Prevention; and the Substance Abuse and Mental Health Services Administration

COMMON ACRONYMS

ART – Antiretroviral therapy

AUD – Alcohol use disorder

IDU – Injection or intravenous drug use

MSM – Men who have sex with men

OD – Opioid use disorder

PEH – Person(s) experiencing homelessness

PEP – Post-exposure prophylaxis

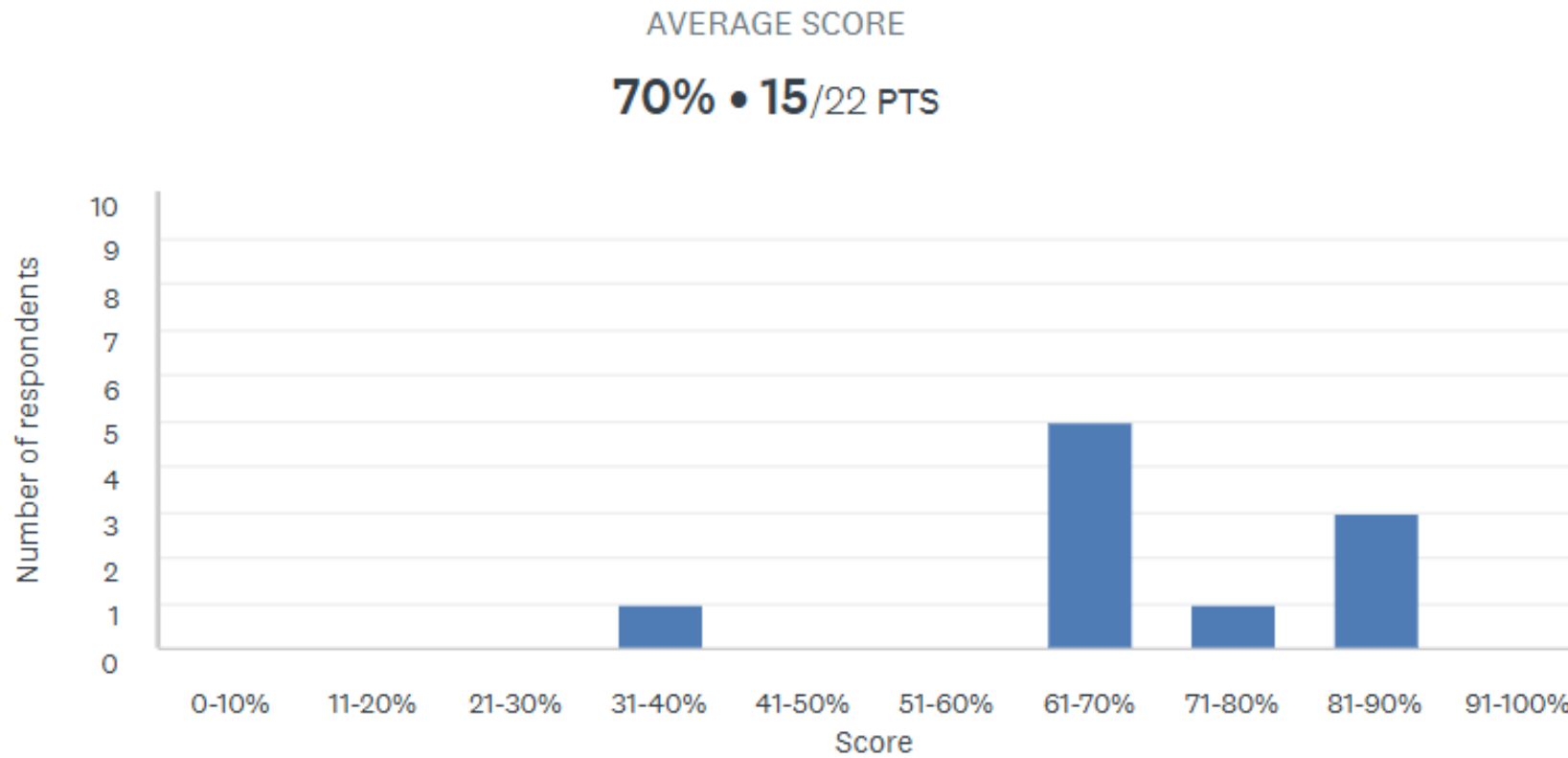
PrEP – Pre-exposure prophylaxis

PLWH – Person(s) living with HIV

PWID – Person(s) who injects drugs

SUD – Substance use disorder

PRE-TEST RESULTS (N=10)



TIME FOR A POLL

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What is the role that best describes your work?

- ☐ Administration/Programs
- ☐ Counselor/Therapist/LADC
- ☐ Case Manager
- ☐ Harm Reduction/Peer Recovery
- ☐ Nurse/Physician
- ☐ Probation Officer/Justice Involved
- ☐ Sexual Health/Community Health Worker
- ☐ Social Worker/Child Welfare/Housing
- ☐ Workforce/Skills Development



UNDERSTANDING HIV

LEARNING OBJECTIVES: UNDERSTANDING HIV

**Define and
distinguish
HIV and AIDS**

**Describe how
HIV causes
illnesses**

**Recognize
how HIV is
transmitted**

**Summarize
HIV
prevalence
and incidence
in Minnesota**

WHAT IS HIV?



HIV is the virus

- » **Human:** the virus can only infect human beings
- » **Immunodeficiency:** the virus destroys T-helper cells, an essential component of our body's immune system, leading to a deficiency in our body's ability to fight infection.
- » **Virus:** the organism is a virus which is incapable of reproducing by itself; it must use a human cell to reproduce.

WHAT IS HIV?

Characteristics

- Ribonucleic acid (RNA) virus
- Classified as retrovirus (the virus inserts a copy of its genetic material (RNA) into the DNA of a host human cell)
- Spread from person-to-person contact by contact with certain body fluids
- Weakens the immune system of a person by replicating inside T cells, a type of white cell also known as CD4 cells. The T cells are destroyed during this process.
- Once established, infection with HIV is chronic.
- HIV is the virus that causes AIDS.

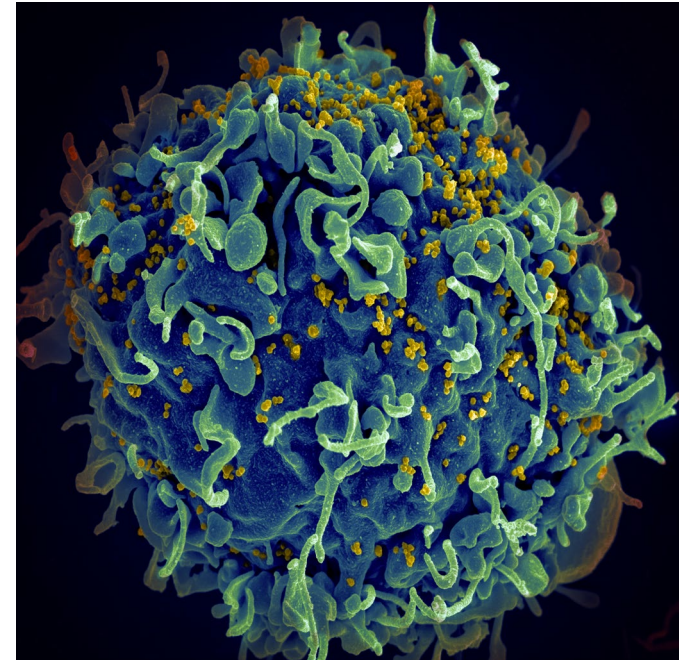
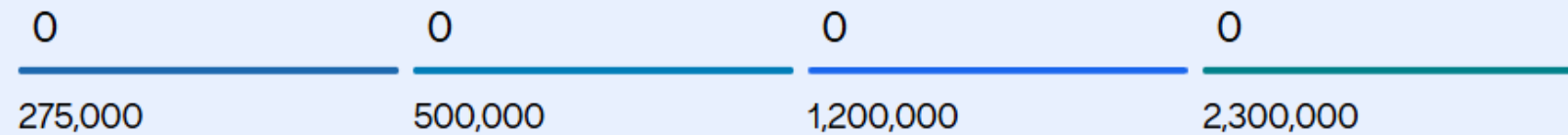


Photo Credit: National Cancer Institute on Unsplash

TIME FOR A POLL

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Approximately how many people in the United States are l



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HIV QUICK FACTS

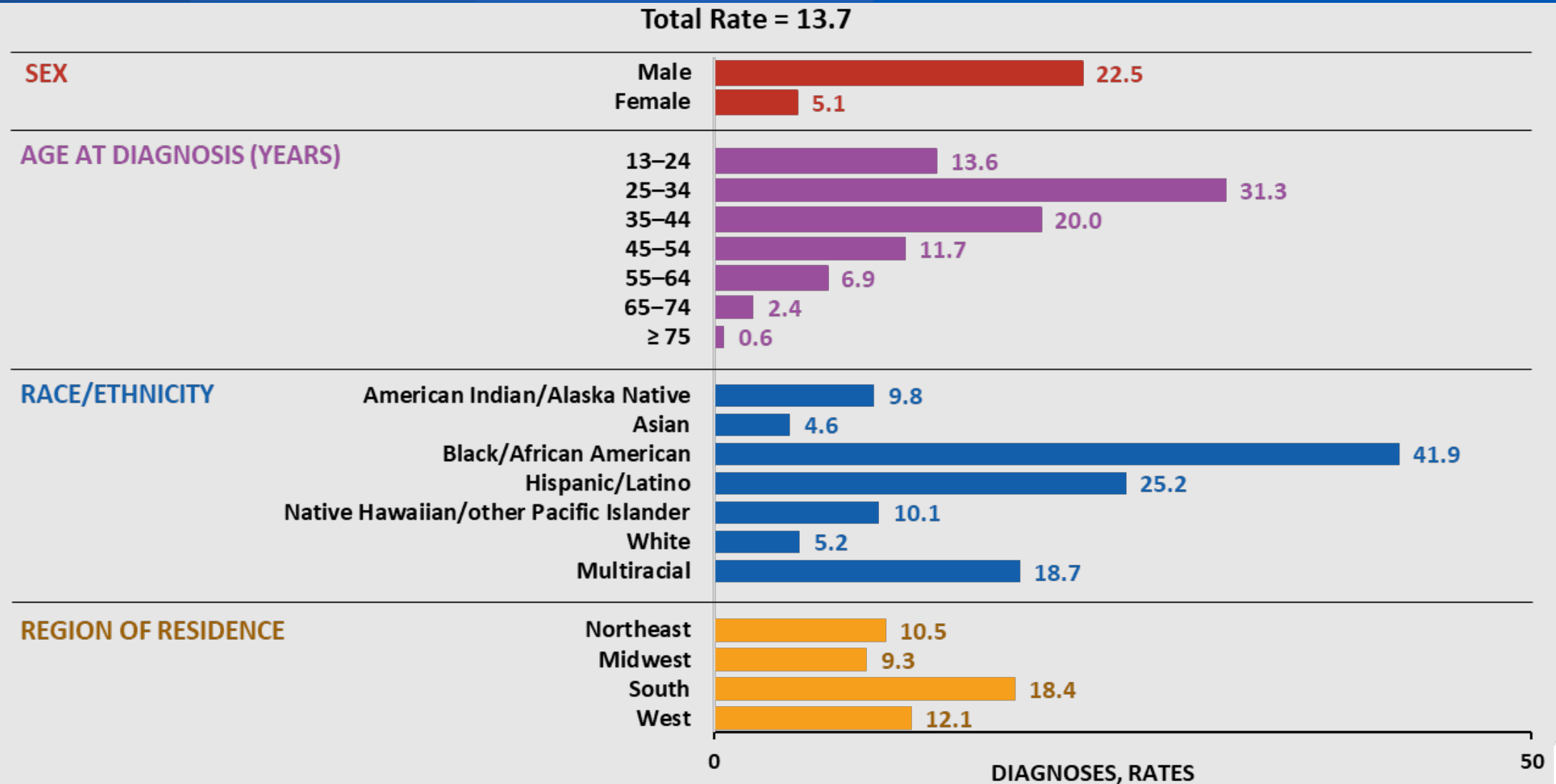
- HIV is a **chronic manageable infection**
- Approximately 1.2 million people are living with HIV in the United States
- In 2023, an estimated **39,000 new HIV infections** occurred in the United States.
- HIV continues to have a disproportionate impact on certain populations, particularly **racial and ethnic minorities and gay, bisexual, and other men who have sex with men.**

<https://www.hiv.gov/hiv-basics>

<https://www.cdc.gov/hiv-data/nhss/hiv-diagnoses-deaths-and-prevalence-2025.html#:~:text=At%20a%20glance,for%20more%20than%20a%20third.>

HIV DIAGNOSES, BY SELECTED CHARACTERISTICS, 2023—UNITED STATES

N=39,201

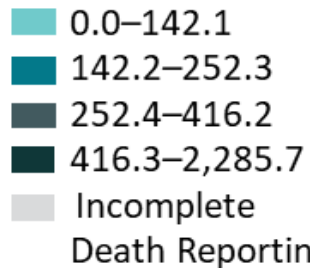


Note. Data are presented for persons aged ≥ 13 years at diagnosis. Rates are per 100,000. Hispanic/Latino persons can be of any race.

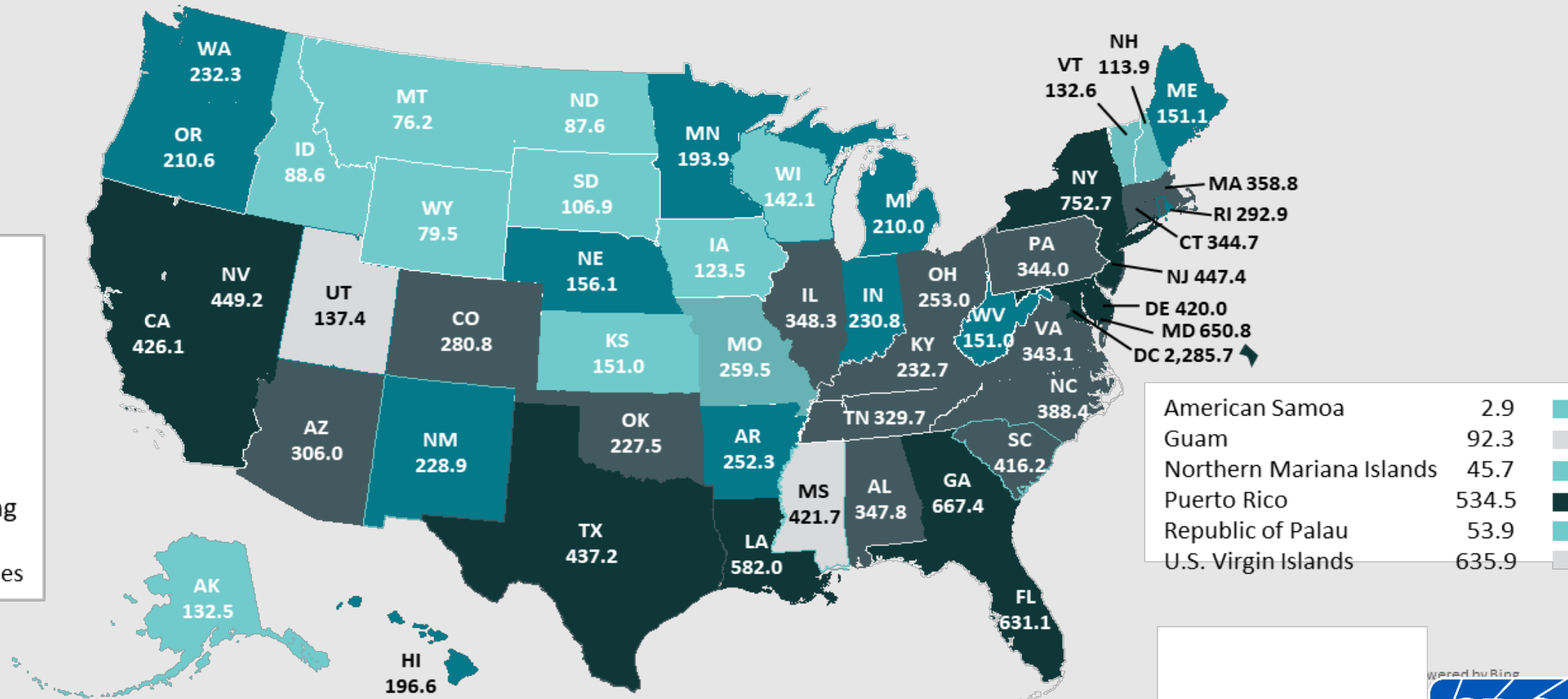
PERSONS LIVING WITH DIAGNOSED HIV (PREVALENCE), 2023—UNITED STATES AND 6 TERRITORIES AND FREELY ASSOCIATED STATES

N = 1,132,739
Total Rate = 394.5

Rates per 100,000
population



Data classified by quartiles



Note. Data are presented for persons aged ≥ 13 years at year-end 2023. Prevalence data should be interpreted with caution due to use of preliminary death data for the year 2023 reported to CDC as of December 2024.

WHAT IS AIDS?

» AIDS is the disease:

- » **Acquired:** HIV is not a condition passed on genetically; a person must become infected with it
- » **Immune:** the immune system's ability to fight off viruses and bacteria becomes much less effective
- » **Deficiency:** the immune system fails to work properly
- » **Syndrome:** there are a wide range of diseases and opportunistic infections a person may experience once the immune system is depleted by HIV

WHAT IS AIDS?

- It is a complex illness with a wide range of symptoms
- AIDS refers to individuals who have particular "AIDS–defining" disease such as:
 - a very low CD4 white blood cell count
 - specific illnesses acquired due to the weakened immune system (e.g., Burkitt's lymphoma, Kaposi sarcoma, pneumocystis pneumonia, toxoplasmosis, wasting syndrome)

STAGES

1. Acute HIV infection

- » HIV establishes infection in the body via replication within 11 days of initial acquisition
- » During acute infection, virus levels in the blood are very high.
- » Very contagious
- » Flu-like symptoms
- » ~ 50% of individuals will feel ill during acute infection

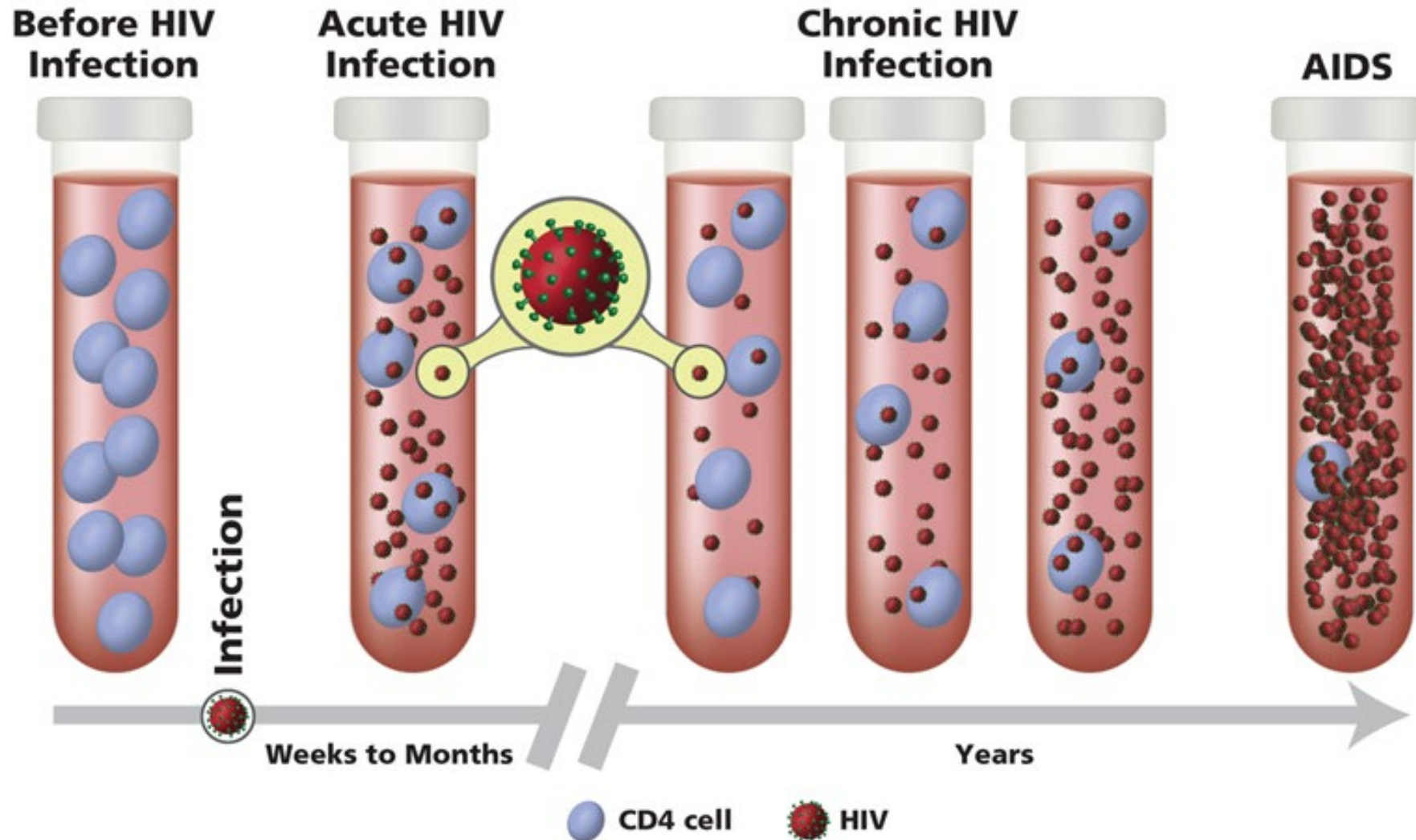
2. Chronic HIV infection

- » Asymptomatic or latent
- » Virus is active but is replicating at low levels
- » May last years
- » Viral load increases, CD4 count decreases

3. AIDS

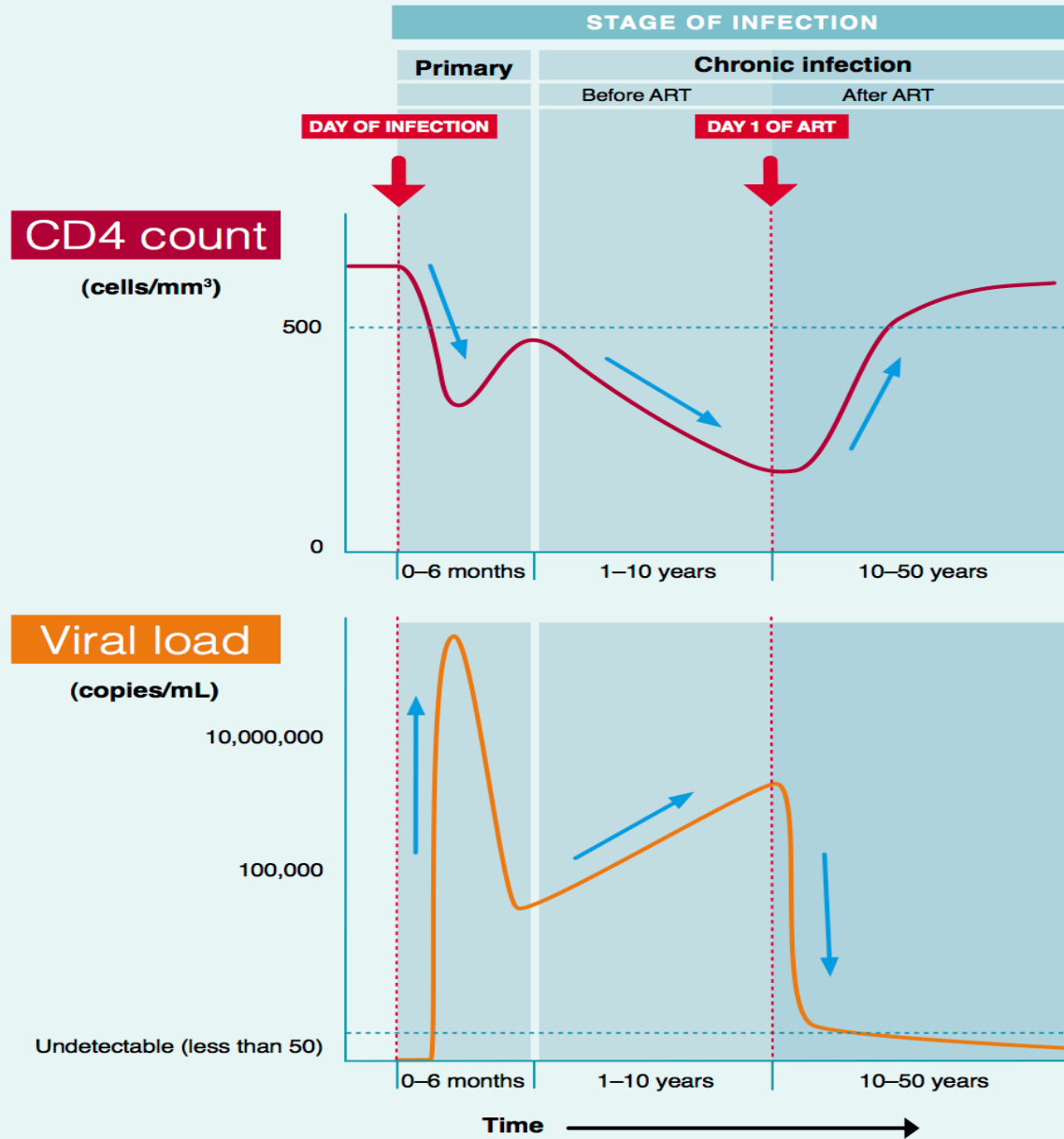
- » CD4 < 200 cells per cubic millimeter or opportunistic infections
- » Can have high viral load and be infectious

HIV Progression



STAGES

The natural history of HIV without ART



SYMPTOMS OF HIV DURING ACUTE INFECTION

» Fevers

» Chills

» Rash

» Night sweats

» Muscle aches

» Sore throat

» Fatigue

» Swollen lymph nodes

» Mouth ulcers

**HIV CAN NOT BE DIAGNOSED BY SYMPTOMS,
PARTICULARLY THOSE SIMILAR TO OTHER ILLNESSES**

CHRONIC INFECTION

- » Once acquired, HIV is a lifelong infection
- » There is no cure for HIV, but the infection can be controlled with medications much like diabetes.
- » With treatment, the life expectancy of people with HIV is nearly the same as those who do not have HIV.
- » Without treatment, most people living with HIV infection will go on to develop AIDS.

LATENT HIV RESERVOIR

- Group of immune cells in the body that are infected with HIV but are not actively producing new HIV virus
- HIV medications do not affect these cells
- If a person stops taking their HIV medications, the infected cells in the reservoir can begin making new HIV virus

Source: <https://hivinfo.nih.gov/understanding-hiv/fact-sheets/what-latent-hiv-reservoir>

GROUP DISCUSSION

What information do you need to better prepare you to work with or care for individuals who are living with HIV?



Please raise your hand if you'd like to share.

REFERENCES

UNDERSTANDING HIV

- >> “About HIV/AIDS.” Centers for Disease Control and Prevention, <https://www.cdc.gov/hiv/basics/whatishiv.html>.
- >> “The Stages of HIV Infection.” National Institutes of Health, U.S. Department of Health and Human Services, <https://hivinfo.nih.gov/understanding-hiv/fact-sheets/stages-hiv-infection>.

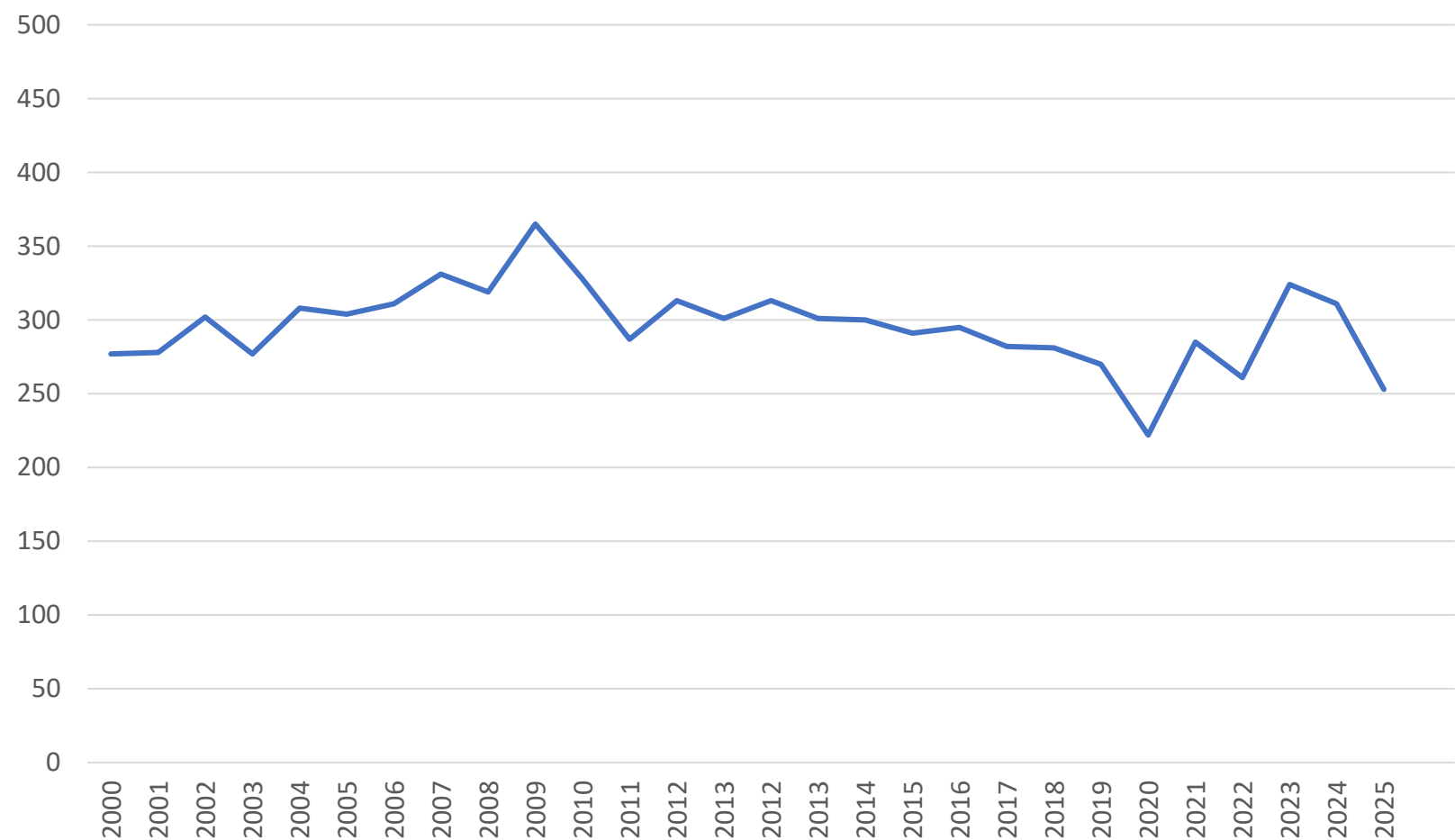
HIV AND SUD IN MINNESOTA

HIV INCIDENCE AND PREVALENCE IN MINNESOTA

- » In 2025, there were 253 newly diagnosed HIV infections reported to MDH. This is a 19% decrease from 2024 (312). While diagnoses decreased from 2023 and 2024, the 2025 total is consistent with pre-COVID incidence trends: 295 in 2016, 279 in 2017, 277 in 2018, and 268 in 2019
- » The number of reported people living with HIV/AIDS in Minnesota is **9,588**.
- » HIV Disparities Persist in Minnesota
 - » Communities of color represented 68% of new HIV diagnoses in Minnesota in 2025.
 - » Incidence rates remained highest among Black African-born people at 34.3 per 100,000, Black African-American people at 17.0 per 100,000, and Hispanic people at 15.8 per 100,000, compared to 1.8 per 100,000 among white people in Minnesota.

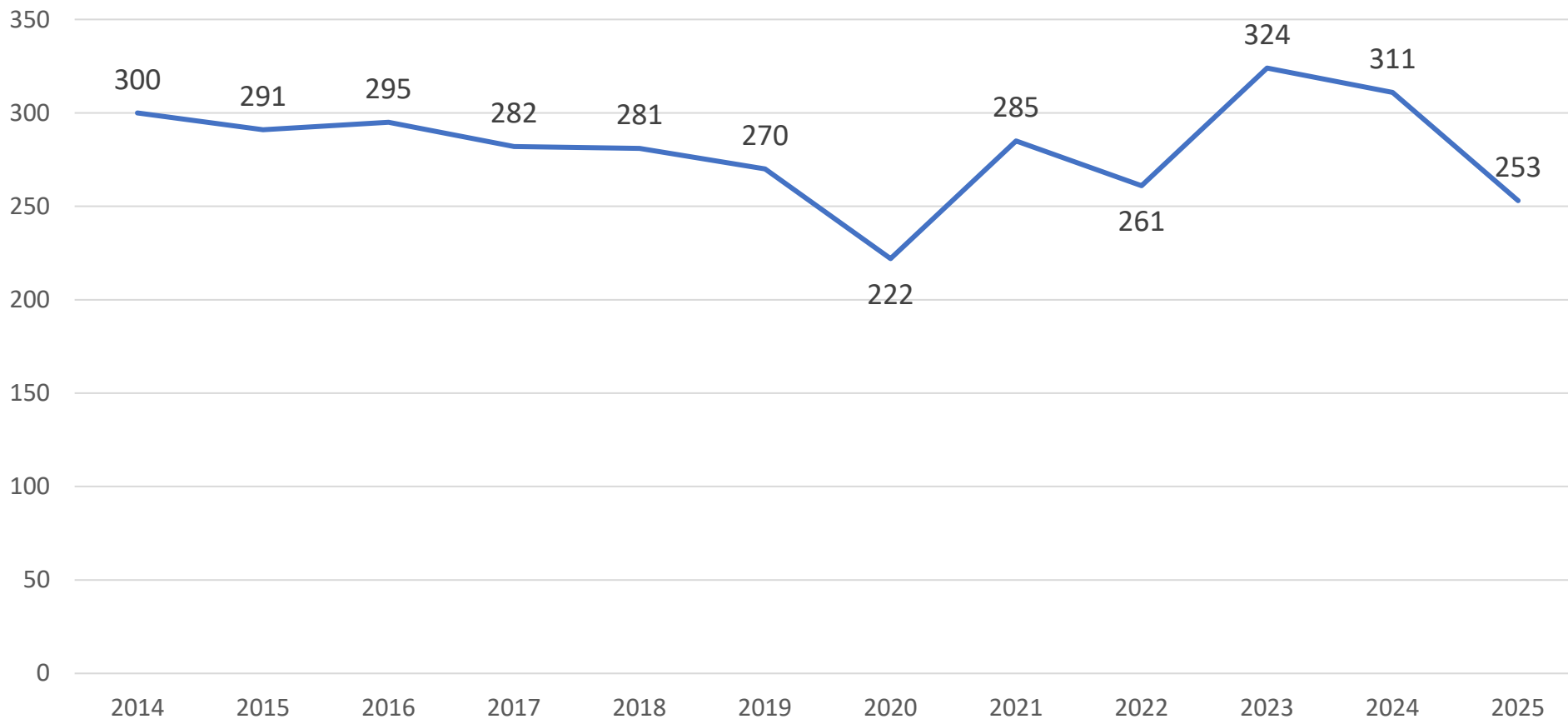
HIV INCIDENCE IN MINNESOTA, 2000-2025

New HIV diagnosis, 2000-2025



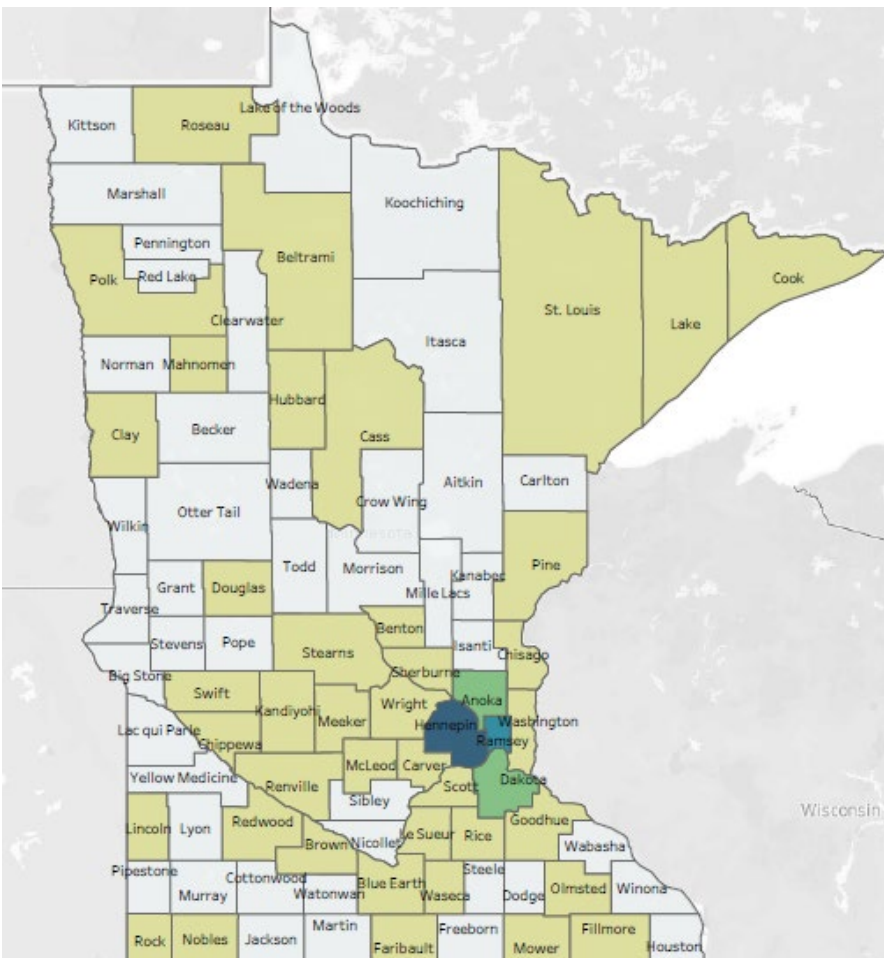
HIV INCIDENCE IN MINNESOTA, 2014-2023

New HIV disease diagnosis, 2014-2025



HIV INCIDENCE IN MINNESOTA BY COUNTY

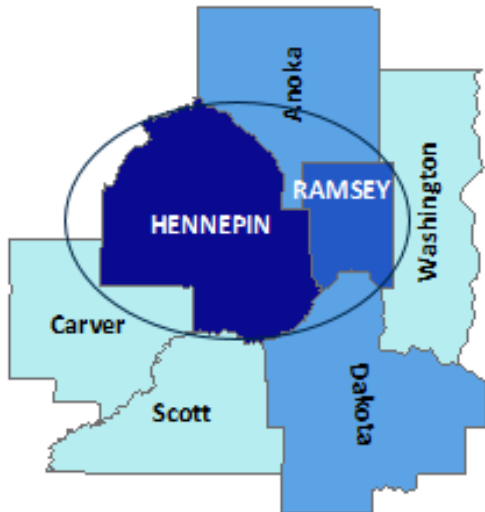
HIV Diagnoses # by County of Residence at Diagnosis, 2025



City of Minneapolis
City of St. Paul
Suburban*
Greater Minnesota
Total

46 cases (23%)
23 cases (12%)
73 cases (37%)
56 cases (28%)
198 cases

HIV OUTBREAK IN HENNEPIN/RAMSEY COUNTIES



- » In February 2020, MDH Health Alert Network declared an outbreak among persons who inject drugs (PWID)
- » Current Case Count: 240 cases
- » Inclusion Criteria:
 - » 106 encampment-related
 - » 134 MSM/IDU & IDU non-encampment

People at high-risk in the current outbreaks:

- » People who inject drugs (PWID) or share needles/works
- » People experiencing homelessness (PEH) or unstable housing
- » People who exchange sex for income or other items they need

HIV OUTBREAK IN DULUTH REGION



- » In March 2021, MDH Health Alert Network declared an outbreak in the Duluth Region (30-mile area) among newly diagnosed HIV cases
- » Current Case Count: 39 cases

People at high-risk in the current outbreak:

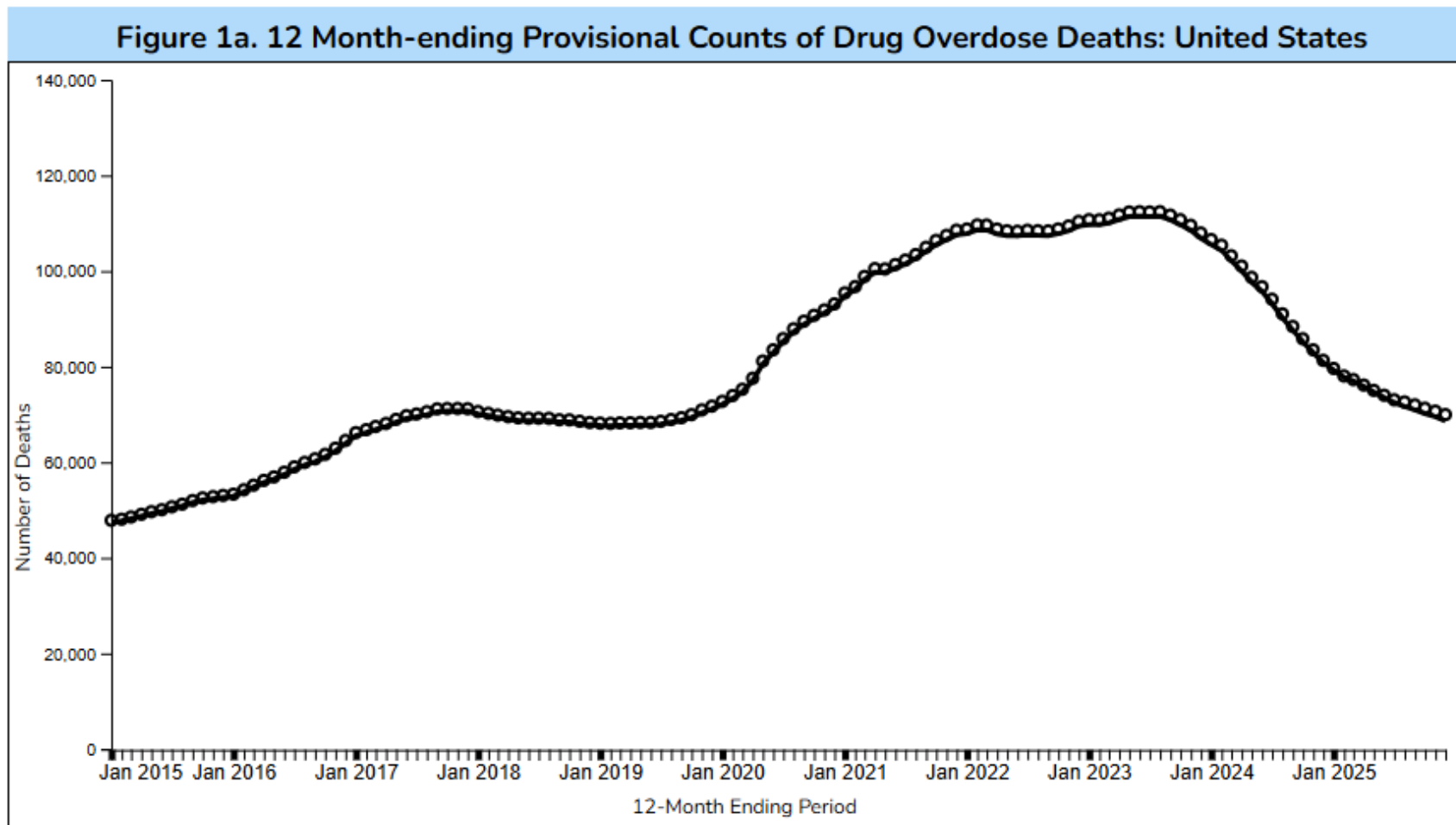
- » People who inject drugs (PWID) or share needles/works
- » People experiencing homelessness (PEH) or unstable housing
- » People who exchange sex for income or other items they need
- » Men who have sex with men

HIV OUTBREAK IN MINNESOTA

- Synergistic with opioid epidemic
- Injection drug use is often a secondary effect of the over-prescription of opioids for pain as a core feature of the opioid epidemic

UNITED STATES DRUG OVERDOSE DEATHS

Based on data available for analysis on: May 3, 2026



United States

September 2025: 70,966

October 2025: 70,202

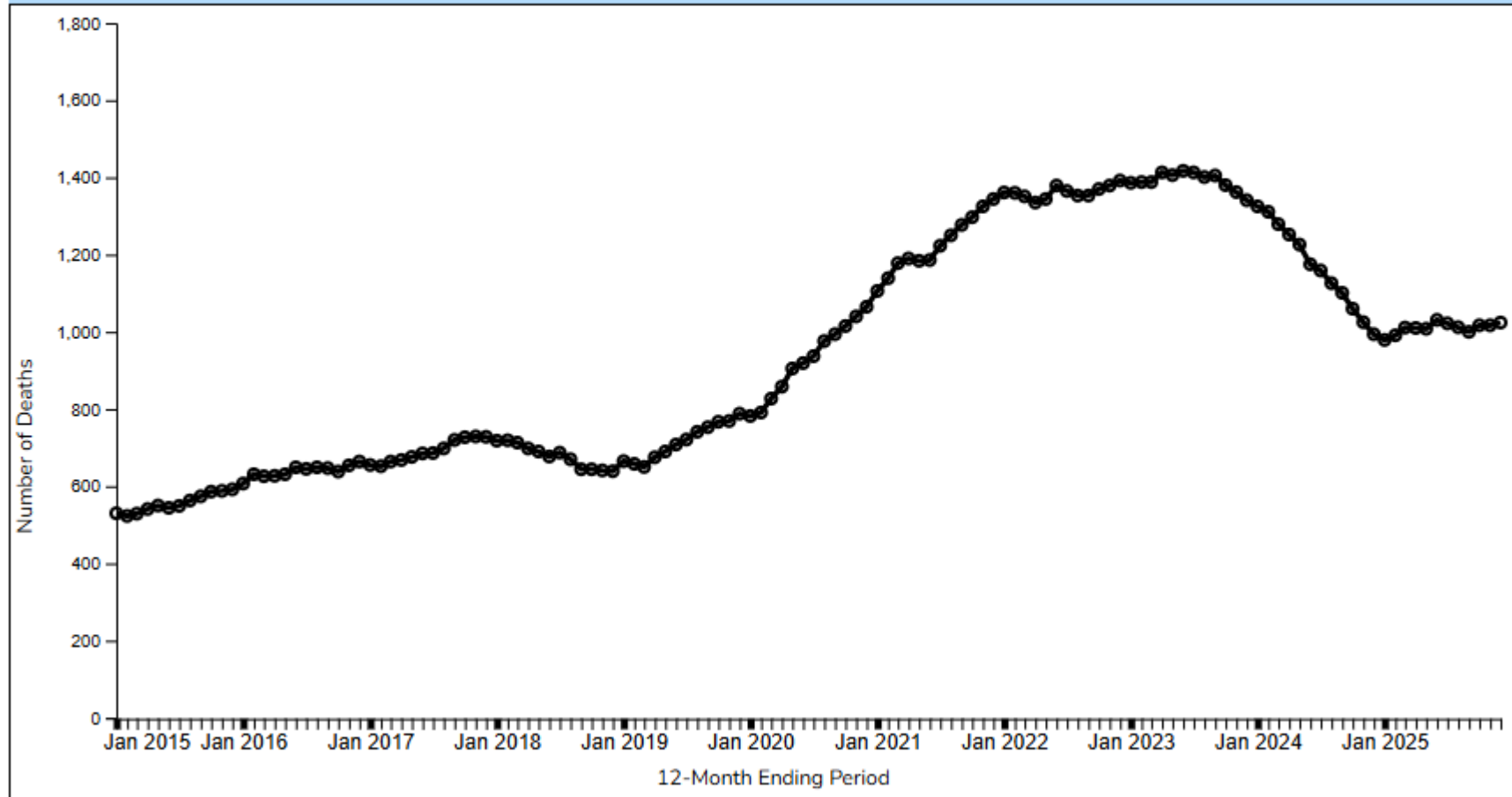
November 2025: 69,509

December 2025: 68,632

OVERDOSE DEATH MINNESOTA

Based on data available for analysis on: May 3, 2026

Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: Minnesota



Source: <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>

Minnesota

September 2025: 1,000

October 2025: 1,017

November 2025: 1,017

December 2025: 1,024

REFERENCES - HIV IN MINNESOTA

- >> Minnesota Department of Human Services: HIV Resources <https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/resources/>
- >> “How the largest known homeless encampment in Minneapolis history came to be,” *The Appeal*. July 15, 2020. <https://theappeal.org/minneapolis-homelessness-crisis-powderhorn-park-encampment/>
- >> “HIV Outbreak Response and Case Counts,” Minnesota Department of Health. <https://www.health.state.mn.us/diseases/hiv/stats/hiv.html>
- >> “ACLU Minnesota, Mid-Minnesota Legal Aid file lawsuit to stop sweeps of homeless encampments,” KARE 11. October 19, 2020. <https://www.kare11.com/article/news/local/aclu-mn-files-suit-over-homeless-encampment-sweeps/89-8d5f49b5-43bd-4602-899b-4fcbe6b7d65a>
- >> “HIV/AIDS Statistics,” Minnesota Department of Health. <https://www.health.state.mn.us/diseases/hiv/stats/index.html>
- >> “Health Advisory: HIV Outbreak and Syphilis Concern in Duluth Area,” Minnesota Department of Health. March 4, 2021. <https://www.health.state.mn.us/communities/ep/han/2021/mar4hiv.pdf>
- >> “Health Advisory: HIV Outbreak in Persons Who Inject Drugs (PWID),” Minnesota Department of Health. February 6, 2020. <https://www.health.state.mn.us/communities/ep/han/2020/feb3hiv.pdf>
- >> “Quick Facts: Minnesota,” U.S. Census. <https://www.census.gov/quickfacts/MN>

HIV TRANSMISSION

HIV TRANSMISSION

HIV is in:

- » Blood
- » Semen
- » Vaginal fluids
- » Anal fluids
- » Breast milk

HIV is **not** in:

- » Tears
- » Sweat
- » Insect bites
- » Utensils and dishes
- » Furniture, toilets, clothes

HIV TRANSMISSION

HIV must be present

- » One person must be currently infected with HIV

There needs to be ENOUGH virus

- » Concentration of HIV determines whether infection will occur
- » In the blood, the virus is very concentrated
 - » It can take a small amount of blood to infect someone
- » In bodily fluids like semen, vaginal and anal fluids, or breastmilk, virus levels can change overtime
 - » The chances of transmitting HIV may be lower for those with lower viral loads

HIV must get into the bloodstream

- » Infectious fluids:
 - » Blood
 - » Semen
 - » Vaginal secretions
 - » Anal fluids
 - » Breast milk
- » HIV can enter through:
 - » Open cut or sore
 - » Mucous membranes like the genitals, anus, and rectum
 - » Orally
 - » HIV cannot cross healthy, unbroken skin
- » Main transmission routes for the HIV virus:
 - » Unprotected sexual intercourse
 - » Sharing needles for IDU
 - » Mother to child transmission

SEXUAL TRANSMISSION

- » Most common HIV transmission route
- » Presence of other sexually transmitted infections can increase the risk of HIV transmission
- » Vaginal Sex
 - » The female is at the greatest risk because the lining of the vagina is a mucous membrane which can provide easy access to the bloodstream for HIV carried in semen
- » Anal Sex
 - » Without a condom, riskiest sexual activity for HIV
 - » Receptive partner is at greatest risk
 - » Cell wall of the rectum is very thin
 - » Anal tissue can be easily bruised or torn during sex which then provides easy access to the bloodstream for HIV carried in semen
 - » Insertive partner also at some risk as the membranes inside the urethra can provide entry for HIV

SEXUAL TRANSMISSION CONT.

>> Oral to Anal

- >> Poses minimal HIV risk

>> Oral sex

- >> Mouth is an unfriendly environment for HIV
- >> Saliva contains enzymes that break down the virus and the mucous membranes in the mouth are more protective than anal or vaginal tissue
- >> Risk only for the person performing the oral sex
- >> With a female partner - performing oral sex on a woman who is menstruating increases the risk because blood has more HIV than vaginal fluid

TIME FOR A POLL

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Approximately how many days can HIV survive in a syringe at room temperature?

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0 None

0 24 hours

0 5 days

0 10 days

0 21 days

0 42 days



NON-SEXUAL TRANSMISSION

- >> Typically involve medical settings or accident scenes
- >> Injection drug use
 - >> Very high risk for HIV transmission
 - >> Sharing a syringe is the most efficient way as it passes blood directly from one person's blood stream to another's
 - >> At **room temperature**, HIV can live as long as **21 days in a syringe**
 - >> When the temperature is **cold** (near freezing), HIV can live up to **42 days in a syringe**
 - >> An HIV-negative person has a **1 in 160** chance of getting HIV every time they use a needle that has been used by someone with HIV.
- >> Tattoos and piercings
 - >> No documented cases, but theoretical risk of transmission
- >> Mother to infant
 - >> By exposure to blood and vaginal fluids
 - >> During birth or through breast milk during feeding

Source: <https://news.yale.edu/2000/09/06/cooler-temperatures-enhance-survival-hiv-syringes>

Source: <https://www.cdc.gov/hiv/basics/hiv-transmission/injection-drug-use.html>

HIV AND HEPATITIS C (HCV) CO-INFECTIONS

- HCV is a bloodborne virus transmitted through direct contact with the blood of an infected person.
- Approximately 21% of people with HIV in the United States are coinfecting with HCV; among people with HIV who inject drugs, the prevalence of HCV coinfection can be as high as 80%. (CDC, 2024)
- In co-infected persons, age at time of HCV infection, immune cell (CD4) count and level of alcohol consumption are associated with a higher rate of liver fibrosis.
- Risk of HCV similar to those of HIV:
 - Injecting drug use (most common)
 - Long term hemodialysis
 - High risk sexual contact
 - Occupational exposures to blood or blood products
 - Transmission from HCV-infected mother to infant.

HIV AND HEPATITIS C CO-INFECTIONS

- » As of Dec. 31, 2024, there were **31,292** persons who were reported to MDH and are assumed alive and living in Minnesota with chronic hepatitis C virus (HCV)
 - » Includes acute, chronic, and probable chronic cases
- » The U.S. Public Health Service/Infectious Diseases Society of America guidelines **recommend that all HIV-infected persons be screened for HCV infection** (CDC, 2014).

REFERENCES - HIV TRANSMISSION

- >> “HIV and Injection Drug Use”, Centers for Disease Control and Prevention (2021), <https://www.cdc.gov/hiv/basics/hiv-transmission/injection-drug-use.html>.
- >> “How Is HIV Transmitted?”, HIV.govDate (2019), <https://www.hiv.gov/hiv-basics/overview/about-hiv-and-aids/how-is-hiv-transmitted>.

HIV TESTING AND TREATMENT

LEARNING OBJECTIVES: HIV TESTING AND TREATMENT

Explain HIV testing and methods, including testing and treatment policies in MN; Describe ART, what does ART stand for, and how it is used

Describe the relationship between substance use practices and increased risk of acquiring HIV

Explain the relationships between HIV and Hepatitis C

Describe the options and indications for pre- and post-exposure prophylaxis (PrEP and PEP) and treatment of HIV infection

HIV QUICK FACTS

- » Approximately 60% of adults in the United States **have never been tested** for HIV.
- » Nationally, less than 30% of people in the United States most at risk of acquiring HIV were tested in the past year (gay, bisexual and other MSM, transgender women, and IDU).
- » In the 50 local jurisdictions where more than half of HIV diagnoses occur, less than 35% of people recommended for annual HIV testing were tested in the past year.

<https://www.cdc.gov/media/releases/2019/p0627-americans-hiv-test.html>



GROUP DISCUSSION

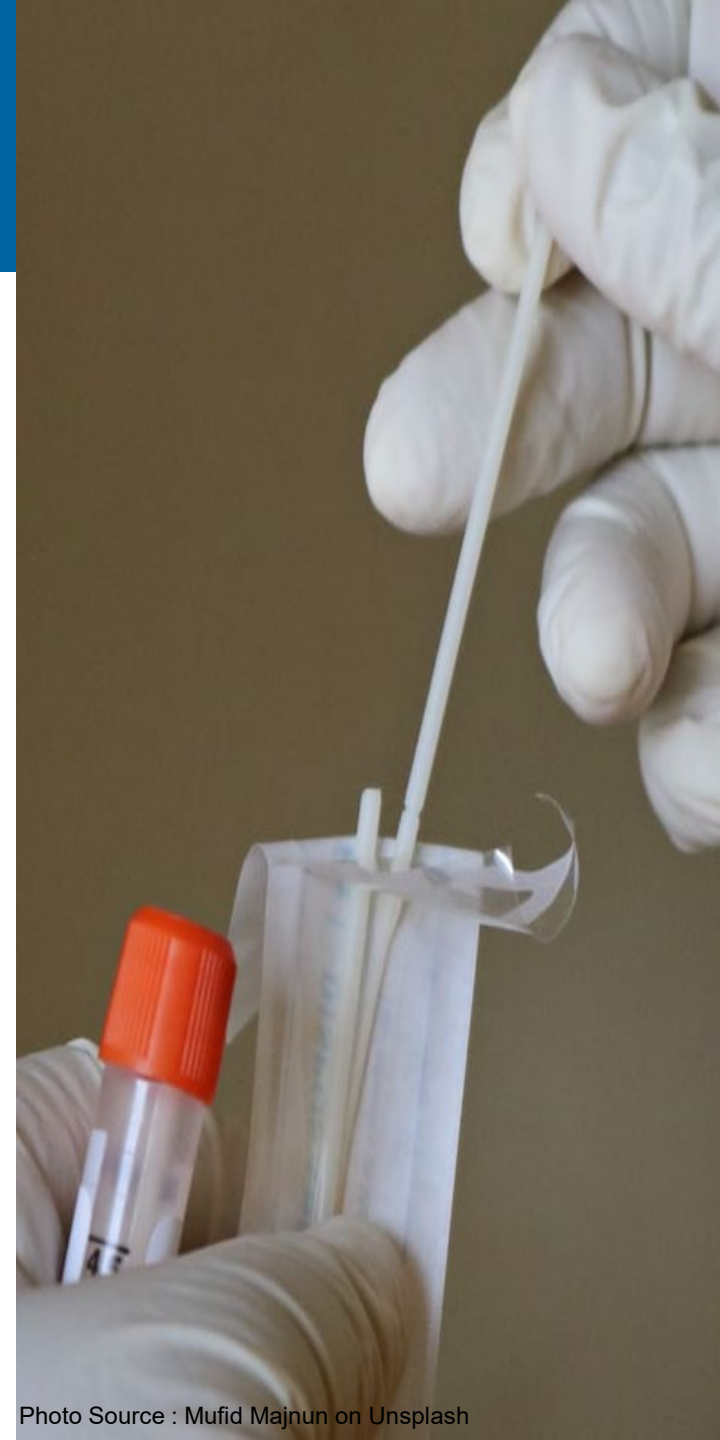
What myths or barriers exist that prevent more people from getting an HIV test?



Please raise your hand if you'd like to share.

HIV TESTING

- » First step in HIV diagnosis and preventing the spread of HIV
- » Testing is a crucial step in engaging people living with HIV into care
- » CDC recommends everyone 13 to 64 years old get tested for HIV at least once as part of their routine care
- » Additionally, clients should be tested if the client:
 - » Has engaged in risky behaviors
 - » Has ever had a sexually transmitted infections (STI)
 - » Has a history of sharing drug injection equipment
 - » Is presenting with any of a number of symptoms that might indicate recent infection with HIV or early symptomatic infection



TYPE OF TESTS

- » Testing has become more sophisticated; 4th or 5th generation tests look for HIV antibodies and antigens
- » Antibody tests look for the body's antibodies to HIV in the blood or oral fluids
 - » Measure immune response to HIV
 - » Not useful in acute infections
 - » Rapid tests and FDA-approved HIV self tests
- » Antigen tests detect actual particles of the HIV virus that trigger the body to make antibodies
- » Antibody/Antigen tests detect both and most common test in the US
- » Nucleic acid test (NAT) looks for the actual virus in blood. Very expensive. Can detect HIV infection 10 to 33 days after an exposure.



RAPID HIV TESTS

- » Several FDA approved tests are available for use; provides results in 10 to 40 minutes
- » Look for the presence of HIV antibodies
- » Either negative or reactive
 - » Negative means no HIV antibodies were detected
 - » If individual has had 3 or more months without an HIV risk exposure, the person can be considered negative
 - » If individual has had exposure, the person should be tested again after 3 months
 - » Reactive means antibodies have been detected
 - » A confirmatory test is required before diagnosis is given
 - » A supplemental (4th generation) antibody immunoassay or NAT test is generally used as the confirmatory test
 - » This is done with a blood draw and processed at a medical lab
 - » Results given in one to two weeks
 - » Minnesota Department of Health (MDH) allows funded programs to do rapid to rapid confirmatory testing shortening this window
 - » Can also use a more recent antibody/antigen test to confirm

MINNESOTA REPORTING

- » In Minnesota, anonymous testing is no longer offered due to reporting requirements.
 - » Confidential testing continues to be available.
- » Minnesota's reporting law requires testing sites to pass along all identifying information about the client to the Minnesota Department of Health (MDH).
- » This means a testing client's information is only used if a test is reactive, and then only to facilitate the process of linking clients to care.
- » Getting clients into care soon after they test HIV-positive will greatly improve their health and decrease their chance of spreading the virus.

TREATMENT



- » There are now many medications a person living with HIV can take to slow the progression of the disease.
- » When taken as prescribed, these medications can keep a person's health stable for a very long time
- » When taken as prescribed these medications can also greatly reduce the ability to pass HIV to others.
- » Medications can be taken either daily by pill or every other month by injection

Photo Source (left to right) : Naassom Azevedo, Joel Muniz, Jed Villejo, Dario Valenzuela, and Kaleidico. All on Unsplash

WHAT HAPPENS IF DIAGNOSED HIV POSITIVE?

- >> A thorough medical history is an important step to help the clinician proceed to clinical evaluation and formulate a treatment plan.
- >> Before starting antiretroviral therapy (ART) in any patient, laboratory studies should be done and may include HIV ribonucleic acid (RNA) (or viral load), CD4+ T cell counts, blood counts, screening chemistries, syphilis, toxoplasmosis, purified protein derivative (PPD), hepatitis A, B, and C viruses, and chest x-ray.
- >> **All patients with HIV should be tested and begin treatment with antiretrovirals as soon as possible, regardless of disease status.**
- >> Adherence should be maintained because non-adherence can lead to the rapid development of drug resistance and disease progression.
- >> One means to encourage adherence is to educate clients and their significant others about HIV/AIDS treatment (TIP 37; SAMHSA, 2008).
- >> It is difficult for unhoused individuals to maintain adherence

WHAT IS ANTIRETROVIRAL THERAPY?

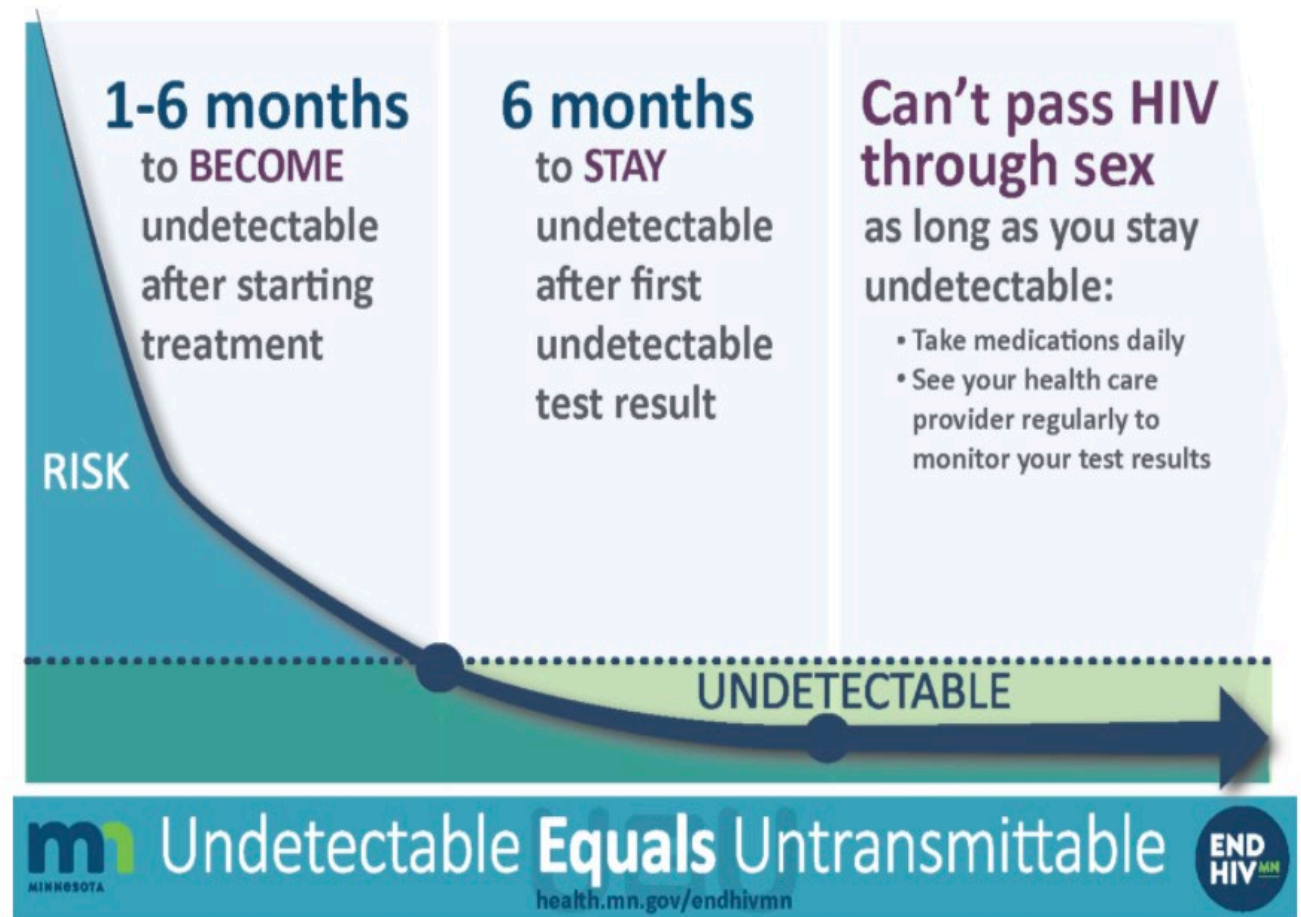
- » Antiretroviral therapy (ART)
 - » Medicines used to treat HIV
 - » Do not cure or remove virus from the body
 - » Stops the virus from replicating
 - » Combination of HIV medications taken daily
 - » From different drug classes
 - » Blocks HIV at different stages of HIV life cycle
 - » **Goal: undetectable viral loads**

"Viral load suppression" is usually defined as having fewer than 200 copies of HIV per milliliter of blood (copies/mL).

"Undetectable" is now commonly defined as having fewer than 20 copies/mL because a lot of lab tests can now "detect" HIV at that level.

UNDETECTABLE = UNTRANSMITTABLE (U=U)

- » People cannot transmit the HIV through sexual contact when their viral load is undetectable
- » Undetectable means too low to be measured (<20 copies per mL)
- » This can take up to 6 months after initiating HIV medications
 - » Confirmed by a blood test given by your doctor
 - » Should be followed up with another blood test 6 months afterwards



U = U FOR NON-SEXUAL TRANSMISSION

- » Undetectable viral loads also crucial to pregnancy, breastfeeding, and injection drug use
 - » The risk of transmitting HIV during pregnancy with an undetectable viral load is one in one thousand
 - » The risk is not eliminated during breastfeeding, but an undetectable viral load reduces the risk of passing HIV*
 - » Unsure of how much the risk is reduced when sharing needles during injection drug use



U = U AND SEXUAL PARTNERS

- » Involving partners in treatment plan can help patients adhere to treatment
- » Encourage HIV-positive patients to talk to current and potential partners about what undetectable means
- » Counsel patients and their partners to use strategies to maintain healthy sexual lives
 - » Condoms – to prevent pregnancy and sexually transmitted infections (STIs)
 - » HIV treatment adherence (ART) for an HIV-positive patient
 - » Pre-exposure Prophylaxis (PrEP) and Post-exposure Prophylaxis (PEP) for an HIV-negative partner



MEDICATION RESISTANCE

- » Stopping and re-starting treatment can cause drug resistance to develop
- » People receiving intermittent ART have twice the rate of disease progression compared to those receiving continual treatment
- » Transient increases in viral load followed by a dip back to undetectable called 'blips'
 - » Blips are common and are not indicative of a treatment failure
- » U.S. HIV treatment guidelines recommends viral load be measured every 3 – 4 months until undetectable, then less frequent

Photo Source :Myriam Zilles on Unsplash

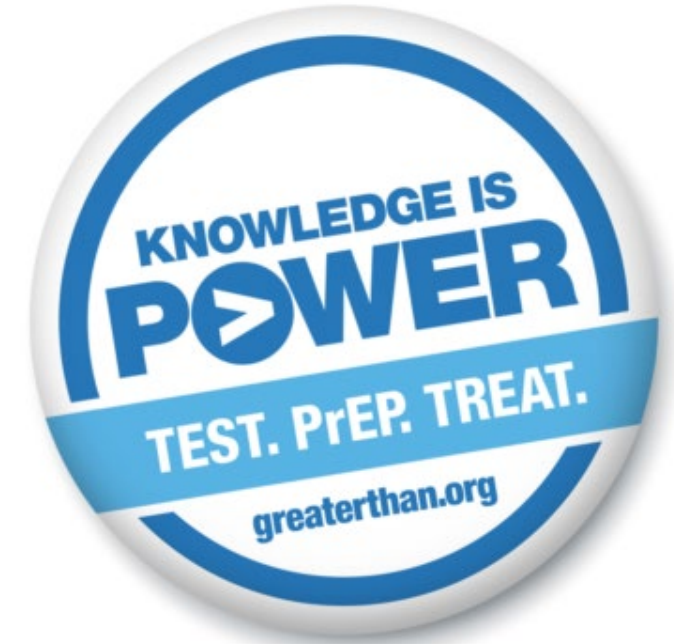
REFERENCES - HIV TESTING AND TREATMENT

- >> Centers for Disease Control and Prevention (2019), “CDC Press Release: Most Americans Have Never Had an HIV Test, New Data Show.”
<https://www.cdc.gov/media/releases/2019/p0627-americans-hiv-test.html>.
- >> Minnesota Dept. of Health, “Undetectable = Untransmittable (U=U).”,
<https://www.health.state.mn.us/diseases/hiv/prevention/uu/index.html>.
- >> NYC Health, “HIV: Undetectable Equals Untransmittable (U=U).”
<https://www1.nyc.gov/site/doh/health/health-topics/hiv-u-u.page>.

HIV PREVENTION

HIV PREVENTION

- » Safer sex practices like condom use
- » Antiretroviral advances
 - » Can reduce HIV viral load to undetectable levels making it less likely to be transmitted
- » Post-exposure Prophylaxis (PEP)
 - » For individuals who have been exposed to HIV
- » Pre-exposure Prophylaxis (PrEP)
 - » For HIV-negative individuals
 - » Reduce the risk of being infected with HIV by 92%-99%



PrEP

PrEP (pre-exposure prophylaxis) is medicine people at risk for HIV take to prevent getting HIV from sex or injection drug use. When taken as prescribed, PrEP is highly effective for preventing HIV.

- » CDC endorsed PrEP for HIV prevention in May 2014
- » Once-daily pill
- » Long-acting injectable PrEP
- » Taken by individuals at high risk including, but not limited to:
 - » People who inject drugs
 - » People with HIV+ sexual partners
 - » Individuals who intermittently or never use condoms

PrEP AND WOMEN

- Woman-controlled option to prevent HIV
- Does not require negotiation or disclosure such as with condom use
- Especially important for women experiencing intimate partner violence
- Yet, underutilized in women due to systemic barriers to access



Photo Source : LinkedIn Sales Solutions on Unsplash

PEP

PEP (post-exposure prophylaxis) means taking medicine to prevent HIV after a possible exposure.

PEP should be used only in emergency situations and must be started within 72 hours after a recent possible exposure to HIV.

- » Taking medicine to prevent HIV after a possible exposure
 - » During sex
 - » Through needle sharing
 - » Occupational exposures such as needle sticks
 - » If sexually assaulted
- » Only used in emergency situations
 - » Two antiretroviral medications taken daily for 28 days
 - » Afterwards, you need to return to doctor for a HIV test
 - » If you have frequent exposures to HIV, then PEP is not right for you. You should take PrEP.

HIV AND COVID-19

- » People with HIV may be more likely to get severely ill from COVID-19
- » However, evidence suggests those virally suppressed are at no greater risk - booster is still generally recommended but should be at the advice of their physician
- » Vaccines are safe for HIV-positive patient
 - » A third dose of mRNA COVID-19 vaccination is recommended after the initial two doses
 - » Booster shots are already available
- » However:
 - » It may not fully protect them
 - » They should follow all precautions of an unvaccinated person
 - » They should continue taking their ART (or PrEP for uninfected individuals)
 - » Make sure you have a 30- to 90-day supply of medicine, if possible

REFERENCES - HIV PREVENTION

- » CDC: Prevention Basics
<https://www.cdc.gov/hiv/basics/prevention.html>
- » NIH.GOV: The Basics of HIV Prevention:
<https://www.cdc.gov/hiv/basics/prevention.html>

QUESTIONS?

5-MINUTE STRETCH BREAK!



THE SCIENCE OF ADDICTION, SCREENING, AND ASSESSMENT

LEARNING OBJECTIVES: THE SCIENCE OF ADDICTION, SCREENING, AND ASSESSMENT

Describe at least two ways in which dopamine influences OUD recovery and treatment

Explain the neurobiological contributions to developing and sustaining addiction

Define and distinguish screening, assessment, and American Society of Addiction Medicine (ASAM) level of care determination

TIME FOR A POLL

Join at menti.com | use code 3549 3034

Which of the following do you think is the *root* cause of substance disorders?

Personal choice and behaviors

Impact of trauma and other adverse life events

Abnormalities of neurochemicals in the brain

I haven't decided yet

→ Show correct answer

Mentimeter

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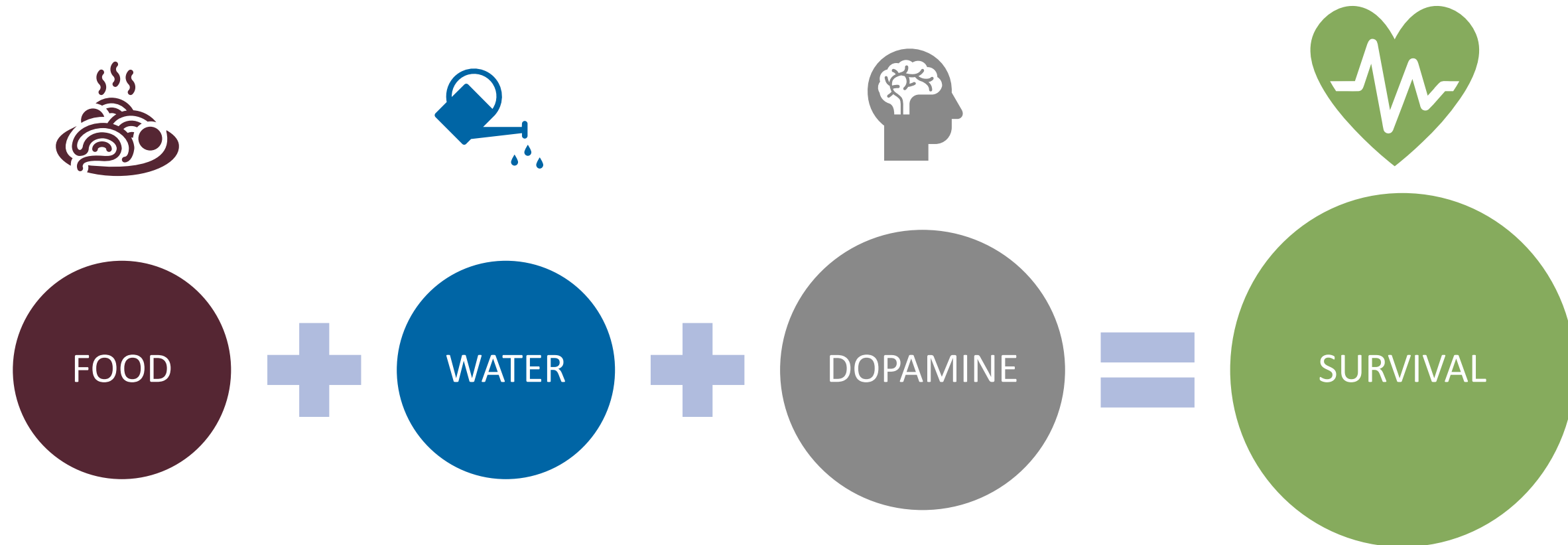
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POLL

Which of the following do you think is the *root* cause of substance use disorders?

- a) Personal choice and behaviors
- b) Impact of trauma and other adverse life events
- c) Abnormalities of neurochemicals in the brain
- d) I haven't decided yet

SCIENCE OF ADDICTION



HOW ADDICTIVE SUBSTANCES AFFECT THE BRAIN

- All addictive substances result in the activation of the reward pathway.
- The same pathway activated by naturally rewarding substances and events.

Thinking part
of brain

Parts of
brain
focused on
survival

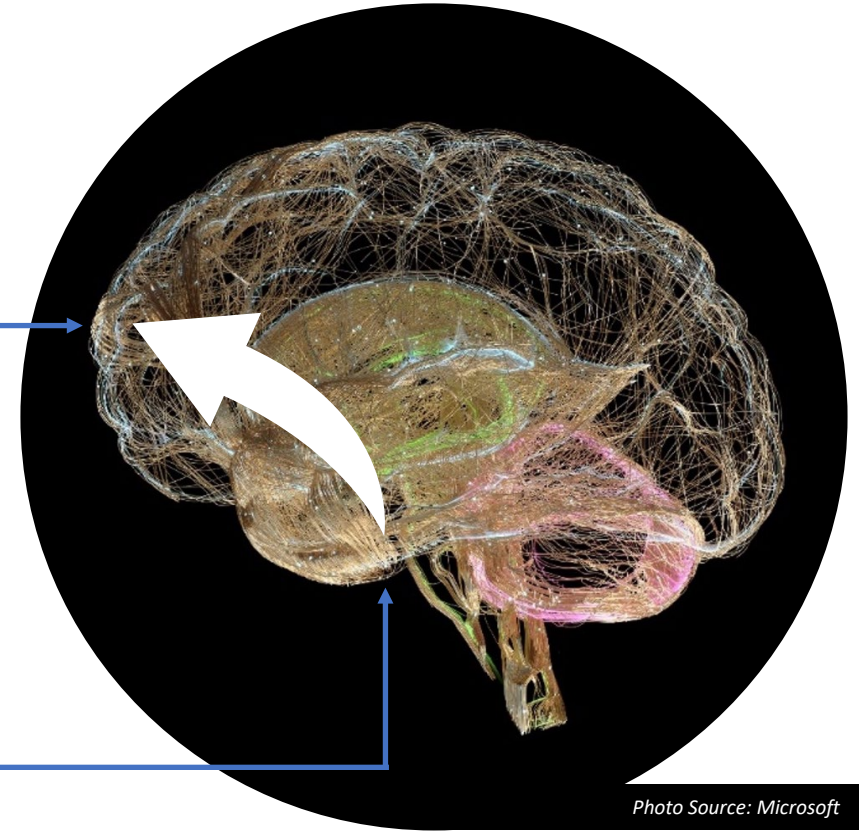
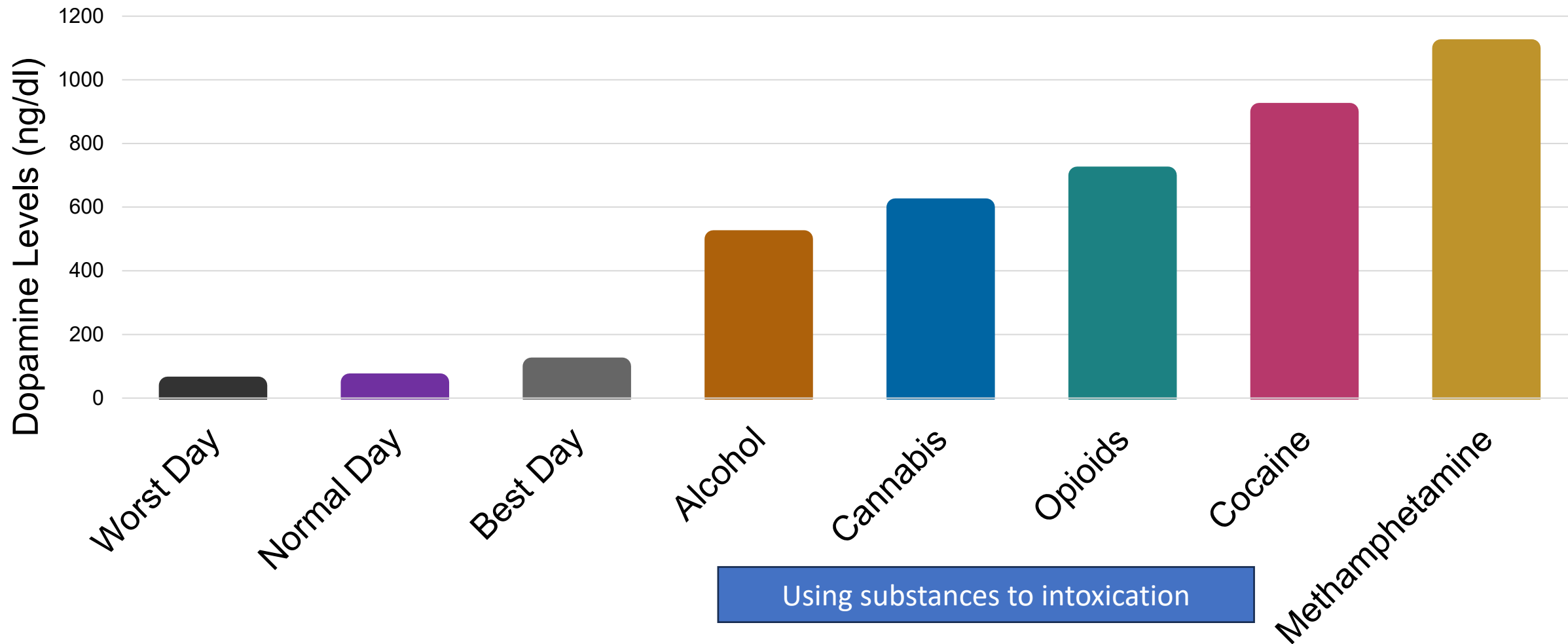


Photo Source: Microsoft

National Institute on Drug Abuse (NIDA). (2011). Drug, brains, and behavior: Science of addiction drug and the brain.
<https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drugs-brain>.

DOPAMINE RESPONSE



INTENSITY OF CRAVINGS

A direct, or indirect, force pulling someone towards a substance or behavior



DSM-5: DIAGNOSIS OF OPIOID USE DISORDER (OUD)

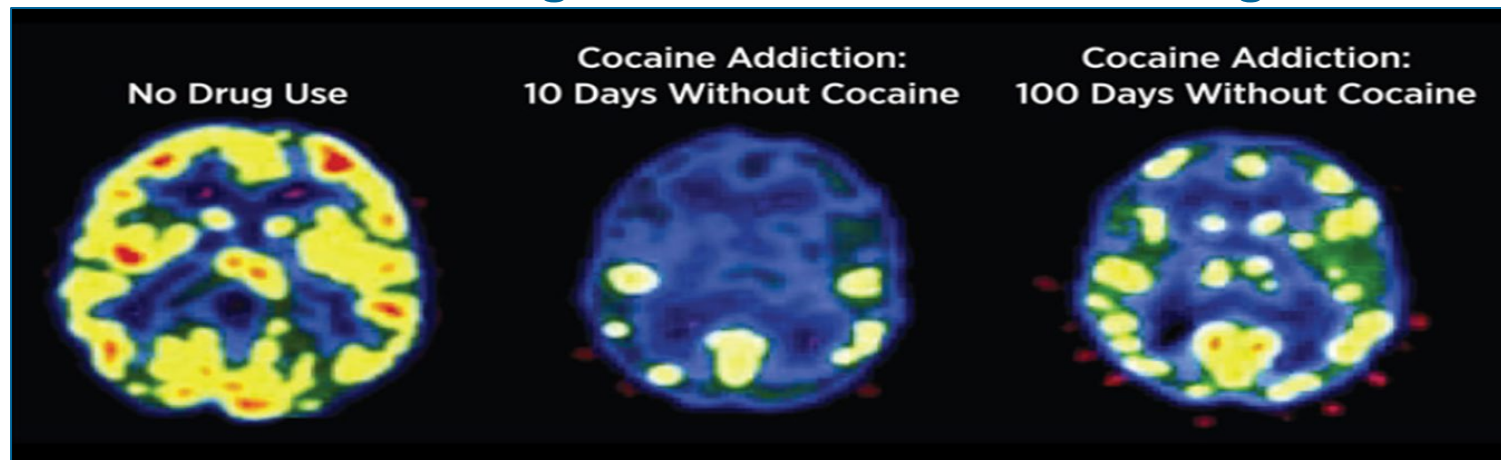
TABLE 1 Summarized DSM-5 diagnostic categories and criteria for opioid use disorder

Category	Criteria
Impaired control	• Opioids used in larger amounts or for longer than intended • Unsuccessful efforts or desire to cut back or control opioid use • Excessive amount of time spent obtaining, using, or recovering from opioids • Craving to use opioids
Social impairment	• Failure to fulfill major role obligations at work, school, or home as a result of recurrent opioid use • Persistent or recurrent social or interpersonal problems that are exacerbated by opioids or continued use of opioids despite these problems • Reduced or given up important social, occupational, or recreational activities because of opioid use
Risky use	• Opioid use in physically hazardous situations • Continued opioid use despite knowledge of persistent physical or psychological problem that is likely caused by opioid use
Pharmacological properties	• Tolerance as demonstrated by increased amounts of opioids needed to achieve desired effect; diminished effect with continued use of the same amount • Withdrawal as demonstrated by symptoms of opioid withdrawal syndrome; opioids taken to relieve or avoid withdrawal

IT TAKES TIME FOR YOUR BRAIN TO RECOVER

- Brain function takes over 1 year to return to “normal” after stopping addictive substances.
- If treatment stops before a year, the benefits of those treatments may be lost.

How the Brain Changes and Recovers from Drug Use

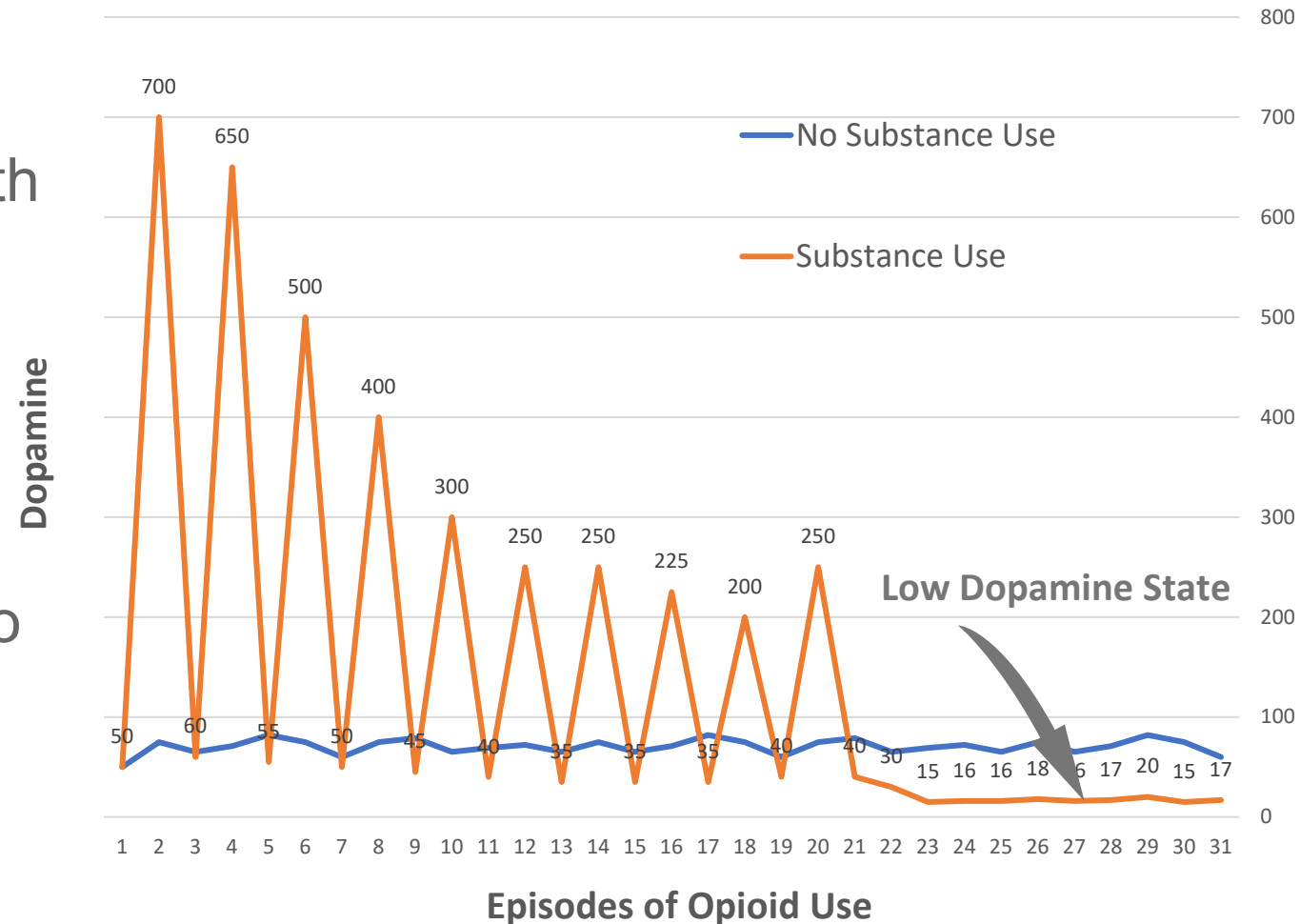


Sources: National Institute on Drug Abuse. (2007). Bringing the power of science to bear on drug abuse and addiction.
<https://nida.nih.gov/publications/teaching-addiction-science/bringing-power-science-to-bear-drug-abuse-addiction>

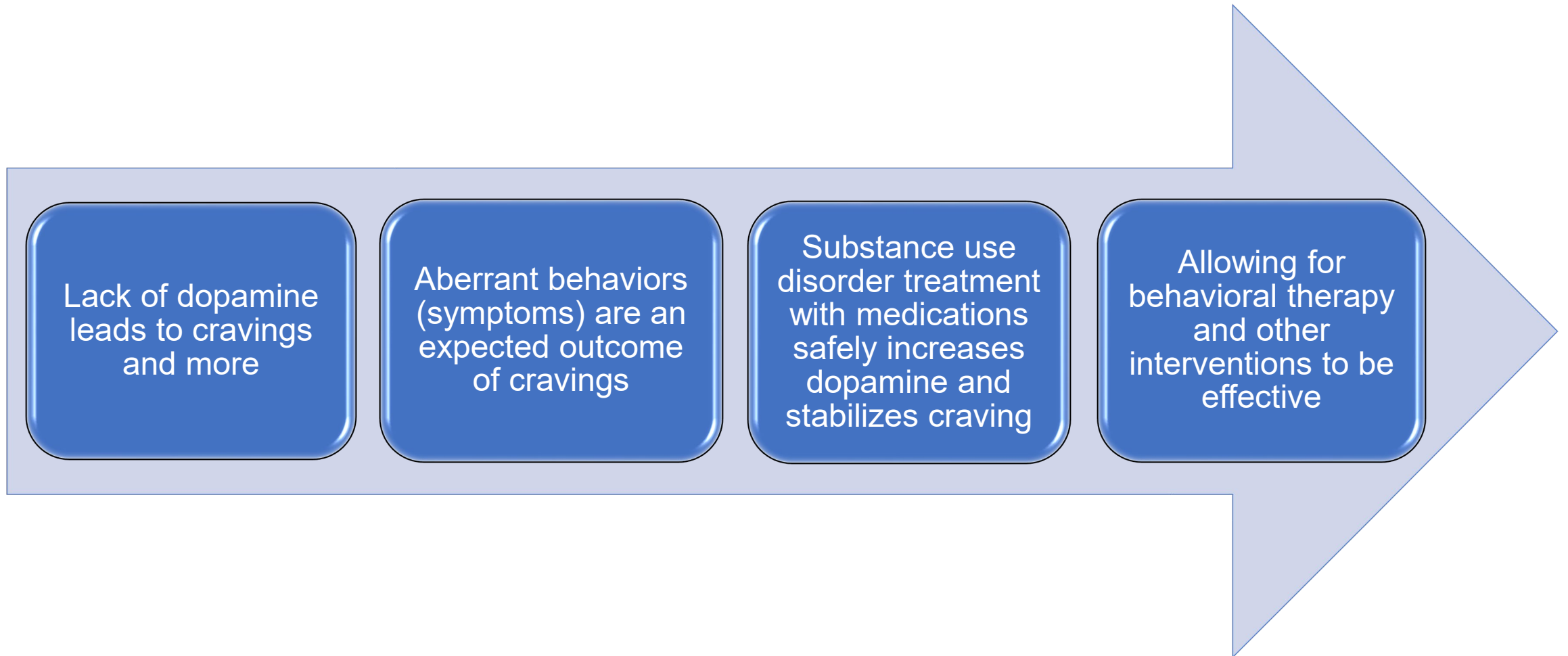
DOPAMINE DEPLETION EFFECTS RECOVERY

Addressing Dopamine Depletion

- » Substance use disorder treatment with medications for opioid use disorder (OUD)/alcohol use disorder (AUD)
- » Contingency Management
- » Transitioning from external rewards to internal rewards



SCIENCE OF ADDICTION: TREATMENTS



ANSWER TO THE POLL

Which of the following do you think is the *root* cause of substance use disorders?

- a) Personal choice and behaviors
- b) Impact of trauma and other adverse life events
- c) Abnormalities of neurochemicals in the brain**
- d) I haven't decided yet

TIME FOR A POLL

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Which statement about screening & testing for SUD is the most accurate?

- ☐ Universal toxicology testing is the most equitable way to identify substance use disorder (SUD) across Minnesota.
- ☐ For some groups, evidence-based verbal screening tools are about as effective as toxicology tests in identifying SUD.
- ☐ Urine and serum toxicology tests are so sensitive, their results don't require a confirmatory test.
- ☐ Hospitals can obtain a toxicology sample without obtaining consent.
- ☐ Decisions about what screening tools to use are generally made based on data from research studies.

 **Mentimeter** GV ▼

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Open Menti to edit

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POLL

Which statement about screening & testing for SUD is the most accurate?

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SCREENING AND ASSESSMENT

SCREENING, ASSESSMENT, LEVEL OF CARE

Screening:

A rapid evaluation to determine the possible presence (risk) of a condition (high sensitivity, usually low specificity)

Assessment:

A more detailed evaluation meant to solidify the presence of a disease and sometimes assess disease severity (lower sensitivity, high specificity)

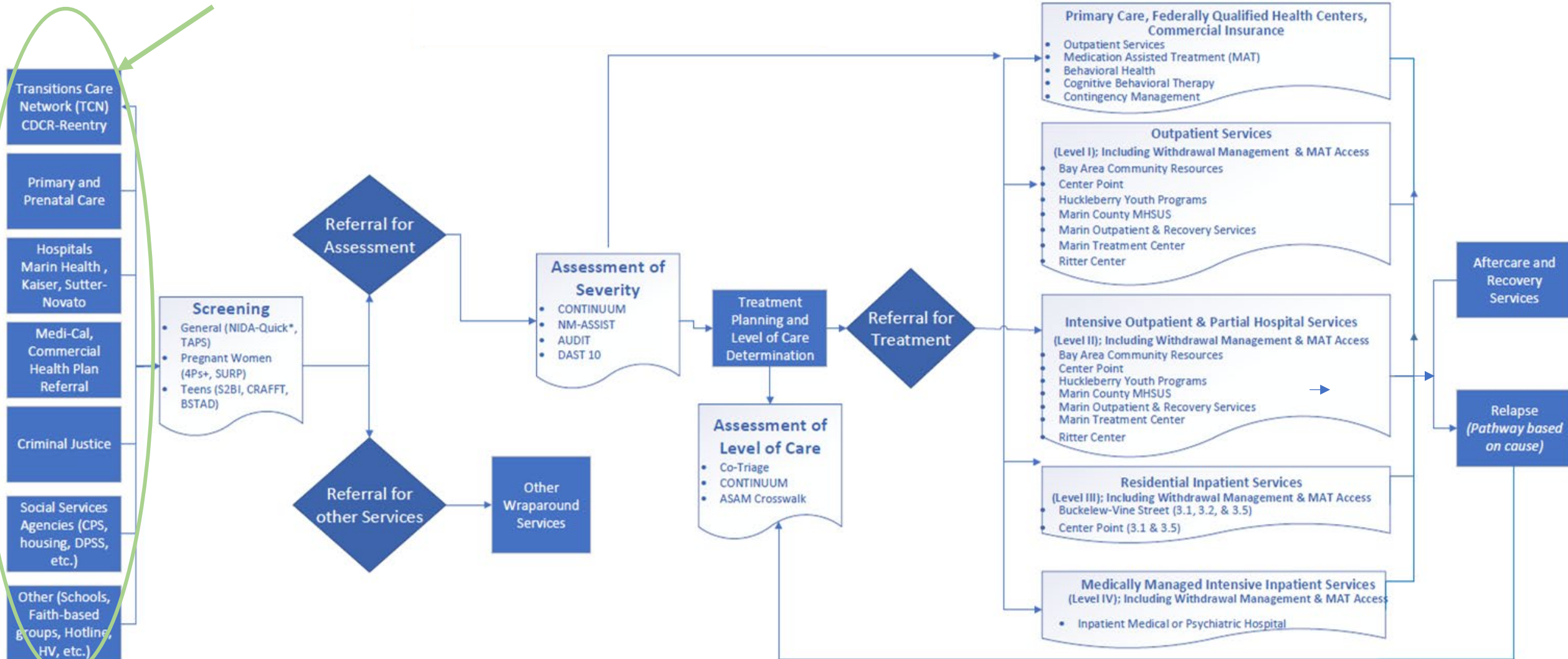
Level of Care Determination:

Evaluation of various biopsychosocial and other factors to determine/recommend the most appropriate level of care for the severity of the condition identified (outpatient vs inpatient).

SCREENING – WHEN TO SCREEN

- Key is to screen patients to determine who should have further assessment
- Screening is also sometimes used as part of the recovery agreement / contractual relationship.
- Times not to screen:
 - Recent screen → Set interval for repeat screening
 - Current/recent diagnosis of SUD
 - Presumptive positive
 - Legal involvement (substance related arrest, DUI)
 - Toxicology results
 - Patient report

SCREENING – WHERE TO SCREEN AT ALL POINTS OF ENTRY INTO HEALTH OR HUMAN SERVICES



The conundrum of universal screening – “Is it really universal if it only happens in _____?”

VALIDATED SCREENING TOOLS

- >> Screening tools are validated for use in specific populations
- >> *Screening for co-morbid conditions and suicide is also critical*

General Population	Pregnant Persons	YOUTH
+ National Institute for Drug Addiction (NIDA) – Quick Screen + Tobacco, Alcohol, Prescription, and other Substances (TAPS) + AUDIT (Alcohol only) + <i>Patient History Questionnaire (PHQ-9)</i> + <i>General Anxiety Disorder (GAD-7)</i> + <i>PTSD Checklist (PCL-5)</i> + <i>Columbia Suicide Severity Rating Scale (C-CCRS)</i>	+ NIDA – Quick Screen* + 4 P's plus (license fee) + Substance Use Risk Profile – Pregnancy (SURP) + CRAFFT – for 12 -26 yo women (Car, Relax, Alone, Forget, Friend/Family, Trouble) + <i>Perinatal Mood and Anxiety Disorder (PMAD) – Edinburgh, PHQ-9</i>	+ Brief Screener for Alcohol, Tobacco and other Drugs (BSTAD) (12-17yo) + Screening to Brief Intervention (S2BI) (12-17yo) + Problem oriented screening instrument for Teens (POSIT) + CRAFFT* + <i>Patient History Questionnaire (PHQ-9) for adolescents</i>

SCREENING AND TOXICOLOGY

A Brief Word About Toxicology Testing Terminology

- Screen: a qualitative (detected/ not detected) test; usually designed to detect many drug classes; confidence in results may be poor but depends on the assay. Also called preliminary immunoassay point of care test (POC).
- Confirmation: a test designed for very high confidence in identification of individual drugs/compounds; may be qualitative or quantitative (reports the amount of drug present).
- Cutoff: the concentration above which the substances is indicated as detected & below which the result indicates the substance was not detected; defined by the “kit” manufacturer, or by the limit of quantification (LOQ).

SCREENING, THE ROLE OF TOXICOLOGY TESTING, AND CAVEATS

- Typically, does not test for alcohol or tobacco use
- “Routine” toxicology screen (big 5) may miss key substances (e.g., methadone, fentanyl and other synthetics)
- Potential for false positive and false negative results
- Complicated relationship between toxicology, criminal justice and child welfare involvement
- Test results do not assess social, parenting capabilities or other qualities
- Often applied selectively
- Positive toxicology test does not establish the diagnosis of SUD



SCREENING: THE START OF A RELATIONSHIP AND CONVERSATION

BEST PRACTICES FOR SCREENING: USE MOTIVATIONAL INTERVIEWING TO START A CONVERSATION

- » *For a pregnant person...* “An important part of primary care/prenatal care [supporting you to stay with / reclaim custody of your baby] is screening for any risky conditions. Some of these conditions can be scary to talk about but are pretty common. Also, no matter the issue we have the ability to help work through it.”
- » Is it ok if I ask you some questions about those risks?
- » *For someone in treatment...* We’re doing a urine drug test today, will there be any findings on that test I’m not expecting?

POLL ANSWER

Which statement about screening & testing for SUD is the most accurate?

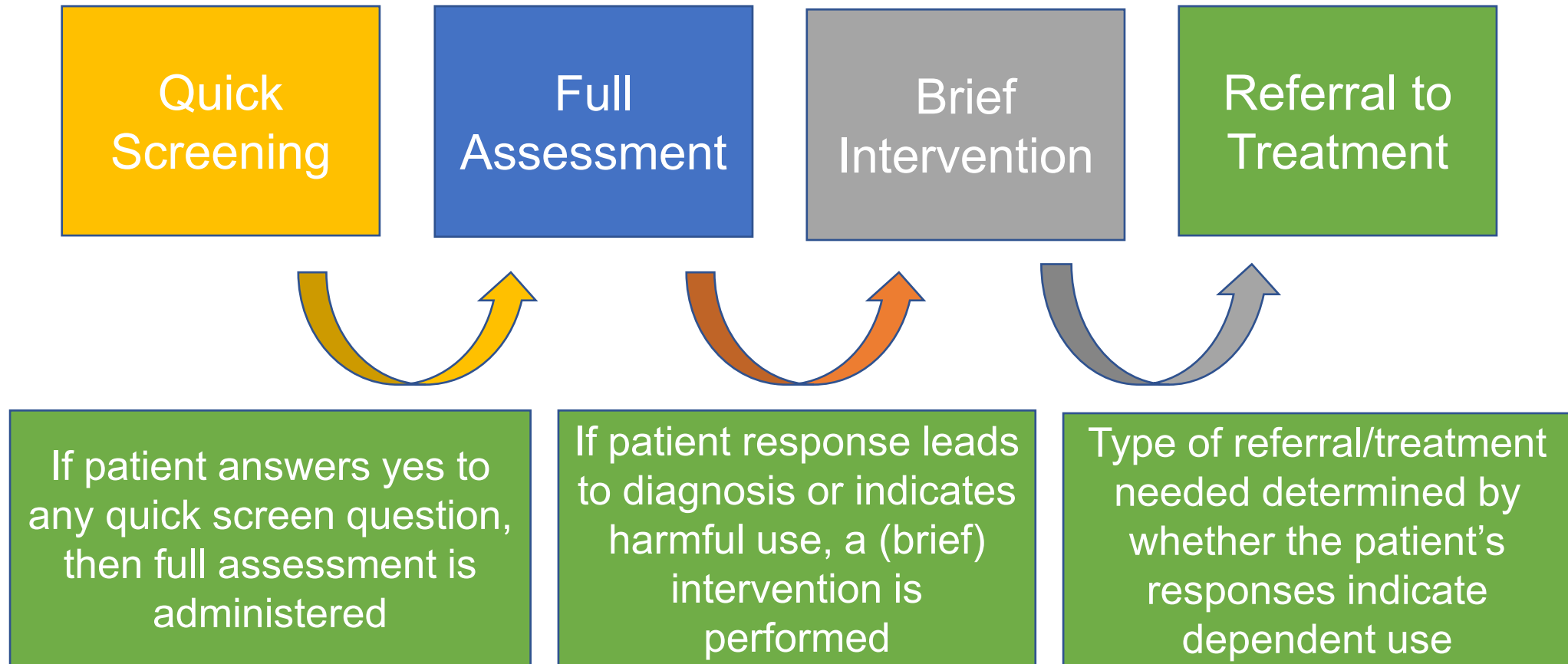
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SCREENING BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT/SABIRT)

- » **Screening** – universal screening for substance use and impact of that use
- » **[Assessment** – use of validated assessment tool to determine diagnosis and severity]
 - Alcohol Use Disorders Identification Test (AUDIT)
 - Drug Abuse Screening Test (DAST-10)
 - Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
- » **Brief intervention** – use of motivational interviewing concepts to reduce problematic substance use
- » **Referral to treatment** – referral to specialty substance use treatment or, in some cases, simply referral to continued assessment and follow up with their primary provider



S(A)BIRT FLOW



OBJECTIVES OF A BIO-PSYCHO-SOCIAL ASSESSMENT (BPS)

- » A comprehensive biopsychosocial assessment provides:
 - » Insight into the patient's past and current life experience
 - » Data to make an accurate (preliminary) diagnosis
 - » An opportunity to build rapport with the patient
 - » Information needed to make an accurate level of care determination
 - » Assesses biopsychosocial criteria to inform American Society of Addiction Medicine (ASAM) Level of Care determinations

BIOPSYCHOSOCIAL ASSESSMENT

- A comprehensive biopsychosocial assessment includes:
 - General information (housing status including who live with, religious affiliation, referral source, insurance)
 - Medical information (past/present medical conditions, medications, surgeries, childbirths, hospitalizations)
 - Education and Employment (highest grade, difficulty in school, past and current employment, income (legal and illegal), dependents, Social Security Benefits/Disability Benefits (SSI/SSDI), date of last employment, skill trade or technical education)
 - Legal (past and current legal issues, arrests, charges, convictions, DUI, other driving offenses, incarceration time)

BIOPSYCHOSOCIAL ASSESSMENT CONT.

- Psychological (Mini mental status exam; current and past medications, inpatient and outpatient treatment, anxiety, depression, hallucinations, suicidal or homicidal)
- Family and Social (who raised, siblings, past and current relationship with family, family with past/current SUD and Department of Corrections (DOC), children, partner (with SUD?), friends and supports, hobbies, spirituality, marital status)
- SUD History - (Substance(s)) first used and date of first use, how many days used in past 30, lifetime use and route of administration of every substance
 - Substance(s) of choice, date of last use, frequency, overdose, and/or delirium tremens (DTs), \$\$ spent on substances in last 30 days, knowledge of safe drug practices
 - SUD treatment type and level of care (past, current, # of times, if currently on buprenorphine or methadone),
- Examples of evidence-based assessment tools:
 - NIDA Modified Assist – (not a biopsychosocial tool) – public domain
 - Brief Addiction Monitor (BAM) – public domain
 - Addiction Severity Index – public domain

ASSESSMENT— FOURTH EDITION AMERICAN SOCIETY OF ADDICTION MEDICINE CRITERIA

SCREENING → DIAGNOSIS → SEVERITY → READINESS AND RELAPSE POTENTIAL

Patient Placement Criteria

DIMENSIONS

1
Intoxication
Withdrawal and
MAT

2
Biomedical

3
Emotional,
behavioral Cognitive
(psychiatric)

4
Substance Use
Related Risks

5
Recovery
Environment &
Interactions

6
Person-Centered
Considerations

DECISION RULES

LEVEL OF CARE

1 Outpatient

2 Intensive / High-
Intensity Outpatient

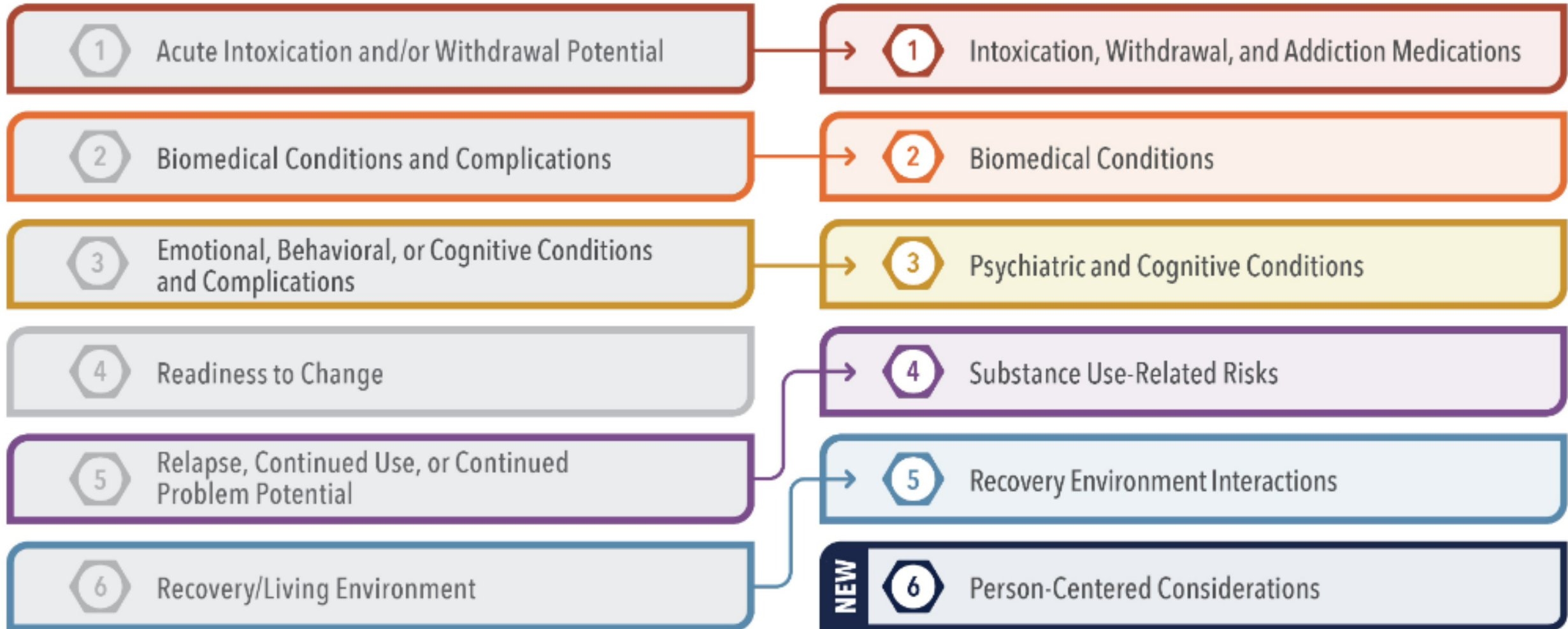
3 Residential

4 Inpatient Services
(Medically Managed)

FOURTH EDITION ASAM LEVEL OF CARE CHANGES

Third Edition

Fourth Edition



LEVEL OF CARE (LOC) DETERMINATION

» ASAM Criteria is Gold Standard

» CONTINUUM® and Co-triage® tool

» ASAM Criteria Navigator® for utilization review/management

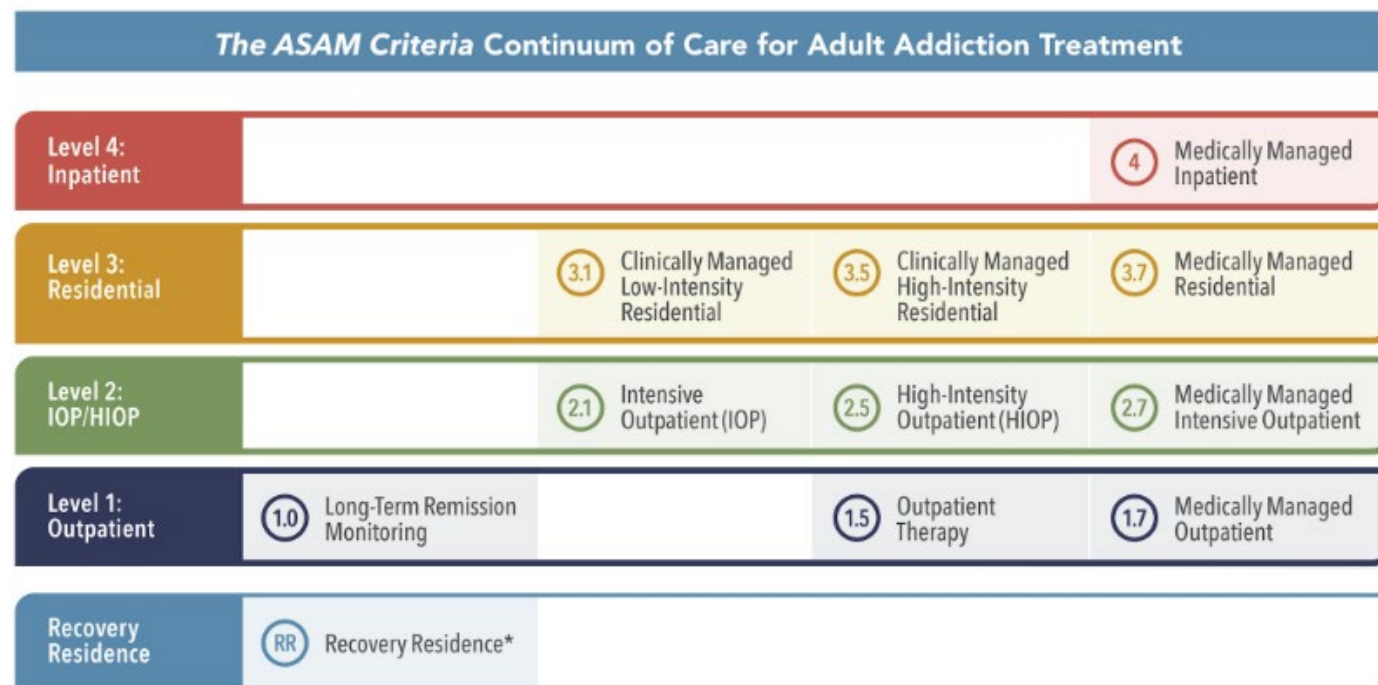
» Criteria are required in assessment tools used by providers

» Complete for high/severe assessments

» Available online

» Done by RN, LCSW, PA/NP, or MD/DO

» Part of S(A)BIRT payment



Source: The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (2023).

ASAM AND LEVEL OF CARE (LOC) DETERMINATION IN MN

MN Medicaid Section 1115 Waiver and related legislation requires that providers of SUD services use the ASAM Level of Care criteria

- » The legislation codifies required service standards for participating providers that are consistent with ASAM criteria

- » “All 87 Minnesota counties, 11 American Indian Tribes, and eight managed care organizations (MCOs) are required to conduct an assessment that incorporates the six dimensions of the ASAM placement criteria”

- ➔ » SUD treatment providers must certify ASAM LoC plan and enroll in waiver to avoid non-payment

- » Residential SUD providers by Jan 1, 2024

- » Non-residential SUD providers by Jan 1, 2025

ASAM AND LEVEL OF CARE (LOC) DETERMINATION IN MN (CONT.)

» Providers enrolled in the 1115 demonstration evaluating use of the criteria must be compliant with the ASAM-based Standards (June 30, 2021)

» Other requirements

- ➔ » Co-occurring disorder license ([MN Statutes 245G.20](#)) – standards for staffing, supervision. Documentation and interventions
- » Comprehensive assessment (c/w with ASAM criteria)
- » Assessment summary within 3 calendar days after service initiation (or same day if comprehensive assessment is used to authorize services)
- » Initial Services Plan
- ➔ » Patient Referral Arrangements and Agreements for providers who don't offer MOUD

» Current 1115 Waiver is extended to Mar. 31, 2031

**** ASAM Training meetings fourth Wednesday of the Month at Noon CT*

ASAM Criteria Level of Care – Other Treatment and Recovery Services																															
ASAM Criteria Level of Care	ASAM Level	Dimension 1 Substance Use, Acute Intoxication and/or Withdrawal Potential					Dimension 2 Biomedical Condition and Complications					Dimension 3 Emotional, Behavioral, or Cognitive Condition and Complications					Dimension 4* Readiness to Change					Dimension 5* Relapse, Continued Use, or Continued Problem Potential					Dimension 6* Recovery/Living Environment				
Severity/Impairment Rating		0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
Outpatient Services	1																														
Intensive Outpatient Services	2.1																														
Partial Hospitalization >= 20 hours	2.5	Service currently unavailable																													
Clinically Managed Low-Intensity Res. Services	3.1																														
Clinically Managed population specific, High-Int Res. Ser.	3.3																														
Clinically Managed Med (youth) & High (adult) – Int Res. Ser.	3.5																														
Recommend inpatient mental health services																															

Recommend inpatient mental health services

Level of Care	Adults	Adolescents
1.0 Outpatient program	8 hours skilled treatment services	6 hours skilled treatment services
2.1 Intensive Outpatient Program	9-19 hours skilled treatment services	6-19 hours skilled treatment services
3.1 Clinically Managed Low-Intensity Residential	At least 5 hours of skilled treatment, peer recovery, and treatment coordination	
3.3 Clinically Managed Population-Specific High-Intensity Residential	At least 30 hours of skilled treatment services, peer recovery and treatment coordination provided to individuals with a TBI or cognitive impairment.	
3.5 Clinically Managed High-Intensity Residential	At least 30 hours of skilled treatment services, peer recovery and treatment coordination provided to individuals. 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full therapeutic community.	

ASAM Criteria Level of Care – Withdrawal Management See pages 147 – 173 for detailed recommendations	ASAM Level	Dimension 1 Substance Use, Acute Intoxication and/or Withdrawal Potential					Dimension 2 Biomedical Condition and Complications					Dimension 3 Emotional, Behavioral, or Cognitive Condition and Complications					Dimension 4 Readiness to Change					Dimension 5 Relapse, Continued Use, or Continued Problem Potential					Dimension 6 Recovery/Living Environment				
Severity/Impairment Rating		0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4
Ambulatory W/M with Extended On-Site Monitoring	2 - WM																														
Clinically Managed Residential W/M	3.2- WM																														
Medically Monitored Inpatient W/M	3.7 – WM																														

1115 WAIVER ASSESSMENT AND PLACEMENT GRID

LEVEL OF CARE (LOC) TRANSITIONS - CONTINUED SERVICE CRITERIA (ASAM CRITERIA)

Retain at the present level of care if:

1. Making progress, but not yet achieved goals articulated in individualized treatment plan. Continued treatment at present level of care necessary to permit patient to continue to work toward his or her treatment goal

Or
2. Not yet making progress but has capacity to resolve his or her problems. Actively working on goals articulated in individualized treatment plan. Continued treatment at present level of care necessary to permit patient to continue to work toward his or her treatment goals;

And/or
3. New problems identified that appropriately treated at present level of care. This level is least intensive at which patient's new problems can be addressed effectively.

LEVEL OF CARE (LOC) TRANSITIONS - TRANSFER/DISCHARGE SERVICE CRITERIA (ASAM CRITERIA)

Transfer or discharge from present level of care if s/he meets the following criteria:

1. Has achieved goals articulated in his or her individualized treatment plan, thus resolving problem(s) that justified admission to current level of care.
or
2. Has been unable to resolve problem(s) that justified admission to present level of care, despite amendments to treatment plan. Treatment at another level of care or type of service therefore is indicated.
or
3. Has demonstrated lack of capacity to resolve his or her problem(s). Treatment goals might be better achieved at another level of care or type of service.
or
4. Has experienced intensification of his or her problem(s), or has developed new problem(s), and can be treated effectively only at a more intensive level of care.

LEVEL OF CARE (LOC) DETERMINATION: SUMMARY

- » Comprehensive assessment requires evaluation of all 6 Dimensions
- » Additional assessments better position us to fully address a client's needs
- » Treatment planning can begin before LOC determination
- » The LOC might have to change based on availability, but it doesn't mean we can't get started
- » Where someone gets care really matters
- » Implementation of ASAM assessment criteria is evolving in MN

REFERENCES - SCREENING, ASSESSMENT, AND LOC DETERMINATION

- » ASAM, (2020) National Practice Guidelines for the Treatment of OUD.
- » MINNESOTA Statutes Minnesota Statutes, Chapter 245A. 09, Subdivision 7, paragraph (e); chapter 245G
- » Center for Adolescent Substance Abuse Research, Children's Hospital of Boston. The CRAFFT screening interview. Boston (MA) CeASAR; 2009.
- » Chasnoff, I. J., McGourty, R. F., Bailey, G. W., Hutchins, E., Lightfoot, S. O., Pawson, L. L., ... & Campbell, J. (2005). The 4P's Plus© screen for substance use in pregnancy: clinical application and outcomes. Journal of perinatology, 25(6), 368.
- » JA Ewing "Detecting Alcoholism: The CAGE Questionnaire" JAMA 252: 1905-1907, 1984
- » Reisfield, G. et al., The ASAM Essentials of Addiction Medicine (2020), Practical Considerations in Drug Testing; p 659-66
- » Laskar, D., Chemistry Toxicology General, Editor Zynger, D., 4-2019
- » The Clinical Toxicology Laboratory, AACCC Press, 2003, pp. 491-2
- » Broussard L, Handbook of Drug Monitoring Methods, Humana Press, 2007
- » Smith, H. Opioid Metabolism (July, 2009). Mayo Clinic Proceedings; 84(7): 613–624.
www.ncbi.nlm.nih.gov/pmc/articles/PMC2704133

GROUP DISCUSSION

What concepts from today's discussion about the science of SUD, screening, assessment and LOC determination will stick with you (any "ah ha" moments?) and how can you put that to use in your work?



Please raise your hand if you'd like to share.

QUESTIONS?

30-MINUTE LUNCH BREAK



SESSION 2



CHATTER FALL

Please respond to following prompt by typing into the chat box

Please share a curiosity you bring with you today regarding today's topics

Ethical and Legal
Issues

HIV Risk
Reduction

HIV and
Stigma

Funding and Policy
Considerations

SUD Harm
Reduction

Motivational
Interviewing

Type your response and
don't click enter.

ETHICAL AND LEGAL ISSUES, FUNDING AND POLICY CONSIDERATIONS

LEARNING OBJECTIVES: ETHICAL AND LEGAL ISSUES, FUNDING AND POLICY CONSIDERATIONS

Describe the ethical considerations related to HIV disclosure and how those have changed over time

Explain privacy protection and the considerations that affect those protections related to HIV testing and disclosure

List the purpose and key components of the Ryan White Programs

Summarize at least 3 critical steps needed to end the HIV Epidemic

PRINCIPLES OF BIOETHICS IN AMERICA

- » Autonomy / Respect for Persons – respecting decisions of autonomous persons
 - » Assumes capacity
 - » Protecting the vulnerable, those without capacity to make autonomous decisions
- » Beneficence – act in the best interest of the patient
 - » Minimize risks and balance benefits
- » Justice – fair treatment
 - » Benefits and burdens are distributed fairly in society





CONSIDERING ETHICS: STRUCTURAL LENS

- » Ethical principles should NEVER be applied rigidly, mechanically, or in absolute terms
- » Sometimes the principles are in conflict
- » Our understanding of HIV/AIDS has changed dramatically and influences how policies and regulations are made and interpreted
 - » Better understanding of progression and how to mitigate
 - » Phenomenal advances in treatment and prevention

Photo Source : Brandon Day on Unsplash

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HEALTH MANAGEMENT ASSOCIATES

CONFIDENTIALITY: GENERAL

- » A core duty (ethical and legal) of medical practice that requires providers to keep patients' personal health information private
 - » Prohibits disclosure without consent
 - » Encourages steps to ensure security of records/info and prevention of unauthorized access
 - » Extends to all communication about patient
 - » HIPAA, 42 CFR Part 2, FERPA
- » Exceptions to release without consent
 - » Exposed Emergency Medical Services (EMS) and Correctional personnel
 - » Partner information to the PH Commissions only
 - » Public health and safety
 - » HIPAA exceptions: treatment, operations, billing/payment
 - » 42 CFR Part 2 Exceptions: emergency, child abuse, Dept. Veterans Affairs, court ordered, qualified services organizations

TESTING, REPORTING, AND DISCLOSURE

- » In MN, there is no specific law requiring written informed consent or pre-test counseling for HIV testing
- » Generally, consent must be obtained, EXCEPT in cases of an EMS exposure
- » Mandatory provision of HIV education materials for clients in chemical dependency treatment programs



TESTING, REPORTING, AND DISCLOSURE CONTINUED

- » Results are held confidential with exceptions:
 - » Results are treated as confidential unless the client approves release of results
 - » Name-based reporting must be provided to MN MDH within one business day (any reactive test)
 - » “Anonymous” testing is not completely anonymous
 - » In MN it is a criminal offense to knowingly “transfer” a communicable disease to another through “direct transmission”
 - » HIV+ individuals must disclose to sexual partners and those with whom they share needles (in a court of law, self-disclosure is a defense in the former, but not in the latter)
 - » But what about disclosure for those with undetectable viral load?

DISCLOSURE AND VIRAL SUPPRESSION

- » In 2017, MDH joined several state health departments in supporting **Undetectable = Untransmittable (U=U)**
- » U=U is behind the concept of treatment as prevention
- » When an HIV+ person has a confirmed undetectable viral load within the last 12 months the MDH will not take partner notification action.
- » Partner notification is a practical precaution if there is any reason to believe that a partner may have been exposed to HIV.
- » Providers or people living with HIV may still carry out partner notification independently or with assistance from the MDH Partner Services Program.

DISCLOSURE AND VIRAL SUPPRESSION

Precedent

The law basically says disclose or provide “practical means of preventing transmission”.

In Minnesota, a case has been tried where a person argued that they used a condom and therefore did not expose their partner, and they won the case. That precedent setting case informs us that in MN, a person could use a condom and not inform their partner of their HIV+ status and still be within their legal rights.

Most people feel like the U=U defense would be upheld in MN, but it hasn't happened (to their knowledge).

GROUP DISCUSSION

1. Would a HIV+ virally suppressed individual need to disclose their status to the partner?
2. In a monogamous relationship with a virally suppressed individual, should the HIV- partner be on PrEP?



Please raise your hand if you'd like to share.

DISCLOSURE AND VIRAL SUPPRESSION

Thoughts for Providers

- Change the paradigm that people with HIV having sex is bad/risky to normalize people with HIV having sex.
- Reduce the emotional charge often present to help people navigate this in a sensitive, client centered and less stigmatizing way.
- Help people understand that most people with HIV are concerned about transmission, do what they need to reduce risk and that disclosure is a complex issue
- Discuss and promote treatment as prevention

Great resource on decriminalization of HIV:

<https://legacy.lambdalegal.org/know-your-rights/article/hiv-criminalization>

FUNDING AND POLICY CONSIDERATIONS

RYAN WHITE HIV/AIDS PROGRAM

- Provides a comprehensive system of care for people living with HIV
- Most funds support primary medical care and other medical-related and support services
- Provides ongoing access to HIV medications
- Small amount of funds used for technical assistance, clinical training, and development of innovative models of care

RYAN WHITE HIV/AIDS PROGRAM

- Includes 5 Parts: A, B, C, D, and F
- Administered by the HIV/AIDS Bureau (HAB), within the Health Resources and Services Administration (HRSA)
- RWHAP Parts designed to work together to ensure a comprehensive system of care in urban, suburban, and rural communities throughout the U.S.
- **Payor of last resort**

RYAN WHITE HIV/AIDS PROGRAM PART A

Part A – Epidemically/Geographically Targeted

- » Funding for areas hardest hit by the HIV epidemic
- » Funding for two categories of metropolitan areas:
 - » **Eligible Metropolitan Areas (EMAs)**, an area must have reported at least 2,000 AIDS cases in the most recent five years and have a population of at least 50,000.
 - » **Transitional Grant Areas (TGAs)**, an area must have reported 1,000 to 1,999 AIDS cases in the most recent five years and have a population of at least 50,000.
- » Funds are used to develop or enhance access to a comprehensive system of high-quality community-based care for low-income PLWH

RYAN WHITE HIV/AIDS PROGRAM PART B

Part B – All states

- » Funding to all 50 States, DC, Puerto Rico, U.S. territories and jurisdictions to improve the quality, availability, and organization of HIV health care and support services
- » Provides funds for medical and support services
- » Includes the AIDS Drug Assistance Program (ADAP), which provides access to HIV-related medications, through direct purchase and purchase of health insurance
- » Also provides funds to emerging communities with a growing epidemic, reporting 500-999 new cases in the past 5 years

RYAN WHITE HIV/AIDS PROGRAM PART C

Part C – Early Intervention

- Funding to support “**early intervention services**”: comprehensive primary health care and support services for PLWH in an outpatient setting
- Competitive grants to local community-based organizations, community health centers, health departments, and hospitals
- Priority on **services in rural areas** and for traditionally underserved populations
- Capacity development grants provided to help public and nonprofit entities deliver HIV services more effectively

RYAN WHITE HIV/AIDS PROGRAM PART D

Part D – Population Targeted

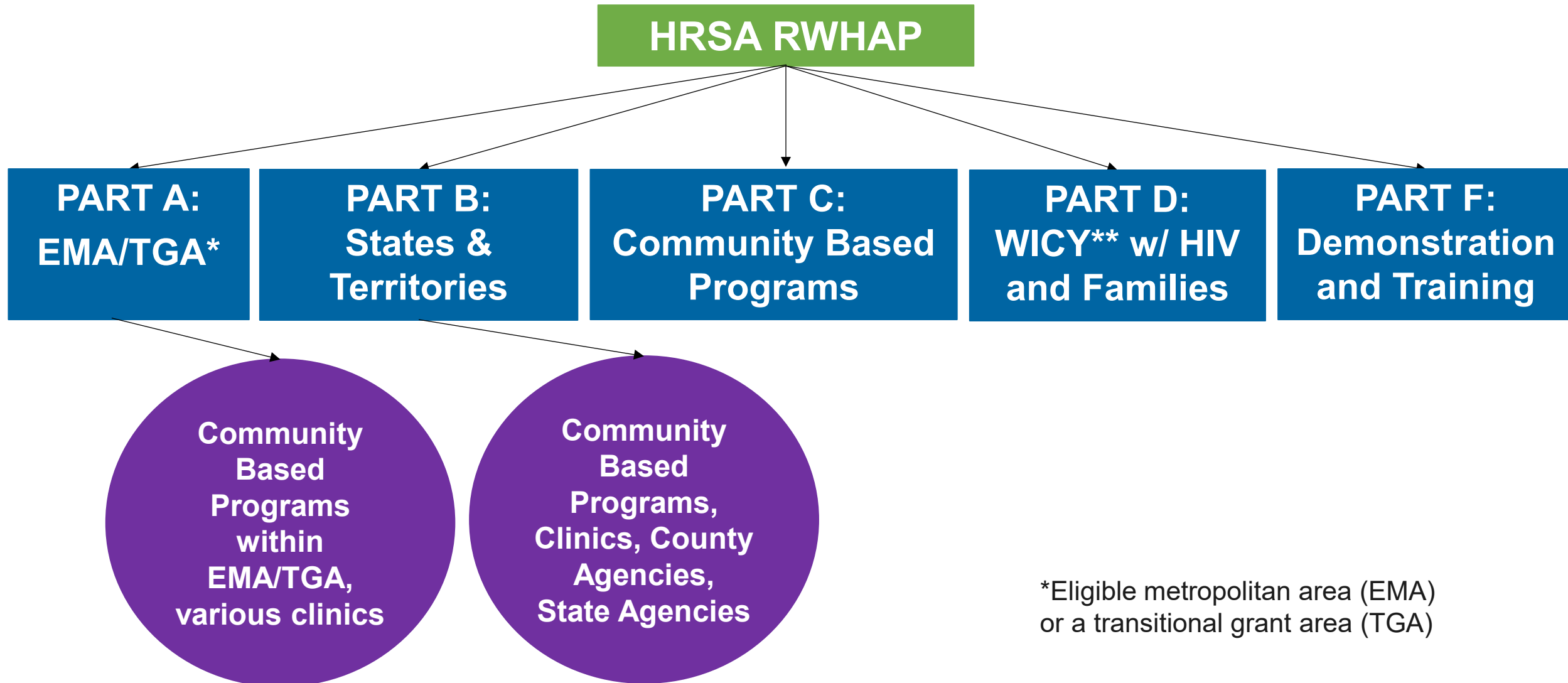
- Funding to support family-centered HIV primary medical and support **services for women, infants, children, and youth** living with HIV
- Competitive grants to local public and private health care entities, including hospitals, and public agencies
- Includes services designed to engage **youth with HIV** and retain them in care
- Recipients must coordinate with HIV education and prevention programs designed to reduce the risk of HIV infection among youth

RYAN WHITE FEDERAL PROGRAMS PART F

Part F – Dental and Special Funds

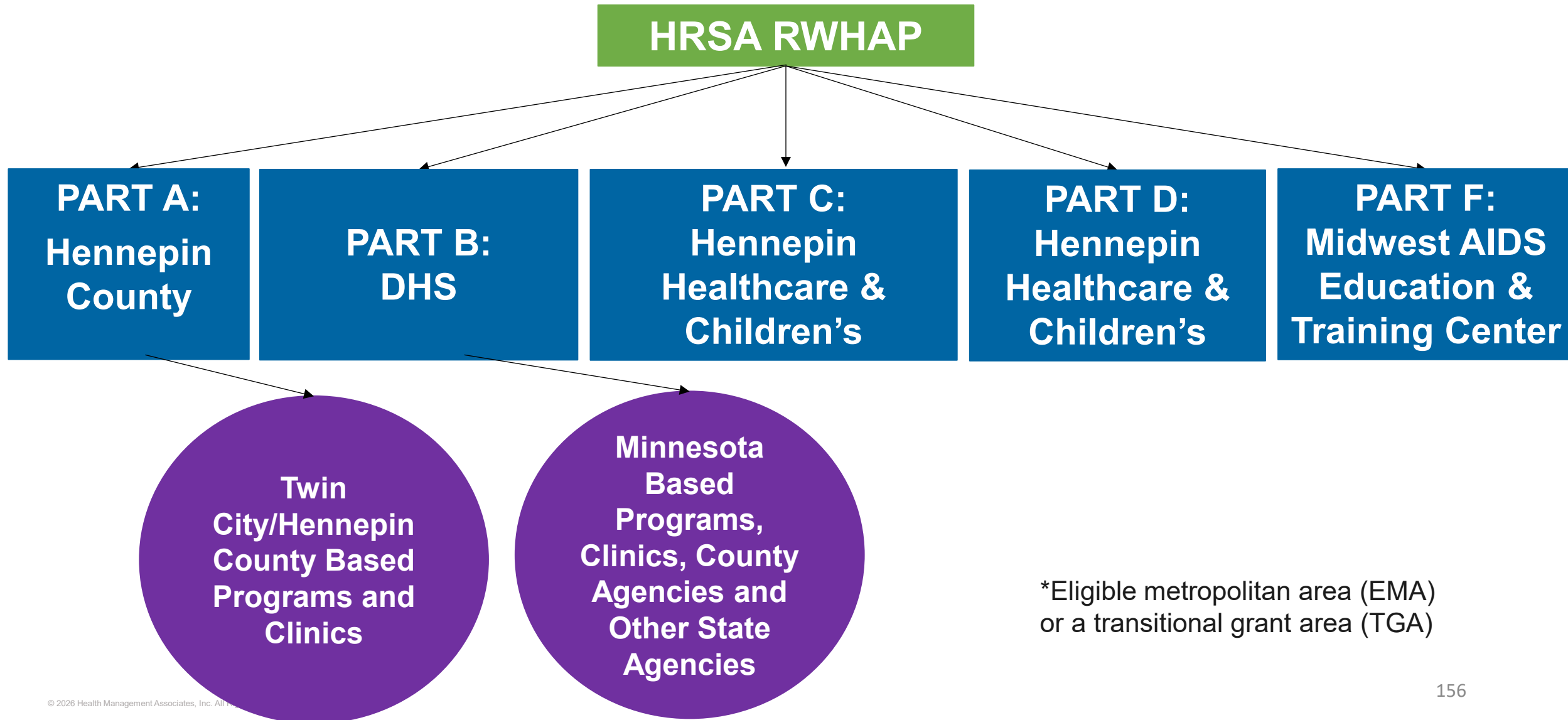
- Funds support **clinician training, dental services, and dental provider training**. In addition, Part F funds the development of innovative models of care to improve health outcomes and reduce HIV transmission.
- Funds Minority AIDS Initiative (MAI)
- Funds Special Project of National Significance (SPNS)
- Funds AIDS Education and Training Centers (AETCs)

RYAN WHITE FEDERAL PROGRAMS: MN SPECIFICS



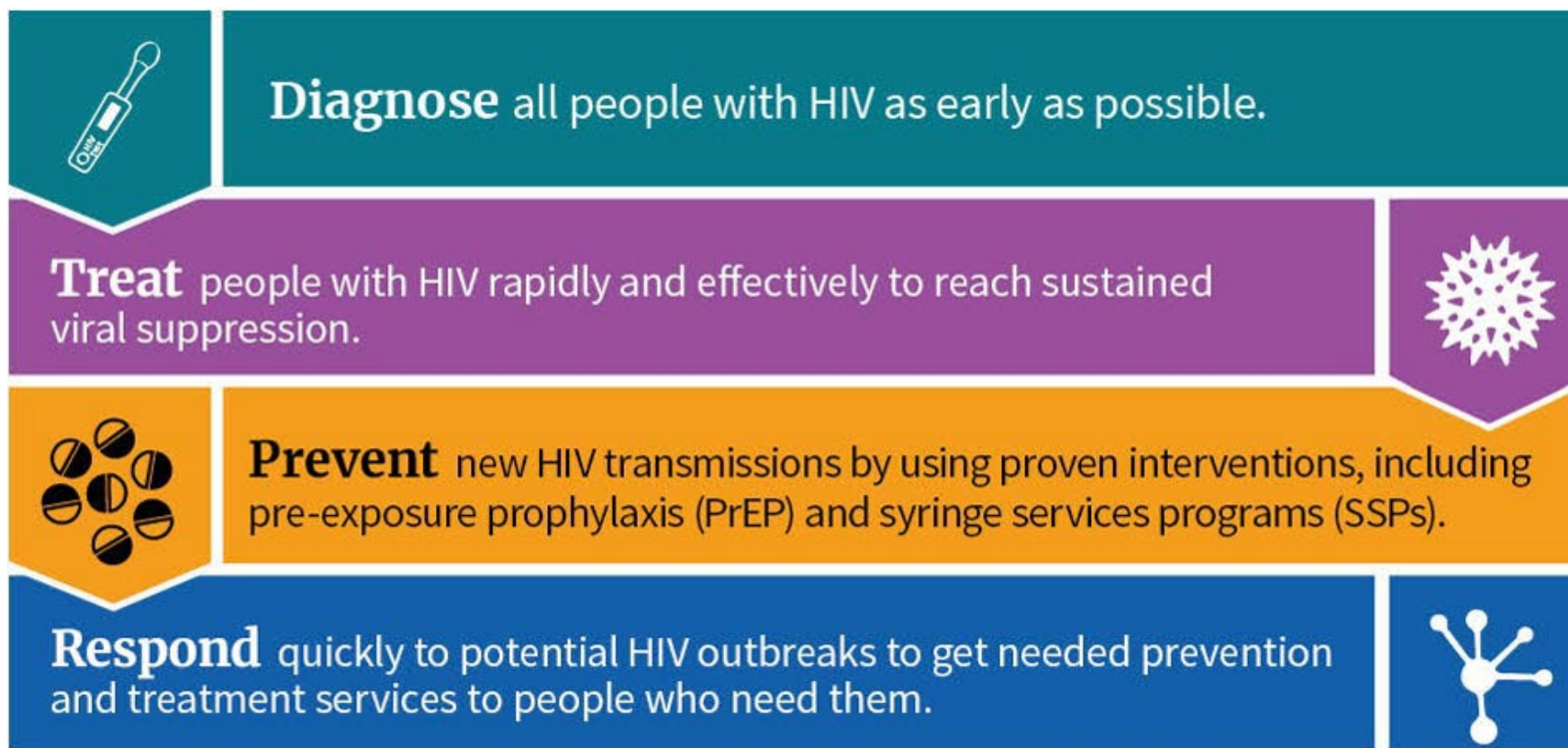
*Eligible metropolitan area (EMA) or a transitional grant area (TGA)

RYAN WHITE FEDERAL PROGRAMS: MN SPECIFICS



ENDING THE HIV EPIDEMIC

The Ending the HIV Epidemic initiative focuses on four key strategies that, implemented together, can end the HIV epidemic in the U.S.





TOGETHER
WE CAN END HIV.

MINNESOTA'S STRATEGY TO END HIV

- END HIV MN is a comprehensive long-term plan to end new HIV infections and improve health outcomes for people living with HIV in Minnesota.
- This legislatively mandated plan was created over several years by the Minnesota Department of Health (MDH), the Minnesota Department of Human Services (DHS), and the Minnesota HIV Strategy Advisory Board.
- The Minnesota Legislature identified four outcomes for END HIV MN.

END HIV MN: MEASURING SUCCESS: 4 AMBITIOUS GOALS



90%

Increase the percentage of Minnesotans living with HIV who know their HIV status to at least 90% by 2025

90%

Increase the percentage of Minnesotans diagnosed with HIV who are retained in care to at least 90% by 2025

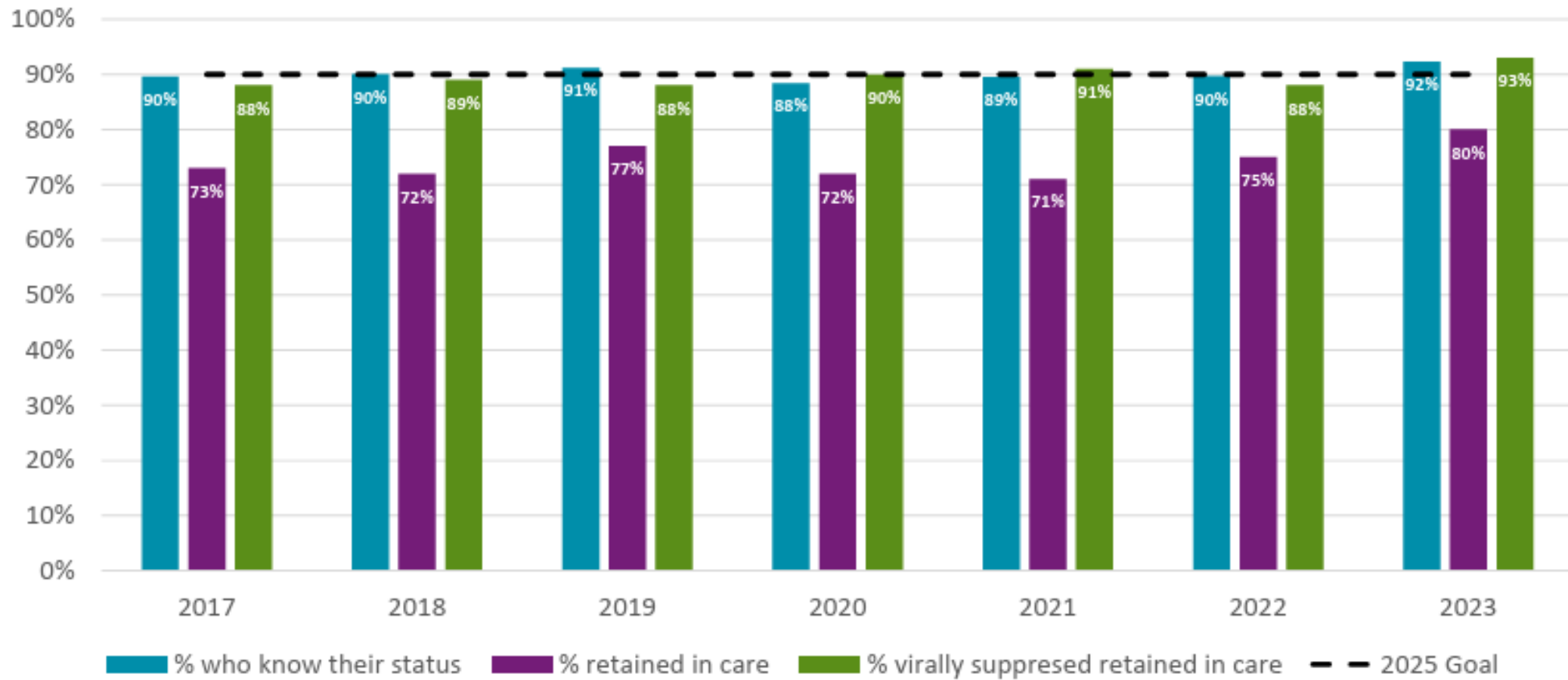
90%

Of individuals retained in care increase the percentage of Minnesotans who are virally suppressed to at least 90% by 2025

75%

Reduce the annual number of new HIV diagnoses in Minnesota by at least 25% by 2025 (225 cases) and at least 75% by 2035 (75 cases)

END HIV MN OUTCOMES, 2024



FUNDING

- » For FY 2026, the Trump administration submitted a budget request in May 2025 that proposed significant changes to federal HIV funding.
- » The proposal generally maintained funding for HIV care and treatment programs such as the Ryan White HIV/AIDS Program, while proposing major reductions or eliminations for several HIV prevention programs, particularly CDC HIV prevention activities.

State Opioid Response Grants: \$1.5 Billion over 2 Years

September 2025, HHS and SAMHSA announced more than **\$1.5 billion** in FY 2025 continuation funding for the State Opioid Response (SOR) and Tribal Opioid Response (TOR) programs, including about \$1.48 billion for states.

SAMHSA has continued to identify SOR as an active grant program and notes that annual continuation awards depend on congressional appropriations, grantee performance, and compliance requirements. Administration planning documents for FY 2026 specifically reference the State Opioid Response Grant program as one of the SAMHSA grant programs that would continue operating using available funding balances. Source: <https://www.samhsa.gov/newsroom/press-announcements/202008270530>

REFERENCES: ETHICS AND LEGAL

- » Center for HIV Law and Policy <https://www.hivlawandpolicy.org/states/minnesota>
- » CDC Compendium of State Laws (includes MN Statutes re: criminalization of knowing transmission) <https://www.cdc.gov/hiv/policies/law/states/index.html>
- » CDC Guidelines on Case Reporting and Surveillance <https://www.cdc.gov/hiv/guidelines/reporting.html>
- » MN Center for HIV Law and Policy <https://www.hivlawandpolicy.org/resources>
- » MN Health Department Disease Reporting Requirements and Resources
 - » Reporting HIV and AIDS (for health professionals) <https://www.health.state.mn.us/diseases/hiv/hcp/report.html>
 - » STD/HIV Partner Services Program for help with partner notification <https://www.health.state.mn.us/diseases/stds/partnerservices.html>
 - » FAQ on Reporting <https://www.health.state.mn.us/diseases/stds/hcp/reportfaq.html>
 - » HIV and TB Fact Info <https://www.health.state.mn.us/diseases/hiv/hcp/hivandtb.html>
- » UCSF Compendium of State HIV Laws Quick Reference https://nccc.ucsf.edu/wp-content/uploads/2014/03/State_HIV_Testing_Laws_Quick_Reference.pdf
- » How Should Physicians Respond if Patient HIV Denial Could Exacerbate Racial Health Inequities? *AMA J Ethics*. 2021;23(5):E382-387. doi: 10.1001/amajethics.2021.382. <https://journalofethics.ama-assn.org/article/how-should-clinicians-respond-if-patient-hiv-denial-could-exacerbate-racial-health-inequities/2021-05>

REFERENCES: FUNDING AND POLICY

- >> HRSA Information about Ryan White Programs:
<https://hab.hrsa.gov/about-ryan-white-hivaids-program/about-ryan-white-hivaids-program>
- >> CDC Information on Ending the HIV Epidemic in the US:
<https://www.cdc.gov/endliv/index.html>
- >> MN Department of Health End HIV MN Resources:
<https://www.health.state.mn.us/endlivmn#:~:text=END%20HIV%20MN%20will%20address,for%20people%20living%20with%20HIV>
- >> CDC Ending the HIV Epidemic Funding Announcement:
<https://www.cdc.gov/nchhstp/newsroom/2021/ehe-funding.html>

5-MINUTE STRETCH BREAK!



HIV RISK AND SUD HARM REDUCTION

LEARNING OBJECTIVES: HIV RISK AND SUD HARM REDUCTION

**Identify at least
3 critical HIV
sexual
transmission
risk reduction
strategies**

**Define
Harm Reduction
as it relates to
both SUD and
HIV and
describe at
least 3 harm
reduction
strategies**

**Describe the
current risks
associated with
synthetic
opioids and
specific harm
reduction
strategies to
mitigate those**

**Describe the
relationship
between SUD
and HIV risk**

DEFINITION OF HIV RISK REDUCTION

HIV risk reduction is the selective application of appropriate techniques and management principles to reduce the likelihood of a risky event and/or the negative consequences of such an event.

- The goal of risk reduction counseling is to help patients decrease risks to themselves and others, thereby decreasing the number of new HIV infections.
- Risk reduction helps decrease the rates of HIV infection through targeted prevention efforts.

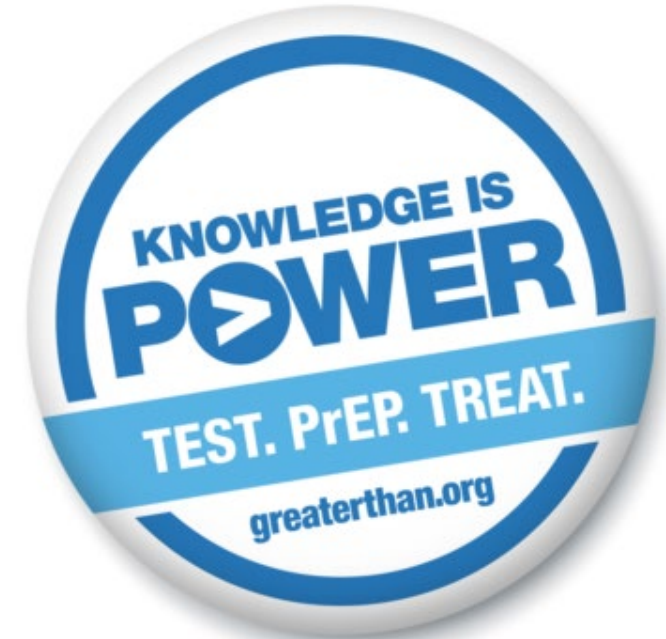
RISKS FOR HIV INFECTION

Risks for HIV infection

- » Unprotected sex
- » Sharing needles
- » Mother to child

Strategies for HIV prevention

- » Safer sex (condoms)
- » Routine testing
- » Antiretroviral advances
 - » Viral suppression (U=U)
 - » PrEP and PEP



PrEP AND PEP

PrEP (pre-exposure prophylaxis) is medicine people at risk for HIV take to prevent getting HIV from sex or injection drug use. When taken as prescribed, PrEP is highly effective for preventing HIV.

PEP (post-exposure prophylaxis) means taking medicine to prevent HIV after a possible exposure. PEP should be used only in emergency situations and must be started within 72 hours after a recent possible exposure to HIV.

INJECTION DRUG USE AND HIV INFECTION

HIV and Hepatitis C

- » Syringe access programs
 - » A variety of syringes to match a variety of injecting practices
 - » Related supplies (e.g., alcohol swabs, ties/tourniquets, etc.)
- » Safe smoking supplies (e.g., clean pipes, straws, lip balm)
- » Sexual health supplies
- » Overdose prevention supplies and education
- » Health educators available for brief interventions
- » Test strips for Fentanyl and other drugs
- » Safe consumption sites
- » Opportunities for Hepatitis C and HIV testing and linkage

SUD HARM REDUCTION

GROUP DISCUSSION

What daily Harm Reduction strategies
are you familiar with?



Please raise your hand if you'd like to share.

DEFINITION OF SUD HARM REDUCTION

Harm Reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use.

Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.

National Harm Reduction Coalition

WHAT HARM REDUCTION PROVIDES

- » Non-judgmental support
- » A collaborative approach
- » An understanding that refraining from drug use may not be the only step in the healing process. Change can happen in other areas even while people are still using.
- » A strong belief in the client's capacity to care for themselves, including prevention of HIV and other drug related health concerns.
- » An educational approach
- » Allows for mental health and substance use concerns to be treated together
- » Supports self-trust, self-efficacy and autonomy
- » Client-centered, client-tailored services

SUBSTANCE USE SPECTRUM

>> *People use substances for different reasons, religious, personal enjoyment, or to cope with stress, trauma, or pain.*

Non-use

Avoiding use of substances

Beneficial Use

Use that has positive health, social or spiritual effects

Lower Risk Use

Use that has minimal impact to a person, their family, friends and others

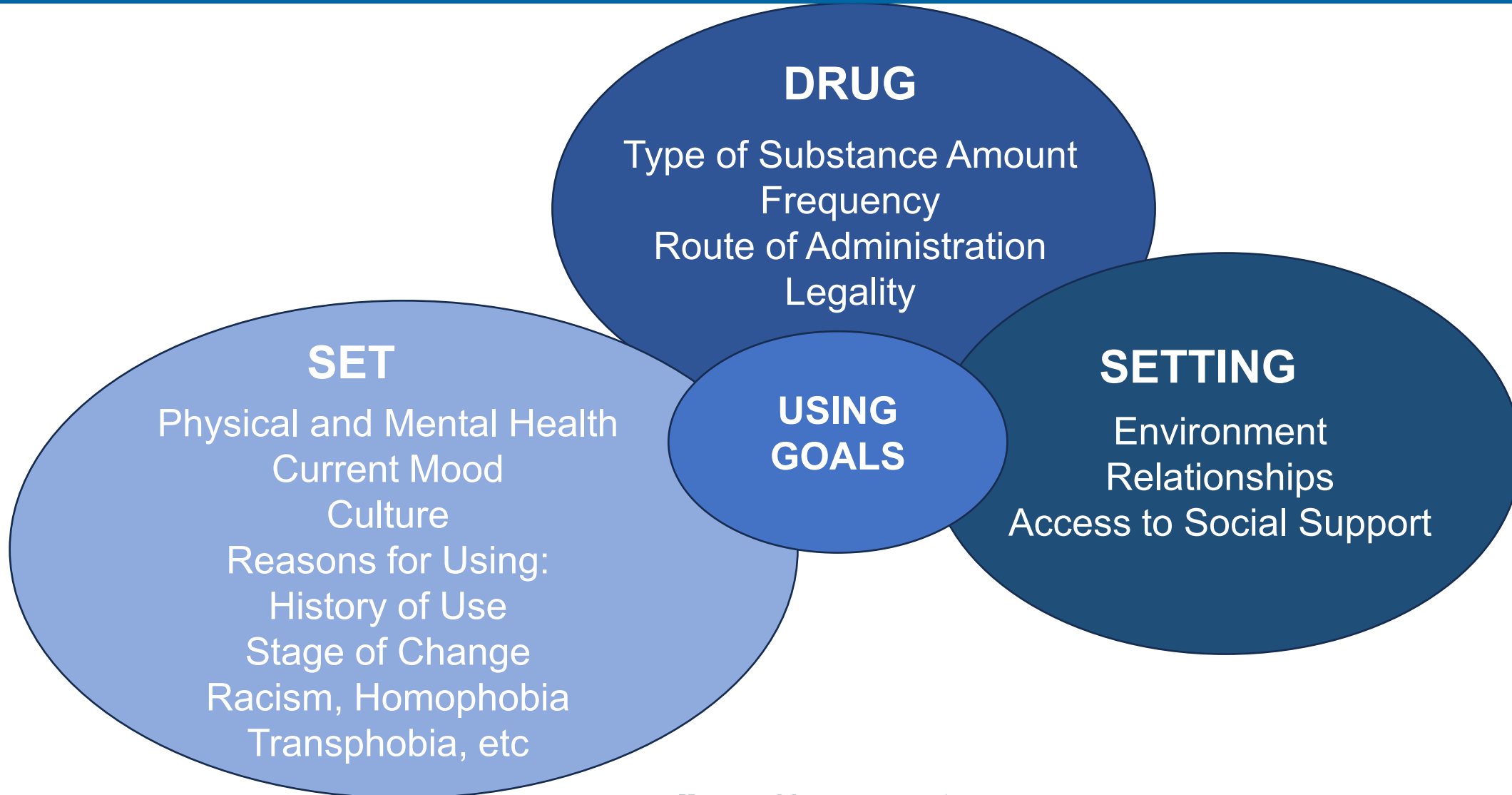
Higher Risk Use

Use that has a harmful and negative impact to a person, their family, friends and others

Addiction

A treatable medical condition that affects the brain and compulsive and continuous use despite negative impacts on the person, family, friends and others

ADAPTED FROM ZINBERG'S MODEL OF DRUG, SET AND SETTING



HARM REDUCTION : ALCOHOL USE AND HIV

- » Explore the pros and cons of drinking
- » Discuss drug, set and setting
- » Consider alternating drinks
- » Discuss budget and finance options
- » Phone Apps (Saying When)
- » Groups
- » PrEP and PEP

HARM REDUCTION: SUBSTANCE USE + SEX

SAN FRANCISCO AIDS FOUNDATION PRESENTS

OD PREVENTION TIPS: **SEX PARTIES**

**MAKE OD PREVENTION PART OF
THE PRE-PARTY SAFETY PLAN.**

DISCUSS WITH SEX PARTNERS BEFOREHAND
WHAT STEPS THEY WOULD LIKE TO TAKE
TO PREVENT AN OVERDOSE.

HAVE NARCAN AND WATER ON HAND.

IF SOMEONE TAKES TOO MUCH GHB, TURN
THEM ON THEIR SIDE ("RESCUE POSITION")
SO THEY DON'T CHOKES ON THEIR VOMIT.

DESIGNATE ONE PERSON TO CALL 911 AND ONE
PERSON TO RESPOND. KNOW YOUR LOCATION
AND WHERE THE NARCAN IS LOCATED.

- » Building Healthy Online Communities - <https://bhocpartners.org/>
- » Testing (including home testing) - <https://together.takemehome.org>
- » Hooking up and meth – [Tweaker.org](https://tweaker.org)
- » San Francisco AIDS Foundation - <https://www.sfaf.org/resource-library/safer-drug-use/>

OVERDOSE PREVENTION – METHAMPHETAMINES AND OPIATES

SAN FRANCISCO AIDS FOUNDATION PRESENTS

OD PREVENTION TIPS: **METH**

WHAT TO DO WHEN YOU GET WAY TOO HIGH ON STIMULANTS...

DRINK PLENTY OF WATER OR GATORADE.

GET SOME REST—
SLEEP REALLY HELPS.

WALK IT OFF IF
YOU CAN'T SLEEP.

REMEMBER TO EAT. EVEN A PIECE OF
FRUIT OR A SMOOTHIE CAN REALLY HELP.

COOL DOWN WITH AN ICE PACK
IF YOU'RE OVERHEATED.

CALL 911 IF YOU ARE EXPERIENCING
CHEST PAIN, SHORTNESS OF BREATH,
OR SIGNS OF STROKE OR SEIZURE.

SAN FRANCISCO AIDS FOUNDATION PRESENTS

OD PREVENTION TIPS: **OPIATES**

**SOMEONE OVERDOSING ON OPIATES
WILL NOT BE RESPONSIVE. THEY WON'T
BE BREATHING, OR THEIR BREATHS
WILL BE SLOW AND SHALLOW.**

OTHER THINGS TO LOOK FOR:

BODY IS LIMP (OR STIFF)

SKIN COLOR CHANGES

COLOR TURNS GRAY OR ASHEN FOR DARKER SKIN,
BLUISH-PURPLISH FOR LIGHTER SKIN. FINGERNAILS
AND LIPS MAY TURN BLUE OR DARK PURPLE

NOISES SNORING, CHOKING,
OR GURGLING

VOMITING



OVERDOSE PREVENTION – SAFER USE

SAN FRANCISCO AIDS FOUNDATION PRESENTS

OD PREVENTION TIPS: *SAFER USING*

**GET HIGH WITH FRIENDS AND
KEEP AN EYE ON EACH OTHER.**

WHEN SMOKING
FENTANYL, SMOKE A
SMALL AMOUNT FIRST.
YOU CAN ALWAYS DO
MORE BUT YOU
CAN'T DO LESS!

**MAKE SURE EVERYONE
HAS NARCAN AND
YOU KNOW WHERE IT
IS. HAVE IT READY!**

**HAVE SOMEONE
NEARBY TO HELP
IN CASE YOU OD.**

WEAR A MASK
AND KEEP 6 FT.
DISTANCE FROM
EACH OTHER
TO PREVENT
COVID-19.

SAN FRANCISCO AIDS FOUNDATION PRESENTS

OD PREVENTION TIPS: *GETTING HIGH ALONE*

**REMEMBER THAT YOU CAN ALWAYS
DO MORE, BUT YOU CAN'T DO LESS.**

HAVE SOMEONE ON THE
PHONE WHILE YOU GET
HIGH SO THEY CAN CALL
FOR HELP IF YOU OD
(BE SURE THEY KNOW
YOUR LOCATION).

TEXT YOUR LOCATION
TO A FRIEND BEFORE
USING. ASK THEM TO
CHECK ON YOU, AND
IF YOU DON'T TEXT
BACK TO CALL 911.

**TRY DOING A SMALL AMOUNT FIRST
TO SEE HOW STRONG IT IS.**

CONSIDER ALTERNATE WAYS OF USING
INSTEAD OF INJECTING:

SMOKING SNORTING BOOTY BUMPING

OVERDOSE PREVENTION

➤ Overdose prevention includes messages, such as:

- Never Use Alone
- Do a test dose
- Go slow
- Don't stack doses
- Don't mix drugs, especially depressants
- Switch from injection to smoking
- Know signs of overdose and how to respond
- Always carry naloxone



Sources: Never Use Alone.
(n.d.). Never use alone.
<https://neverusealone.com>

NALOXONE (NARCAN) SAVES LIVES



- » **What is Naloxone?** A medication that can reverse an overdose.
- » **Signs of overdose:** Unconscious or not responding, not breathing or slow breathing, turning gray or ashen or bluish, gurgling noises, body is limp, skin is clammy.
- » **What to do?** Call their name loudly or clap your hands, sternum rub. If not responding, administer Narcan and call 911.
- » **Ways to administer Naloxone:** Nasal and Intramuscular
 - » Considerations in the Fentanyl era
- » **Who should carry Naloxone?** Everyone
- » MN Good Samaritan/Steve's Law
- » [Naloxone Partners](#)

WHY HARM REDUCTION FOR EFFECTIVE SUPPORT

- » Because it considers a spectrum use, not just drugs or no drugs
- » Because it sees drug use from an ecological lens, not just an individual lens
- » Because it can explore drug-set-setting
- » Because it allows **ambivalence** in the room
- » Because not all drug use is abuse or misuse
- » Because it's about support, not punishment (housing v/s drugs). Inclusion, not exclusion.
- » Because it reduces **stigma** (which is more harmful than drugs)
- » Because it is trauma informed
- » Because it starts from a place of compassion and love
- » Harm Reduction is Shame Reduction

HIV AND SUBSTANCE USE STIGMA

LEARNING OBJECTIVES: HIV AND SUBSTANCE USE STIGMA

Define the three different types of stigma and how stigma influences testing, retention in treatment and outcomes of HIV and SUD

List at least three potential impacts of stigma on clients with SUD and/or HIV

Identify three strategies for reducing stigma faced by clients with SUD and HIV

UNPACKING STIGMA

“I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.”

— Maya Angelou



HOW DO WE DEFINE STIGMA?

CATEGORIES OF STIGMA

Self-Stigma

Social Stigma

Structural Stigma

Category (group)



+ Generalization

Stereotype (label)



+ Judgment

Prejudice (attitude)



+ Action

Discrimination (behavior)



+ Power

**Oppression/ "Isms"
(process, system)**

STIGMA: FUNCTIONAL OUTCOMES AND CONSEQUENCES

Key Elements:

Blame and Moral Judgment
Pathologize and Patronize
Fear and Isolation (the
opposite of connection)
Criminalize

Functional Outcomes of Stigma:

Difference --- To keep people out
Danger ---To keep people away
Discrimination---To keep people
down

HOW DOES STIGMA IMPACT PEOPLE WITH HIV & PEOPLE WHO USE DRUGS?

- » Incarceration
- » Limit to housing options
- » Limit to treatment options
- » Poor or unavailable healthcare services
- » Limit access to culturally concordant services
- » Fewer funds for research
- » Poor treatment for pain
- » Poor treatment for mental health concerns
- » Limit to job opportunities
- » Loss of parenting rights
- » Loss of reproductive rights
- » Disconnection from families or loved ones
- » People are less likely to ask for support
- » Possible hepatitis C (HCV) and sexually transmitted infections (STIs)
- » Lack of access to OD prevention
- » Lack of access to syringes

STIGMA IS OFTEN EXACERBATED BY

Lack of context

Misinformation and myths

Poorly conceived policies

Discriminatory or dehumanizing language

LANGUAGE

Remember:
Beverages are alcoholic,
not people

Laundry is dirty and clean,
not people

FIGURE 4: BETTER LANGUAGE

 USE	 DON'T USE
Person who uses drugs	Drug user
Person with non-problematic drug use	Recreational, casual, or experimental users
Person with drug dependence, person with problematic drug use, person with substance use disorder; person who uses drugs (when use is not problematic)	Addict; drug/substance abuser; junkie; dope head, pothead, smack head, crackhead etc.; druggie; stoner
Substance use disorder; problematic drug use	Drug habit
Has a X use disorder	Addicted to X
Abstinent; person who has stopped using drugs	Clean
Actively uses drugs; positive for substance use	Dirty (as in "dirty screen")
Respond, program, address, manage	Fight, counter, combat drugs and other combatant language
Safe consumption facility	Fix rooms
Person in recovery, person in long-term recovery	Former addicts; reformed addict
Person who injects drugs	Injecting drug user
Opioid substitution therapy	Opioid replacement therapy

GROUP DISCUSSION

What are some of the ways you can begin to dismantle stigma (individually or in your organization)?



Please raise your hand if you'd like to share.

EXPLORE NETWORKS WHICH SUPPORT PEOPLE WHO USE DRUGS SUCH AS: INPUD, VOCAL AND URBAN SURVIVORS UNION



Anti-stigma campaign by UK agency, Release
<https://www.release.org.uk/nice-people-take-drugs>



The Street Lawyers
GADEJURISTEN
HARDCOREHARMREDUCER

<https://supportdontpunish.org/>

Explore networks that support people who use drugs or have HIV, such as: VOCAL, INPUD, Urban Survivors' Union, Unshame CA

HIV, PREGNANCY AND SUD/LOUD

*Throughout this presentation the terms mother or maternal or she or her are used in reference to the birthing person. We recognize not all birthing persons identify as mothers or women. We believe all birthing people are equally deserving of gender-specific care that helps them attain their full potential and live authentic, healthy lives.

LEARNING OBJECTIVES: HIV, PREGNANCY AND SUD/OD

Summarize at least 3 major considerations (important headlines) for HIV+ pregnant persons with SUD

List 3 approaches to reduce the risk of HIV transmission from a birthing person to an infant during pregnancy, breastfeeding

Compare the effectiveness of and considerations for using substance use disorder treatment with medications and other treatments for SUD in pregnant and parenting persons

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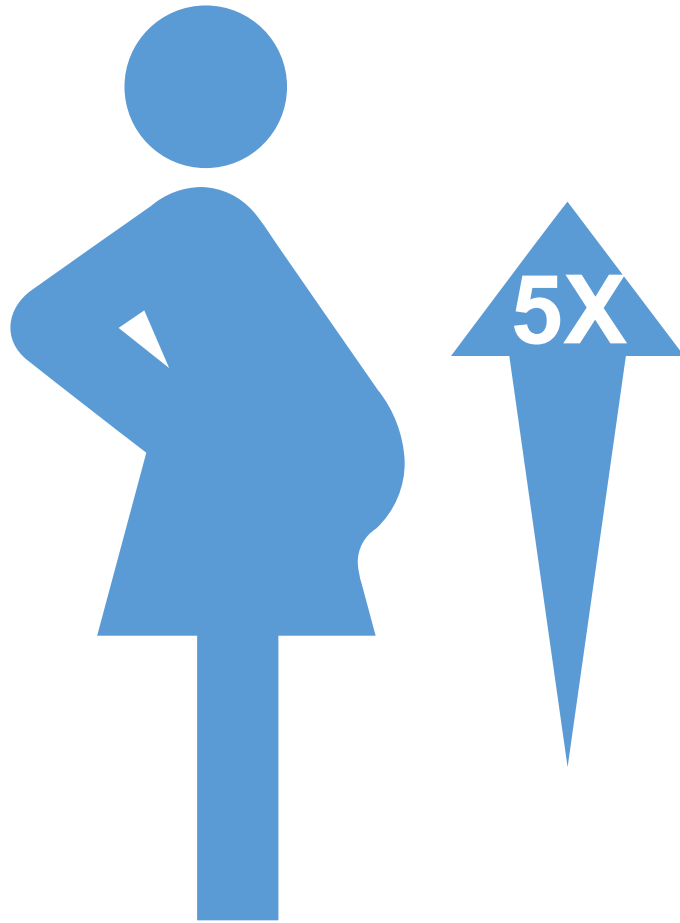
CHATTER FALL

Please take a minute to type your response in the Zoom Group Chat, but don't click enter.

What information do you need to better prepare you to care for pregnant/parenting persons with OUD, SUD, HIV and their affected children?

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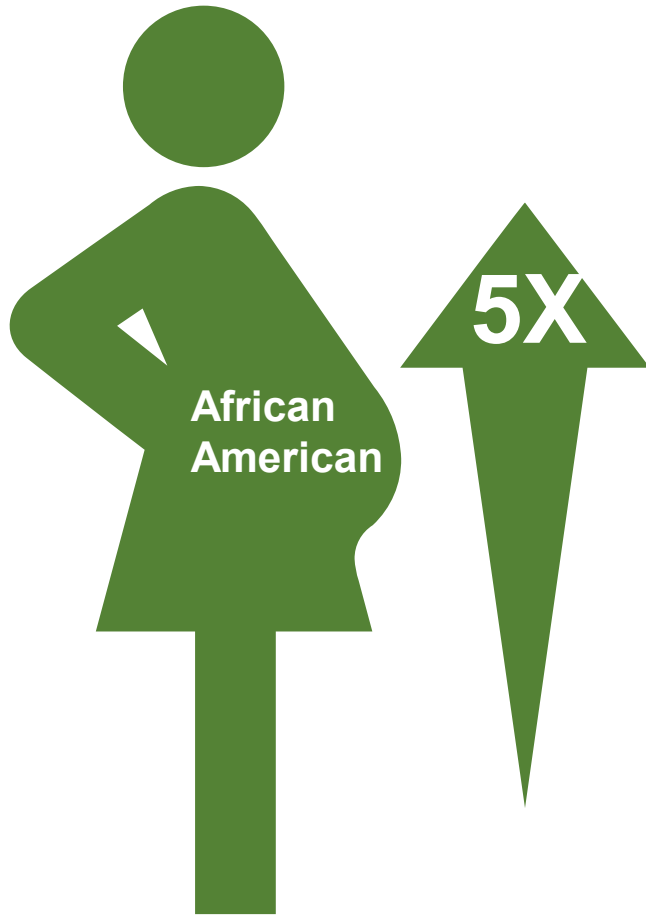
EPIDEMIOLOGY OF SUD DURING PREGNANCY



- SAMHSA data: > 400,000 infants are exposed to alcohol and other potential substance of abuse during pregnancy in the US each year
- Number of pregnant women with OUD increased from 1.5/1000 → 8.2/1000 live births (1999-2017)
- In MN the prevalence of Neonatal Abstinence Syndrome (NAS) was 10.3/1000 live births (7.3/1000 in US)
- Twenty-seven (27%) percent reported they wanted to cut down or stop using but didn't know how
- Eight percent (8%) of women with OUD/SUD receive needed treatment (most are never screened)

Sources: SAMHSA and National Survey on Drug Use and Health, 2022

EPIDEMIOLOGY OF HIV DURING PREGNANCY IN THE UNITED STATES



- >> Approximately 8,000 HIV+ women give birth in the US every year and fewer than 50 infants are born with HIV
- >> Transmission of HIV can occur throughout pregnancy, during childbirth and with breastfeeding (Perinatal Maternal to Child Transmission – PMTCT)
- >> While the US and Europe have experienced steep declines in perinatal HIV transmission (to <1%), African American infants have 5X the incidence of perinatal HIV transmission versus white infants
- >> In MN the incidence of HIV infected neonates has been ZERO since 2018
- >> Approaches to PMTCT prevention vs. treatment vary across the globe

POTENTIAL EFFECTS OF PERINATAL HIV AND SUD ON THE BIRTHING PERSON AND BABY



CASE: KAYLA

Kayla is 23-year-old HIV+ woman with a positive pregnancy test during a primary care visit for persistent nausea. Upon examination, Kayla is found to be 11 weeks pregnant. She states the pregnancy was not expected but she wants to keep the child. **In response to questions from an evidence-based verbal screening tool**, she indicated that she takes both oxycodone and hydrocodone for persistent back pain that resulted from a car accident when she was 19. She is still complaining of back pain and is worried that as the pregnancy goes on, her back pain will worsen. Kayla is **mostly compliant with her ART**, but occasionally skips her specialty follow-up visits. She acknowledges that she takes more than the prescribed amounts of opioids. Although concerned her pain may exacerbate during pregnancy, **she would like assistance with her opioid misuse and is concerned about the risk of HIV transmission to her infant.**



HIV POSITIVE PREGNANCIES: WHERE HAVE WE BEEN?

- By 1987 the approval for AZT (zidovudine) enabled the treatment and prophylaxis of pregnant women with HIV in the US and globally*
- By the 1990s, short course ART or single dose AZT was available across the globe
- We witnessed Perinatal Maternal to Child Transmission (PMTCT) rate decrease from 25% to less than one percent (<1%) in the US and other high-income countries



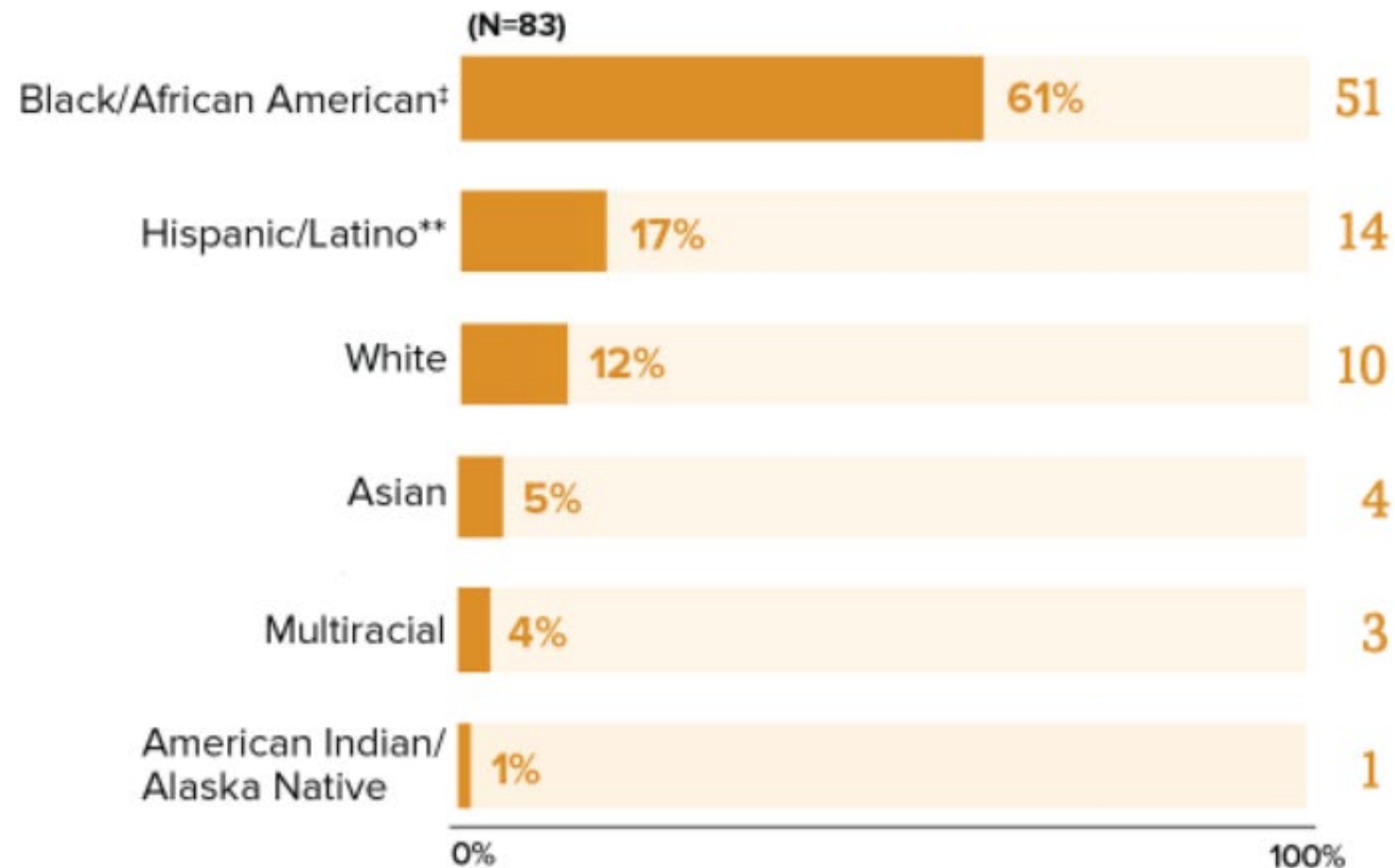
SOURCE: free.unaids.org

PERINATAL HIV INFECTIONS IN THE US AND DEPENDENT AREAS BY RACE/ETHNICITY, 2019

New perinatal HIV diagnoses disproportionately affect certain racial and ethnic groups.



Source: CDC HIV Surveillance Report, 2021;32

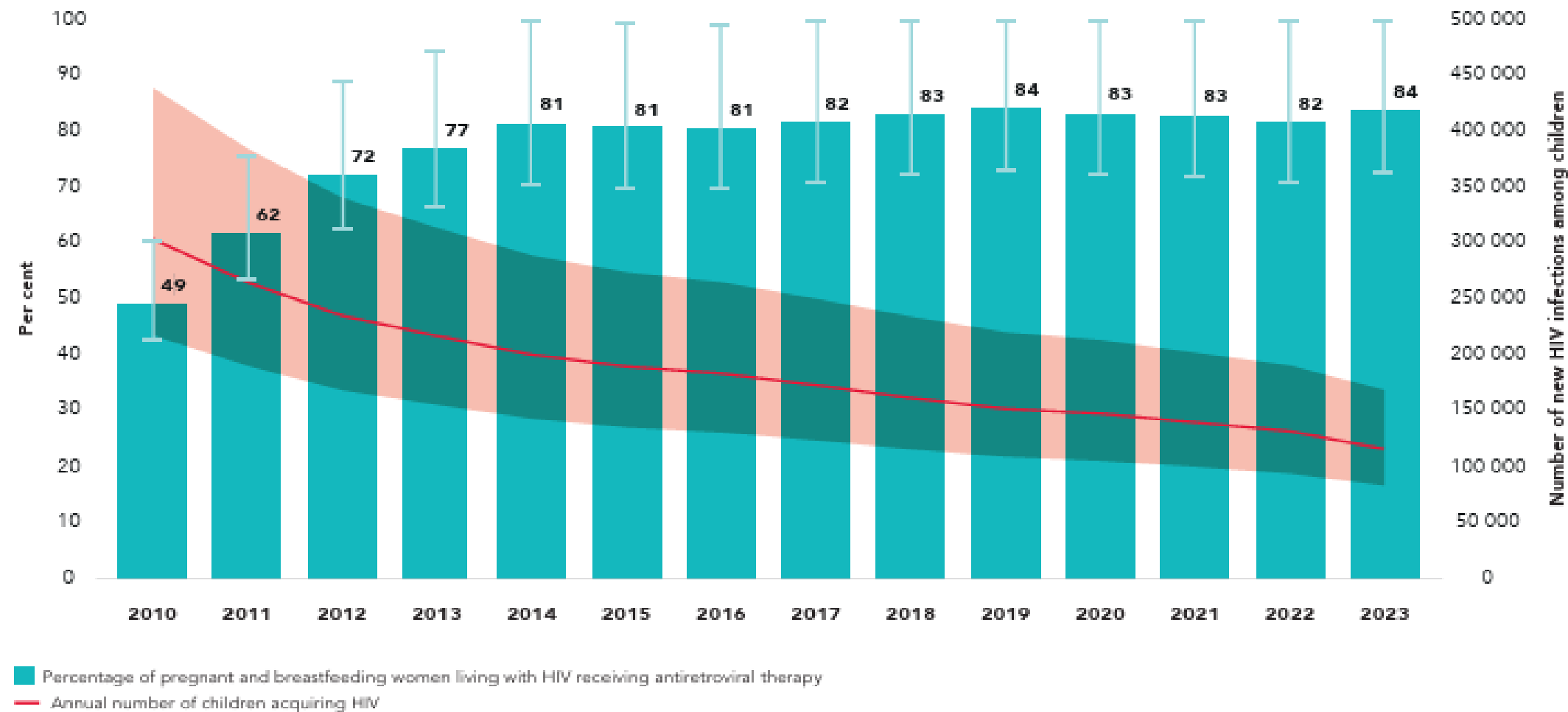


WHERE HAVE WE FAILED IN ADDRESSING PERINATAL HIV/AIDS IN THE US?

- Overall, the number of infants and young children infected from perinatal transmission continues to decline: from 141 cases in 2014 to 51 cases in 2019 (and has been ZERO in MN for the past few years)
- In the United States, the overwhelming majority of new cases of HIV in children occurs among Black/African American Children
 - The racial/ethnic disparity of HIV diagnosed children under 13 years is greater than for adults (60% of children are Black/African American vs 57% of adults)

Source: CDC HIV Surveillance Report, 2021;32

NEW HIV INFECTIONS AMONG CHILDREN AND ART COVERAGE AMONG PREGNANT WOMEN WORLDWIDE



SOURCE: UNAIDS epidemiological estimates, 2024 (<https://aidsinfo.unaids.org/>).

WHERE HAVE WE FAILED IN ADDRESSING PERINATAL HIV/AIDS ACROSS THE GLOBE?

- » The World Health Organization (WHO) and other Global HIV/AIDS guidelines have focused for decades on the prevention of PMTCT – some would say to the exclusion of treatment
- » The PMTCT cascade of tests and treatment are managed in the US and high and middle-income countries, but in low to middle-income countries, the necessary systems are immature to non-existent
- » Integrating PMTCT and Maternal-Neonatal-Child Health programs and simplification for WHO guidelines has improved timely initiation of ART, but post-partum engagement of HIV infected/exposed mothers and infants is still problematic

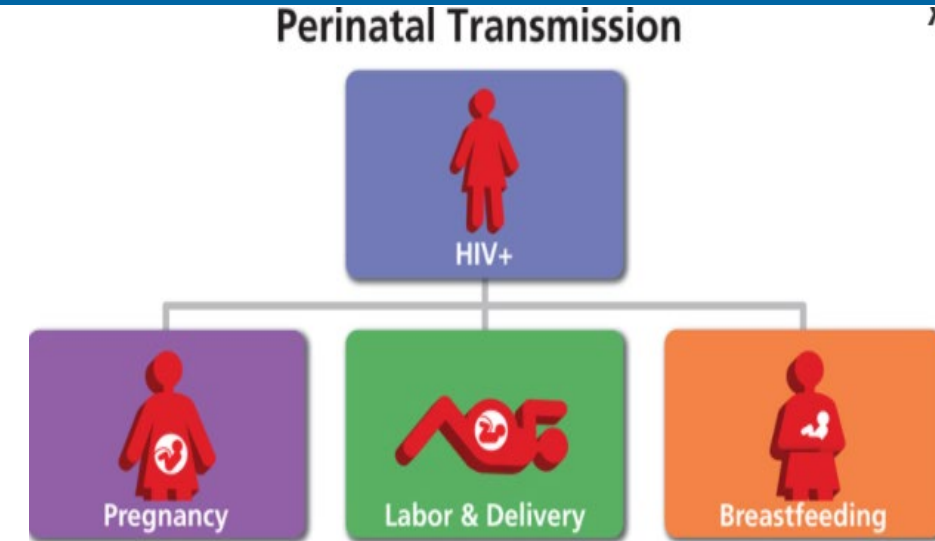


Photo Source: Microsoft Stock Photos

IMPORTANT FACTS TO KNOW ABOUT HIV POSITIVITY DURING PREGNANCY AND PERINATAL TRANSMISSION

HIV infection can be:

- » Passed vertically from mom to fetus during pregnancy
- » Spread through contact with blood and bodily fluids during childbirth
- » Passed through breastmilk
- » Routine HIV screening of all sexually active persons with childbearing potential should occur as early as possible during pregnancy (opt-out)
- » Because of disparities in access to screening, prevention and treatment, we should ensure that individuals from other countries receive information during pre-conception counseling and offered screening and treatment



CONSIDERATIONS WHEN PREGNANCY, HIV, AND SUD COEXIST

- » Some substances are more detrimental to those at risk for or who have HIV than others
 - » Stimulants have been associated not only with increased risky behavior, but with accelerated HIV disease progression, poor ART adherence and lack of viral suppression
 - » Alcohol, benzodiazepine and opioid use all increase risky behaviors associated with HIV; cannabis does not appear to have the same significant effect
- » Screening for SUD should be part of routine clinical care of persons with HIV

SOURCE: Ross EJ et al. Overamped: Stimulant Use and HIV Pathogenesis. Curr HIV/AIDS Rep. 2023 Dec;20(6):321-332

CONSIDERATIONS WHEN PREGNANCY, HIV AND SUD COEXIST (CONT.)



Recommendations for the Use of Antiretroviral Drugs in Pregnant Women with HIV Infection *and* Interventions to Reduce Perinatal HIV Transmission in the United States

- » Individuals on substance use disorder treatment with medications are more likely to initiate and maintain ART regimens
- » Ongoing SUD is NOT a contraindication to prescribing/using ART
 - » Use of low risk, easy ART regimens are preferred
- » ART agents that inhibit or induce the CYP system (liver enzymes) may interact with methadone and buprenorphine (no such interaction with naltrexone)
- » PrEP should always be used for high-risk encounters including during pregnancy and breastfeeding for HIV negative persons

PERINATAL SUD





CHATTER FALL

Please take a minute to type your response in the Zoom Group Chat, but don't click enter.

Medications for Opioid Use Disorder (MOUD) generally should..

- A.** Be increased during pregnancy
- B.** Be decreased during pregnancy
- C.** Not be used during pregnancy

**When instructed, please
click enter.**

TIME FOR A POLL

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MEDICATION FOR OPIOID USE DISORDER IS STANDARD OF CARE IN PREGNANT PERSONS WITH SUD

Treatment	Overdose Deaths	Retention in Treatment	Pregnancy Outcomes	Neonatal Abstinence Syndrome (NAS)
Detoxification/ Withdrawal				
Methadone				
Buprenorphine (Mono)				
Buprenorphine/ Naloxone				
Naltrexone				
	Research indicates use is contraindicated and/or that risks of poor outcome outweigh benefits of use			
	Research is insufficient to conclude that benefits outweigh risks or benefits exceed other meds			
	Research indicates that benefits do outweigh risks or that benefits do exceed those of other meds			

ADDITIONAL CONSEQUENCES OF OPIOID USE DURING PREGNANCY

- » Fetus exposed to unstable opioid levels
- » Mother less likely to get prenatal care
- » Fetus & mother more likely to be exposed to morbidity & mortality from IDU & risky behaviors
 - » HIV, HCV
 - » Endocarditis, cellulitis
 - » Trauma



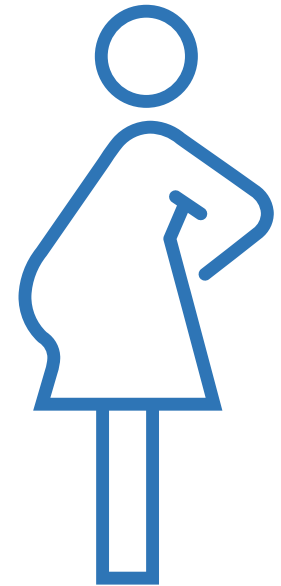


BENEFITS OF MOUD USE DURING PREGNANCY

- » Reduced complication of IDU
- » Seventy-five percent (75%) less likely to die related to their addiction
- » Improves adherence to prenatal care & addiction
- » Safer and healthier communities
- » Reduced cravings
- » Reduced illicit opioid use
- » Reduced OD events
- » Reduced criminal behavior
- » Reduced risk of obstetric complications

CASE STUDY: KAYLA'S NEWBORN

- » Baby M was born in February 2019
- » Initially ambivalent, Kayla warmed to the idea of being a mom
- » Mom is HIV+ (adherent on ART) with undetectable viral load 1 week prior to delivery. She has not been adherent with buprenorphine and has continued intermittently using pressed opioid pills and occasional alprazolam
- » Total infant stay was 28 Days
- » Total morphine need was:
 - » 50.6 mg total
 - » 18.7 mg/day
 - » 2.3 mg/dose
- » Infant stayed on 4 different hospital units
- » Kayla felt judged, inadequate and powerless



CONSEQUENCES OF PERINATAL SUD

	Preterm Labor	Low Birthweight	Fetal demise	Cognitive or Developmental Effects	Other
Tobacco	X	X	X		Birth defects
Alcohol	X	X		X	Fetal Alcohol Spectrum Disorders (FASD)
Cannabis		X	X	X	Mood/ behavioral disorders
Opioids	X	X		X	Abruption, Neonatal Abstinence Syndrome (NAS)

SOURCE: See consolidation of Perinatal Outcome References at end of this presentation

TIME FOR A POLL

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Note:
Methadone (MTD)
Neonatal Abstinence Syndrome (NAS)

TIME FOR A POLL

Which of the following statement(s) is/are most accurate about infants exposed to opioids?

- A. Infants born of mothers receiving SUD treatment with Buprenorphine or Methadone for more than 6 weeks during the pregnancy rarely have symptoms of neonatal abstinence syndrome (NAS).
- B. The modified Finnegan score is the gold standard for monitoring infants with NAS.
- C. Mothers on substance use disorder treatment with medications should never breast feed their infants.
- D. Cannabis use causes fewer short and long-term effects on exposed infants than do opioids.
- E. A significant percentage of opioid exposed infants with NAS can be treated without pharmacotherapy.

NAS is a post-birth drug withdrawal syndrome characterized by:

CNS irritability

Autonomic hyperreactivity

GI dysfunction



Photo Source : Jill Suave on Unsplash

NEONATAL ABSTINENCE SYNDROME (NAS): HOSPITAL CARE

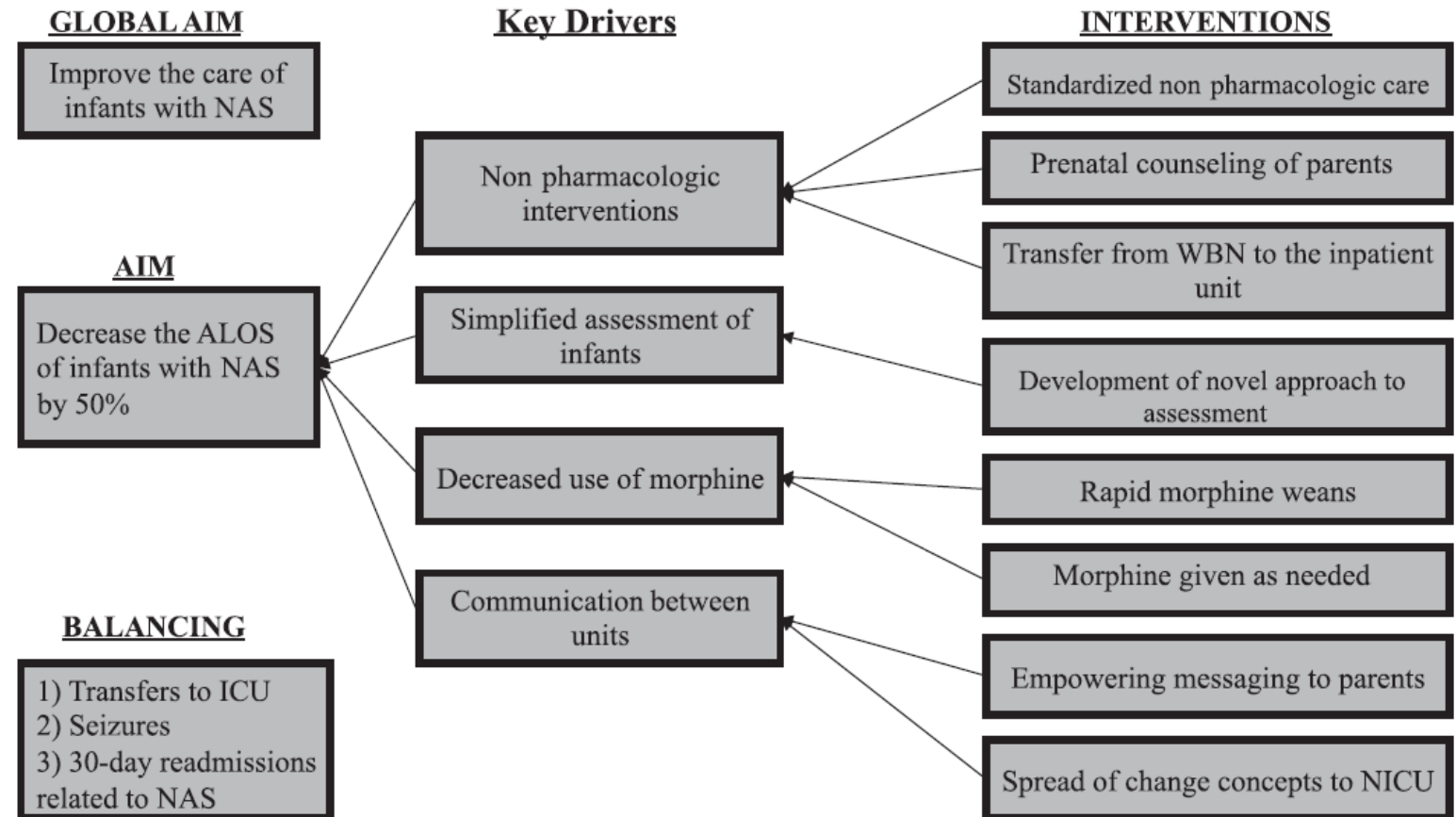
- » NAS may not be recognized (occurs in 50-80% of exposed infants)
- » Goals
 - » Optimize growth and development
 - » Minimize negative outcomes
 - » Support secure attachment and post-discharge opportunity for health and wellbeing
 - » Reduce lengths of stay and treatment
- » Having a protocol for identification and management is critical
- » Historic approaches to management are giving way to new paradigms

CHANGING PARADIGMS OF CARE FOR NEONATES WITH NAS

Eat - ≥ 1 oz or full breast-feeding session

Sleep - ≥ 1 hour between feeds

Console – Cease crying within 10 min. of being consoled



Grossman MR, et al. Pediatrics. 2017;139(6):e20163360

Picture from Admin of Children and Families.

CHANGING PARADIGMS OF CARE FOR NEONATES WITH NAS

- » **Special ward setting** (non-ICU)
- » **Staffing** - dedicated, trained
- » **Mom's Roles** – assessments
- » **Improved communication**
- » **Comprehensive care**

**Prenatal
Consultation**



**Inpatient Observation &
NAS Treatment while
Rooming In**



**Appropriate Neuro-
developmental + Primary
Care Follow-Up and
Support**

Source: Czynski A. *Family Care Support Services, Women and Infants Hosp, RI*

STANDARDIZED NON-PHARMACOLOGIC CARE BUNDLE

- » Support and coaching for parents (consoling support interventions)
- » Proactive skin protection
- » Environmental Accommodations



- Maternal presence and Rooming-in
- Dim lights
- Reduced NICU admission
- Reduced/coordinated interventions
- Reduction in white noise/sound (location)
- Limit visitors

STANDARDIZED NON-PHARMACOLOGIC CARE BUNDLE CONT.

- » Swaddling
- » Cuddler program
- » Breastfeeding promotion/On demand feeds
- » Non-nutritive sucking
- » Establishing policies and procedures
 - » Non-pharmacologic interventions
 - » As needed (PRN) vs. scheduled Morphine
 - » Guidelines for assessment and monitoring
 - » Methadone and adjunctive therapies
 - » Rapid medication weaning protocol

Outcomes realized:

- Better engaged, more confident parents
- Reduced use and absolute dosage of medication
- Reduced length of stay
- Reduced overall costs of care



EDUCATE STAFF ABOUT NAS AND EMERGING PRACTICES

Identification, evaluation, and treatment

- Clinical providers and staff with strong foundation of knowledge can educate and support families
- Positive interactions with families of newborns with NAS contribute to better outcomes and reduced LOS
- Provider and staff interactions with families should be supportive and non-judgmental
- Families can play valuable role in care, including mothers being encouraged to breastfeed if on stable substance use disorder treatment with medications



Photo Source: Microsoft Stock Images

OPIOIDS and NAS

When reporting on mothers, babies,
and substance use

LANGUAGE MATTERS



I am not an addict.

I was exposed to substances in utero. I am not addicted. Addiction is a set of behaviors associated with having a Substance Use Disorder (SUD).



I was exposed to opioids.

While I was in the womb my mother and I shared a blood supply. I was exposed to the medications and substances she used. I may have become physiologically dependent on some of those substances.



NAS is a temporary and treatable condition.

There are evidence-based pharmacological and non-pharmacological treatments for Neonatal Abstinence Syndrome.



Photo Source: Microsoft Stock Images
Language Matters Information Sheet nationalperinatal.org

EMPOWERING MESSAGES TO PARTNERS

“On the inpatient unit, we explained that our first-line and most important treatment would center around measures to comfort the infant and that these should be performed by a family member. Parents were told that they were the treatment of their infants and must be present as much as possible. Nurses and physicians focused on supporting and coaching parents on the care of their infants.”

BREASTFEEDING AND PARENTAL SUD AND HIV

BENEFITS OF BREASTFEEDING

Breastfeeding reduces the risk of:

- Respiratory infections and otitis media
- Gastrointestinal infections
- Sudden infant death syndrome
- Protection against allergic disease
- Celiac disease, inflammatory bowel disease
- Obesity, diabetes (types 1 and 2)
- Adverse neurodevelopmental outcomes
- Maternal benefits: reduced risk of breast and ovarian cancer
- Maternal bonding/decreased risk of abuse
- Breastfed infants less likely to require pharmacological intervention for NAS
- Reduced symptoms of NAS
- Shorter length of stay for NAS
- Shorter duration of pharmacologic treatment when needed for NAS

CONTRAINDICATIONS TO BREASTFEEDING

- >> Medical contraindications in infant (e.g., galactosemia +/- phenyl ketonuria [PKU])
- >> Specific Maternal infections

- ❖ HIV*

- ❖ Brucellosis (untreated)

- ❖ Cracked nipples in women with HepB/C**

- ❖ COVID-19***

- ❖ Human T-lymphocyte virus (HTLV) I or II

- ❖ Active, untreated tuberculosis (TB)***

- ❖ Active herpes simplex virus (HSV) lesions (including Varicella) on nipple/breast**

- >> Women with SUD (including cannabis) – not stable in treatment

* Updated guidelines encourage informed consent, without actively discouraging breastfeeding

** Pump and dump

*** Pump but avoid close contact

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BREASTFEEDING GUIDANCE FOR PEOPLE WITH HIV – NIH AND CDC, 2023

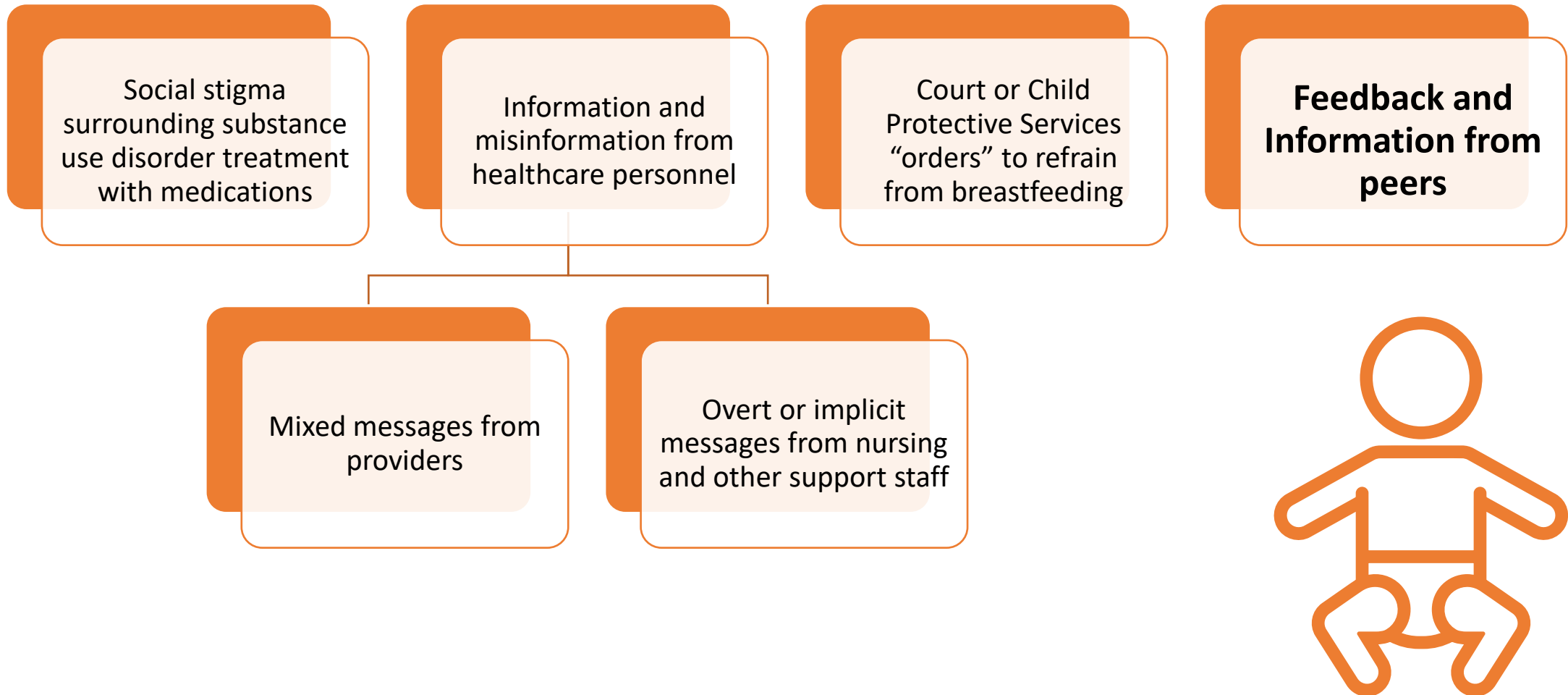
- Mothers who have questions about breastfeeding or who want to breastfeed should receive patient-centered, evidence-based information and counseling on infant feeding options, including ways to reduce the risk of HIV transmission through breast milk including:
 - Replacement feeding with properly prepared formula or pasteurized donor human milk from a milk bank eliminates the risk of postnatal HIV transmission to the infant.
 - Achieving and maintaining viral suppression through ART during pregnancy, delivery, and postpartum decreases risk of transmission through breastfeeding to less than 1%, but not zero.
- If mothers choose to breastfeed, providers should emphasize the importance of adherence to ART.
- Mothers with HIV who choose to breastfeed should receive close follow-up.
- Healthcare providers are encouraged to consult the National Perinatal HIV/AIDS Hotline (1-888-448-8765) if they have questions regarding mothers with HIV who want to breastfeed.

WHAT ABOUT BREASTFEEDING AND SUBSTANCE USE DISORDER TREATMENT WITH MEDICATIONS?

- » Methadone (3%) and Buprenorphine (2.4%) pass thru breastmilk in clinically insignificant amounts
 - » Encourage breastfeeding (especially during NAS)
- » Limited information about naltrexone and breastfeeding
 - » Limited transfer into breastmilk (0.86%)
- » Information on long term effects of substance use disorder treatment with medications exposure is still unclear
- » Benefits outweigh the risks
- » Communication and “informed consent”
 - » Benefits: Mothers should know the benefits of breastfeeding and of taking meds while breastfeeding
 - » Risks: Considerations for breastfeeding while on any Medications (especially other psychotropic medications)
 - » Risks: Mothers should know contraindications and relative contraindications
 - » Risks: Mothers should know risk of relapse and risky behaviors if not on medications

Sachs et al. (2013); <https://www.ncbi.nlm.nih.gov/books/NBK501922>

FACTORS THAT INFLUENCE INFANT FEEDING DECISIONS AMONG PERSONS ON SUBSTANCE USE DISORDER



“INFORMED CONSENT” FOR PERSONS ON MAT WHO ARE INTERESTED IN BREASTFEEDING

- » A process that provides factual information about treatment risks and benefits to ensure clients understand options and make voluntary decisions
 - Explain MAT
 - Provide general info about breastfeeding including the personal and voluntary nature of the decision
 - Risks of breastfeeding while on MAT
 - Benefits of breastfeeding while on MAT
 - Alternatives to breastfeeding while on MAT
- » Always finish the discussion by assessing the client’s understanding and responding to questions



SAMPLE SCRIPT FOR ADDRESSING MARIJUANA USE AND BREASTFEEDING

SANTA CLARA VALLEY MEDICAL CENTER

Importance of highlighting the benefits of breastfeeding and education of families, context is in caring for the mother and baby as a whole...

Marijuana script excerpts

Marijuana, also known as “weed” or “pot” is now legal in California for adults over 21. But this doesn't mean it's safe for pregnant or breastfeeding moms or babies. THC in marijuana gets into breast milk and may affect your baby's brain and development...

Secondhand marijuana smoke is also bad for your baby. Marijuana smoke has many of the same chemicals as tobacco smoke. Some of these chemicals may cause cancer or Sudden Infant Death Syndrome (SIDS). Don't allow anyone to smoke anything in your home or around your baby...

If you choose to smoke, it is really important to have someone who is not under the influence watching your baby. And be sure to keep marijuana, including edibles, out of reach of children...

Given the concerns about possible effects on your baby's brain and development, we recommend not smoking marijuana or using marijuana edibles while you are breastfeeding.

SUPPORTIVE STRATEGIES FOR BREASTFEEDING FOR PERSONS WITH OUD/SUD

- Formulate prenatal care plan that addresses breastfeeding on MAT
- Education and training for **professionals** on breastfeeding
- Stigma abatement
 - Recognize biases among staff
 - Model and train
- Establish rational policies and procedures as a guide
- **Allow time and space for breastfeeding/pumping**

- **Communication and “informed consent”**
 - Mothers should know contraindications and relative contraindications
 - Considerations for breastfeeding while on other psychotropic medications
 - Relapse and risky behaviors
- **Trauma-informed approaches**

“Maternal substance use is not a categorical contraindication to breastfeeding. Adequately nourished narcotic dependent mothers ... stable methadone or buprenorphine-maintained women should be encouraged to breastfeed”... as long as there is no other contraindication to breastfeeding. *American Academy of Pediatrics & Academy of Breastfeeding Medicine*

WHICH OF THE FOLLOWING STATEMENT(S) IS/ARE MOST ACCURATE ABOUT INFANTS EXPOSED TO OPIOIDS? – THE ANSWER

- A. Infants born of mothers on substance use disorder treatment with medications, such as Buprenorphine or Methadone, for more than 6 weeks during the pregnancy are rarely born with symptoms of neonatal abstinence syndrome (NAS).
- B. The modified Finnegan score is the gold standard for monitoring infants with NAS.
- C. Mothers on substance use disorder treatment with medications should never breast feed their infants.
- D. Cannabis use causes fewer short and long-term effects than on exposed infants than do opioids.
- E. A significant % of opioid exposed infants with NAS can be treated without pharmacotherapy.**

Harm Reduction and Radical Acceptance

Abstaining from all recreational substance use during pregnancy and breastfeeding is the safest option

HARM REDUCTION AND PREGNANCY

- » PREGNANCY IS NOT A CONTRAINDICATION TO HARM REDUCTION INTERVENTIONS!
- » Naloxone SHOULD be used in pregnant persons in the event of a withdrawal
- » Other harm reduction considerations for pregnant persons
 - » Low barrier approaches – goal of screening is to engage client in harm reduction behaviors and/or treatment
 - » Discuss the same range of harm reduction approaches
 - » Encourage (other) health behaviors during pregnancy
 - » Pump and store breastmilk before using

Record how much you use. This can help you reduce your use, even if that was not your original goal. 	Set limits on when and where you use, like waiting until after 5:00 to drink or only using at home or with a trusted friend. 
Make a list of the risks and benefits of stopping and continuing to use. Think about where you're at or who you're with when you use. 	Avoid using opioids, alcohol, or other depressants (downers) when you are alone or feeling vulnerable. 
Switch to a safer method – which might be different for each substance. For example, taking a pill is safer than injecting heroin, but it is easier to control your dose of cannabis with smoking rather than eating edibles. 	Set personal limits on what you use, when you use, and how much you use. For example, don't combine substances, or plan to have no more than 3 drinks over 2 hours. 
Making a safety plan before you use. For example, arrange transportation so you don't need to drive. 	Make a parenting plan before any substance use – including alcohol use. Arrange for help with childcare. Know what you'd do in an emergency. 
Attend support groups like Moderation Management, SMART Recovery, NA, or AA. Look for peer support. 	Take good care of your body and mind. Eat healthy foods. Get enough sleep. Exercise. Drink water. 

PLANS OF SAFE CARE INITIATIVE



What is a POSC?



Why are we doing this?



How will this be implemented?

PLANS OF SAFE CARE

Plan of Safe Care is a **formalized plan established by the medical care provider** with the primary caregiver of an infant born with, and identified as being affected by, substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder **to address the immediate needs of the affected infant** as well as the ongoing treatment needs of the affected infant and the health and substance use disorder **treatment needs of the affected family or caregiver.**



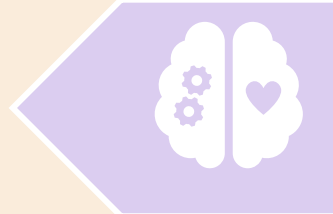
PLAN OF SAFE CARE DOMAINS

Primary, Obstetric and Gynecological Care



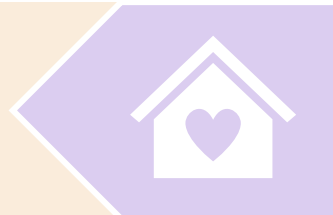
Infant Health and Safety (physical health, neurodevelopment expertise/high risk infants)

Prevention and Treatment of Mental Health and Substance Use Conditions



Infant and Child Development (developmental screening, early intervention, Help Me Grow)

Parenting and Family Support
(home visiting, classes, Road to Resilience)



***Other referrals**
(e.g., addressing social determinants of health)

Source: [ACL 20-122](#)

Family Wellness Plan

A Family Wellness Plan is a working document that will support parents and caregivers as they are navigating the challenges of caring for a baby.



Through this plan you will be given strengths-based support to:

- 1) identify your goals,
- 2) identify the supports that you already have, and those you need, and
- 3) get connected to services

*Note that the hospital is required to offer this plan, but your participation is voluntary.

The information included in the Family Wellness Plan is geared towards supporting you and your family. Please feel free to fill out this document with the information you feel is most relevant and helpful.

Date	Hospital Name
Parent's Name	Parent's Doctor's Name
Preferred Name	Doctor's Phone Number
Preferred Language	Navigator's Name
Phone Number	Navigator's Phone Number
Address	Navigator's Email
Name of Supportive Friend/Family Member	Supportive Person's Phone Number

My Notes:

(This is a place to include any notes about upcoming appointments, contacts to remember, or anything else.)



*This plan acts as the Plan of Safe Care under Child Abuse Prevention and Treatment Act (CAPTA) and the Comprehensive Addiction and Recovery Act (CARA) legislation.

SOURCE:
<https://supportingfamilies.lacounty.gov/>

Family Wellness Plan

Identifying Goals:

What are your goals for yourself and your baby over the next year?

Strengths and Supports:

What strengths and supports do you already have that we can build on to help you achieve your goals, and in what areas do you need support to achieve your goals?

Monitoring and Supporting Babies' Health and Development:

Strengths:

Supports needed:

Social Support:

Strengths:

Supports needed:

Baby Supplies and Resources:

Strengths:

Supports needed:

Dealing with Stress:

Strengths:

Supports needed:





Family Wellness Plan

What services are you and your family already engaged in? What new referrals might help you meet your family's needs as identified above?

Resource/Service	Already Participating	Would Like to Learn More	Referral/ Enrollment Date	Organization
Substance Use Services	Outpatient: ☐ Residential: ☐	☐	Referred for Level of Care Assessment: Enrolled:	Name: Phone #:
Mental Health Counseling	☐	☐	Referred: Enrolled:	Name: Phone #:
Breastfeeding Assistance	☐	☐	Referred: Enrolled:	Name: Phone #:
Child Care	☐	☐	Referred: Enrolled:	Name: Phone #:
Home Visiting	☐	☐	Referred: Enrolled:	Name: Phone #:
Parenting Class	☐	☐	Referred: Enrolled:	Name: Phone #:
Family Resource Center	☐	☐	Referred: Enrolled:	Name: Phone #:
WIC	☐	☐	Referred: Enrolled:	Name: Phone #:
Financial Assistance	☐	☐	Referred: Enrolled:	Name: Phone #:
Other:	☐	☐	Referred: Enrolled:	Name: Phone #:
Other:	☐	☐	Referred: Enrolled:	Name: Phone #:

Family Wellness Plan

My Baby's Information



Baby's Name

Baby's Date of Birth

Baby's Sex ☐ Male ☐ Female

Weight

Length

Baby's Doctor's Contact Information

Baby's Doctor's Name

Medical Office Name

Telephone

Medical Office Address

Special Care Needs for Baby to Remember



RESOURCES

- » Minnesota Women's Recovery Services
mn.gov/dhs/recovery
- » CA SUD Consultation line (UCSF):
<https://nccc.ucsf.edu/clinician-consultation/substance-use-management/california-substance-use-line/>
- » SAMHSA: SAMHSA's National Helpline
<https://www.samhsa.gov/find-help/national-helpline>
- » NCDVTMH Toolkit on Coercion and SUD
<https://ncdvtmh.org/toolkit/coercion-related-to-mental-health-and-substance-use-in-the-context-of-intimate-partner-violence/>



VIDEO – PRINCIPLES OF PERINATAL SUBSTANCE USE



<https://vimeo.com/493418296>

QUESTIONS?

REFERENCES: PERINATAL HIV/AIDS

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- >> AVERT – Global Info and Education on HIV and AIDS. <https://www.avert.org/professionals/hiv-programming/prevention/prevention-mother-child>
- >> CDC <https://www.cdc.gov/hiv/group/gender/pregnantwomen/index.html>
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RESOURCES

The Clearinghouses for Evidence-based Practices

- » The California Evidence-based Clearinghouse for Child Welfare. <https://www.cebc4cw.org/>
- » Title IV-E Prevention and Services Clearinghouse. <https://preventionservices.abtsites.com/>

Home Visiting

- » Maternal Infant and Early Childhood Home Visiting. <https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview>
- » California Home Visiting Program. <https://www.cdph.ca.gov/Programs/CFH/DMCAH/CHVP/Pages/default.aspx>
- » Evidence-based Practices and Resource Center (formerly National Center for Evidence-based Practices). <https://www.samhsa.gov/ebp-resource-center>
- » Child Welfare Information Gateway. Strengthen Families and Education to Prevent Maltreatment. <https://www.childwelfare.gov/pubpdfs/parented.pdf>

CDC Opioid Prescribing Guidelines <https://www.cdc.gov/opioids/providers/prescribing/index.html>

REFERENCES: BREASTFEEDING

- » American Academy of Pediatrics Section on Breastfeeding Policy Statement on Breastfeeding and the Use of Human Milk, and the Transfer of Drugs and Other Therapeutics in Human Breast Milk and more. <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Breastfeeding/Pages/AAP-Policy-on-Breastfeeding.aspx>
- » Association of Women's Health Obstetrical and Neonatal Nurses (AWHONN) Practice Brief #4. [https://nwhjournal.org/article/S1751-4851\(16\)30207-0/abstract](https://nwhjournal.org/article/S1751-4851(16)30207-0/abstract)
- » Drugs and Lactation Database (LactMed) <https://www.ncbi.nlm.nih.gov/books/NBK501922>
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REFERENCES: WOMEN AND PERINATAL SUD

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GLOSSARY OF TERMS (REVISITED)

- » Sexual orientation – a person’s identity in relation to the gender or genders to which they are sexually attracted (straight, gay, lesbian, asexual, bisexual, pansexual)
- » Gender identity and/or expression - internal perception of one’s gender; how one identifies or expresses oneself.
 - » Cisgender – a term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth
 - » Transgender – refers to an individual whose current gender identity and/or expression differs from the sex they were assigned at birth (may have transitioned or be transitioning in how they are living)
 - » Gender Expansive - refers to an individual who expresses identity along the gender spectrum (genderqueer, gender nonconforming, nonbinary, agender, two spirit)
- » Sexual Minority – refers to a group whose sexual identity orientation or practices differ from the majority of and are marginalized by the surrounding society.

SOURCE: Centers for Educational Justice and Community Engagement, UC Berkeley

REFERENCES: STIGMA

- » Botticelli, M. P., & Koh, H. K. (2016). Changing the Language of Addiction. JAMA. 316(13), 1361. doi:10.1001/jama.2016.11874. <https://www.ncbi.nlm.nih.gov/pubmed/27701667>.
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REFERENCES: STIGMA AND HARM REDUCTION

Stigma Abatement Resources

- » Educational Development Center. Words Matter: How Language Can Reduce Stigma. <https://preventionsolutions.edc.org/sites/default/files/attachments/Words-Matter-How-Language-Choice-Can-Reduce-Stigma.pdf>
- » International Network of People who Use Drugs <https://inpu.net/stigma-and-discrimination-have-no-place-in-my-life/>
- » Minnesota Harm Reduction and Overdose Prevention Fact Sheet <https://www.health.state.mn.us/communities/opioids/documents/sudresourcesheet.pdf>
- » Zinberg, N. E. (1984). Drug, set, and setting: The basis for controlled intoxicant use. New Haven: Yale University Press.
- » Project Implicit at Harvard University has a number of implicit bias resources and tests that should be reviewed before you dive in. <https://implicit.harvard.edu/implicit/takeatest.html>
- » SAMHSA Anti-Stigma Toolkit. A Guide to Reducing Addiction-related Stigma. <https://www.montefiore.org/documents/ANTI-STIGMA-TOOLKIT-A-Guide-to-Reducing-Addiction-Related-Stigma.pdf>
- » Unshame California <https://www.unshameca.org/>
- » Urban Survivors Union <https://southwestrecoveryalliance.org/urban-survivors-union/>

Harm Reduction resources for you:

- » Recovery Research Institute <https://www.recoveryanswers.org/resource/drug-and-alcohol-harm-reduction/>
- » National Harm Reduction Coalition - <https://harmreduction.org/our-work/action/california/>
- » California Department of Public Health Injury and Violence Prevention Branch - <https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/Pages/NaloxoneGrantProgram.aspx>
- » HR in Minnesota
- » Southside Harm Reduction (Southside) for SE, street outreach, peer /education <https://southsideharmreduction.org/covid-19/>
- » RAAN (Duluth) for SE, naloxone, educational materials <https://southsideharmreduction.org/covid-19/>

QUESTIONS?

AGENDA FOR TRAINING SERIES

Session	Topics
#1 TUESDAY, JUNE 16 9:00 am to 12:00 pm	☐ Understanding HIV ☐ HIV Testing, Treatment and Prevention ☐ The Science of Addiction ☐ Screening and Assessment
#2 TUESDAY, JUNE 16 12:30 pm to 4:00 pm	☐ Ethical and Legal Issues ☐ Funding and Policy Considerations ☐ HIV Risk Reduction ☐ SUD Harm Reduction ☐ HIV and Stigma ☐ Pregnancy and HIV, SUD/ODU
#3 WEDNESDAY, JUNE 17 9:00 am to 12:00 pm	☐ Working with Justice Involved Persons ☐ Substance Use Disorder Treatment with Medications ☐ Mental Health Treatment and Counseling ☐ Stimulant Use ☐ Chem Sex
#4 WEDNESDAY, JUNE 17 12:30 pm to 4:00 pm	☐ Cultural, Racial and Sexual Identities ☐ Motivational Interviewing ☐ Accessing, Obtaining, and Integrating Services for Individuals with HIV and SUD in Minnesota

NEXT STEPS

- >> Join us **tomorrow** for Day Two at 9:00 AM!
- >> Please complete the evaluation for today's training



Follow-up questions?

Contact Gabriel Velazquez at
gvelazquez@healthmanagement.com

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- » Gender identity and/or expression - internal perception of one’s gender; how one identifies or expresses oneself.
 - » Cisgender – a term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth
 - » Transgender – refers to an individual whose current gender identity and/or expression differs from the sex they were assigned at birth (may have transitioned or be transitioning in how they are living)
 - » Gender Expansive - refers to an individual who expresses identity along the gender spectrum (genderqueer, gender nonconforming, nonbinary, agender, two spirit)
- » Sexual Minority – refers to a group whose sexual identity orientation or practices differ from the majority of and are marginalized by the surrounding society.

SOURCE: Centers for Educational Justice and Community Engagement, UC Berkeley

GLOSSARY OF TERMS (REVISITED)

- Race - is usually associated with inherited physical, social and biological characteristics. In this context that means race is associated with biology. Institutionalized in a way that has profound consequences (White, African American, American Indian Alaskan Native, Native Hawaiian or Pacific Islander)”
- Ethnicity - a term used to categorize a group of people with whom you share learned characteristics and identify according to common racial, national tribal, religious, linguistic, or cultural origin or background. (Hispanic, Non-Hispanic Black, Non-Hispanic Black, etc.)

SOURCE: US Office of Management and Budget: Federal Register Vol. 62(210): 58782

GLOSSARY OF TERMS (REVISITED)

- » Health Insurance Portability and Accountability Act (HIPAA) - required the creation of national standards to protect sensitive patient health information (PHI) from being disclosed without the patient's consent and includes a Privacy Rule addressing disclosure of and access to PHI; the Security Rule protects disclosure of and access to electronic PHI (e-PHI) a subset of information covered by the Privacy Rule
- » Code of Federal Regulations, Title 42, Part 2 (42 CFR Part 2) – a complicated set of regulations that strengthen the privacy protections afforded to persons receiving alcohol and substance use treatment (in addition to the more general privacy protections afforded in HIPAA). The regulations restrict the disclosure and use of alcohol and drug patient records which are maintained in connection with any individual or entity that is federally assisted and holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment (42 CFR § 2.11)
- » Family Education Rights Protection Act (FERPA) - protects the privacy of student education records in public or private elementary, secondary, or post-secondary school and any state or local education agency that receives funds under an applicable program of the US Department of Education.

SOURCE: Centers for Disease Control and Prevention; and the Substance Abuse and Mental Health Services Administration

COMMON ACRONYMS (REVISITED)

ART – Antiretroviral therapy

AUD – Alcohol use disorder

IDU – Injection or intravenous drug use

MSM – Men who have sex with men

OD – Opioid use disorder

PEH – Person(s) experiencing homelessness

PEP – Post-exposure prophylaxis

PrEP – Pre-exposure prophylaxis

PLWH – Person(s) living with HIV

PWID – Person(s) who injects drugs

SUD – Substance use disorder