The Intersection of HIV and Substance Use:

Enhancing the Care Continuum with Evidence-Based Practices

Training Series: Day 1
May 28, 2025

WELCOME!

DEPARTMENT OF HUMAN SERVICES

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Minnesota Department of Human Services

YOUR TRAINING TEAM

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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.

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.
Shannon Robinson, MD	Dr. Robinson 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 and that her husband manufactures suicide resistant bedding and garments.

AGENDA FOR TRAINING SERIES

Session	Topics
#1 **WEDNESDAY,** **MAY 28** 9:00 am to 12:00 pm	❑ **Understanding HIV** ❑ **HIV Testing, Treatment and Prevention** ❑ **The Science of Addiction** ❑ **Screening and Assessment**
#2 **WEDNESDAY,** **MAY 28** 12:30 pm to 4:00 pm	❑ **Ethical and Legal Issues** ❑ **Funding and Policy Considerations** ❑ **HIV Risk Reduction** ❑ **SUD Harm Reduction** ❑ **HIV and Stigma** ❑ **Motivational Interviewing**
#3 **THURSDAY,** **MAY 29** 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 **THURSDAY,** **MAY 29** 12:30 pm to 4:00 pm	❑ Cultural, Racial and Sexual Identities ❑ Pregnancy and HIV, SUD/OUD ❑ Accessing, Obtaining, and Integrating Services for Individuals with HIV and SUD in Minnesota

MENTIMETER INSTRUCTIONS

1 Grab your phone

2 Go to www.menti.com

3 Enter the code
1794 2563

10

GROUP

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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

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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.

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.

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

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

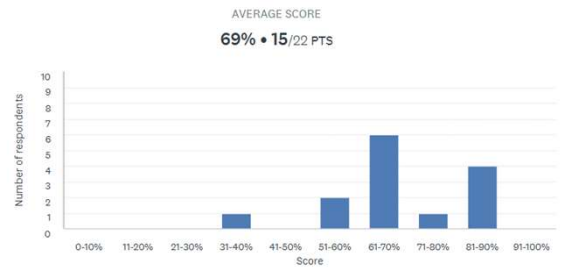
- Health Insurance Portability and Accountability Act (HIPAA) - required the creation of national standards to protect sensitive patient health information (PHI) from being disclosed without the patient's consent and includes a Privacy Rule addressing disclosure of and access to PHI; the Security Rule 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
OUD – 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



TIME FOR A POLL

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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

- **H**uman: the virus can only infect human beings
- **I**mmunodeficiency: 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.
- **V**irus: 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.

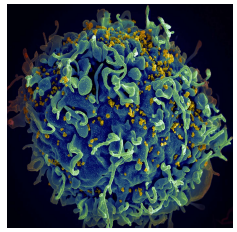

Photo Credit: National Cancer Institute on Unsplash

TIME FOR A POLL

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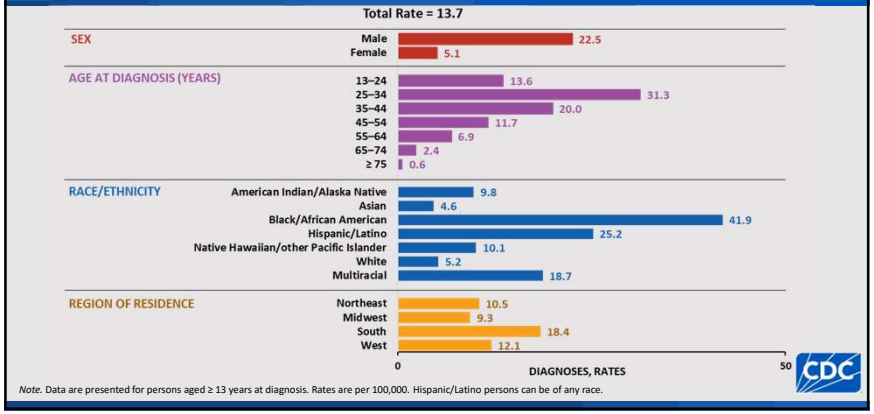
HIV QUICK FACTS

- 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.**

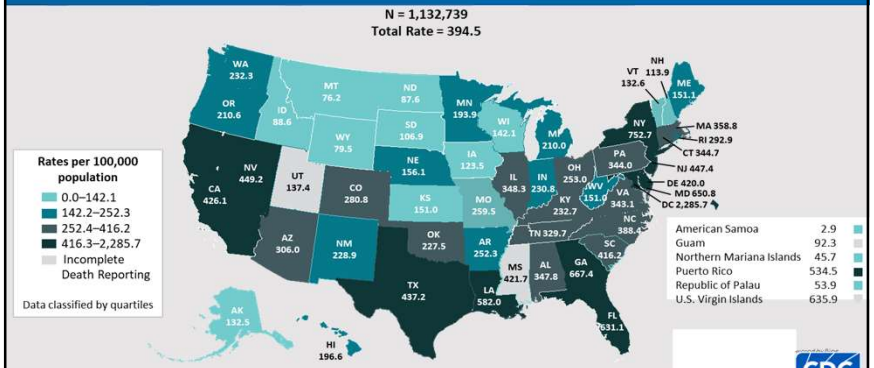
https://www.hiv.gov/hiv-basics
https://www.cdc.gov/hiv-data/nhss/hiv-diagnoses-deaths-and-prevalence-2025.html#:~:text=At%20a%20glance,for%20more%20than%20a%20third.

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



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

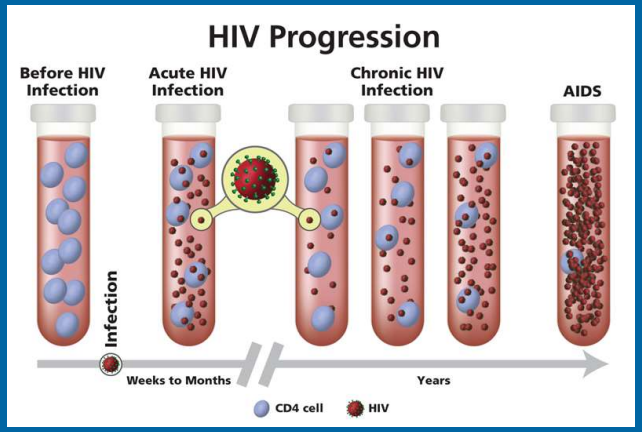
WHAT IS AIDS?

- 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)

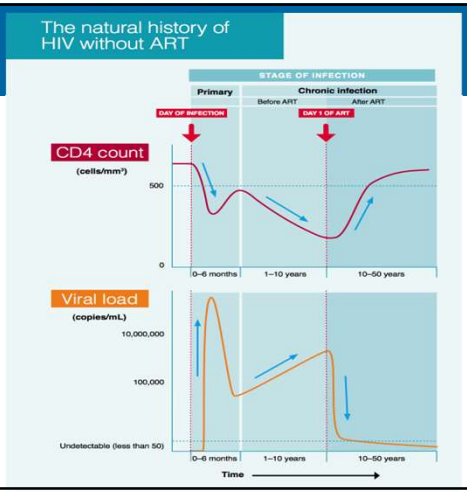
STAGES

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

Source: https://www.cdc.gov/hiv/basics/whatishiv.html



STAGES



https://hivinfo.nih.gov/understanding-hiv/fact-sheets/hivaids-basics

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.

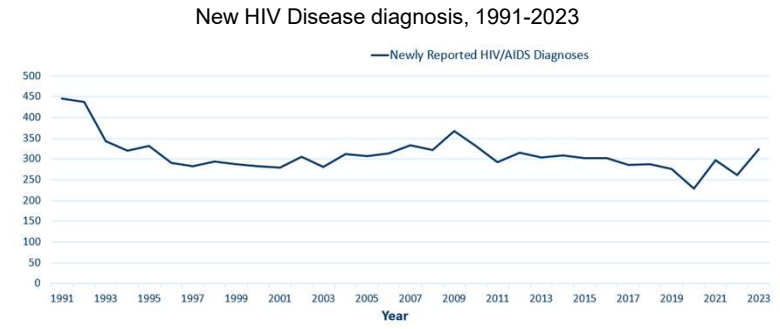
HIV AND SUD IN MINNESOTA

HIV INCIDENCE AND PREVALENCE IN MINNESOTA

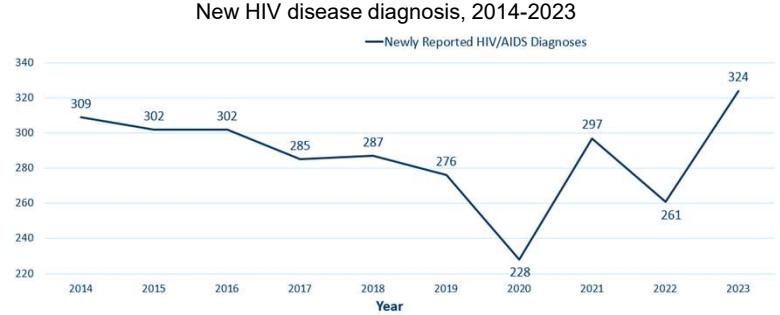
- In 2024, there were 311 newly diagnosed HIV infections reported to MDH, a 4% decrease from 2023 (324). While this is a decrease from the previous year, it also represents a 19% increase from 2022 (261) and an 11% increase from the average over the last decade (279).
- The number of reported people living with HIV/AIDS in Minnesota is **9,826**.
- Disparity
  - Although, there was a decrease in the number of total HIV diagnoses in the state, there were increases in the number of American Indian, Black African American, Black African-born, and Hispanic people diagnosed with HIV in Minnesota.

https://www.health.state.mn.us/diseases/hiv/stats/2024/index.html

HIV INCIDENCE IN MINNESOTA, 1991-2023

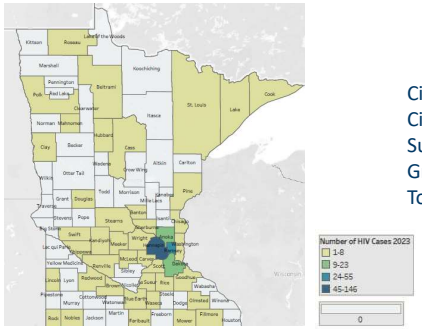


HIV INCIDENCE IN MINNESOTA, 2014-2023



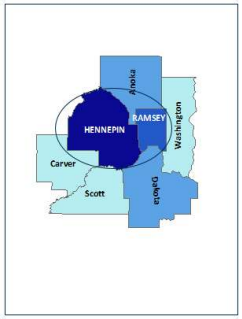
HIV INCIDENCE IN MINNESOTA BY COUNTY

HIV Diagnoses # by County of Residence at Diagnosis, 2023



City of Minneapolis	102 cases (31%)
City of St. Paul	40 cases (12%)
Suburban*	114 cases (35%)
Greater Minnesota	68 cases (21%)
Total	324 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

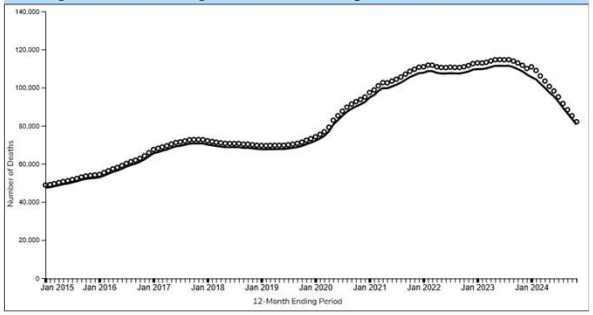
HIV OUTBREAK IN MINNESOTA

- 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: April 6, 2025

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

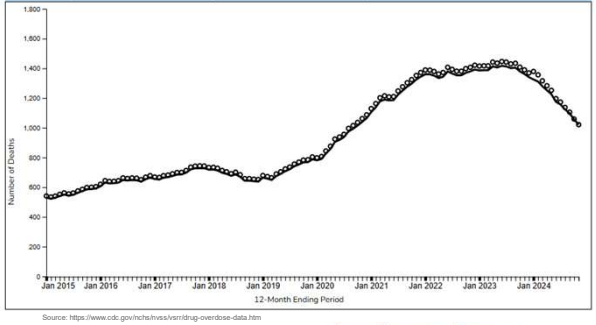


United States
Nov. 2024: 12 Month 80,674
May 2024: 12 month 94,758
May 2023: 12 month 106,539
May 2022: 12 month 107,419

OVERDOSE DEATH MINNESOTA

Based on data available for analysis on: April 6, 2025

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
Nov. 2024: 12 month 1,021
May 2024: 12 month 1,225
May 2023: 12 month 1,404
May 2022: 12 month 1,344

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	There needs to be ENOUGH virus	HIV must get into the bloodstream
One person must be currently infected with HIV	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	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

Reload

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 coinfected 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.

https://www.cdc.gov/hepatitis/hcp/populations-settings/hiv.html

HIV AND HEPATITIS C CO-INFECTIONS

- As of Dec. 31, 2023, there were **31,942** 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 people 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

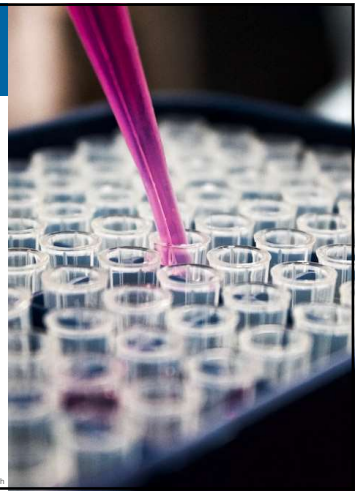


Photo Source : Louis Reedon Unsplash

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

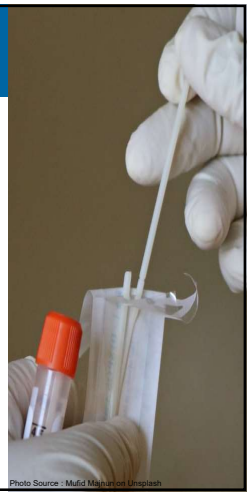


Photo Source : Mufid Majnun on Unsplash

TYPE OF TESTS

- Testing has become more sophisticated; 4th or 5th generation tests look for HIV antibodies and antigens
- Antibody tests look for they 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.

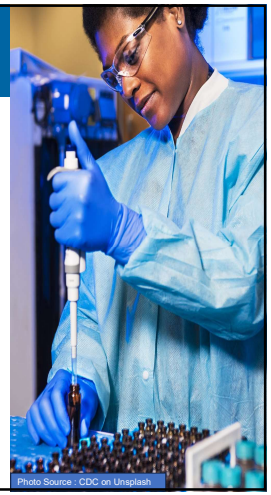


Photo Source : CDC on Unsplash

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)

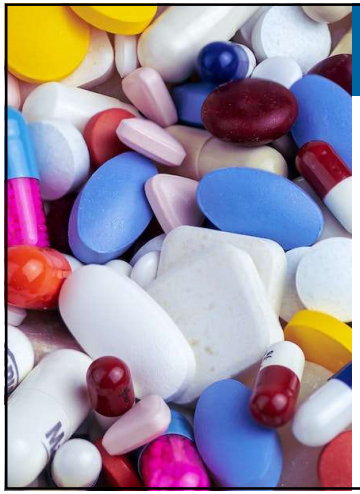
- People cannot transmit the HIV through sexual contact when their viral load is undetectable
- Undetectable means too low to be measured (<20 copies per mL)
- This can take up to 6 months after initiating HIV medications
  - Confirmed by a blood test given by your doctor
  - Should be followed up with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

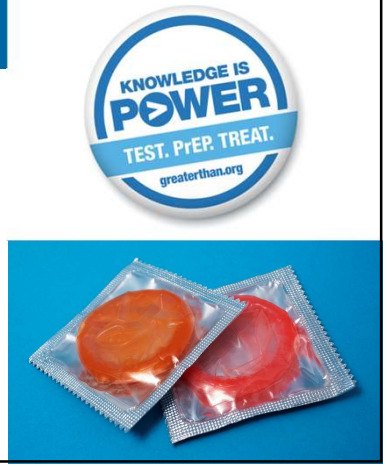


Photo Source : greaterthan.org and Reproductive Health Supplies Coalition on Unsplash

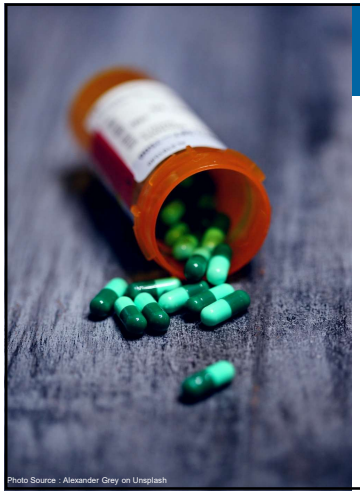


Photo Source : Alexander Grey on Unsplash

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
- 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

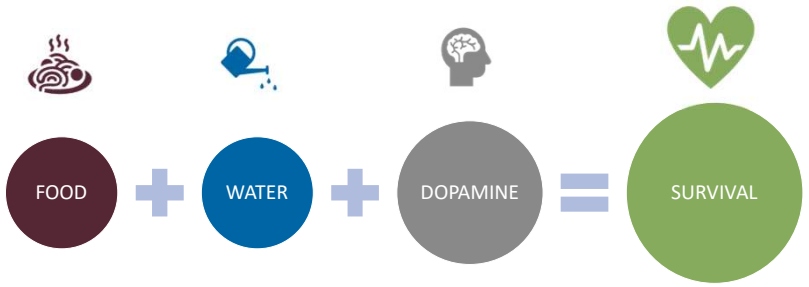
LEARNING OBJECTIVES: THE SCIENCE OF ADDICTION, SCREENING, AND ASSESSMENT

- 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

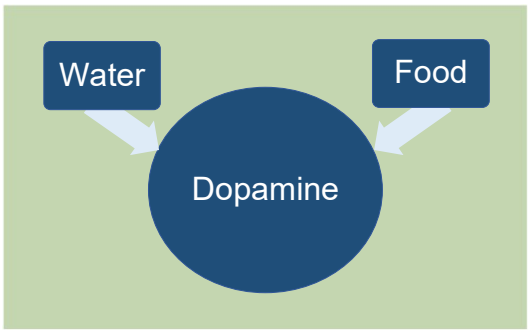
Reload

SCIENCE OF ADDICTION

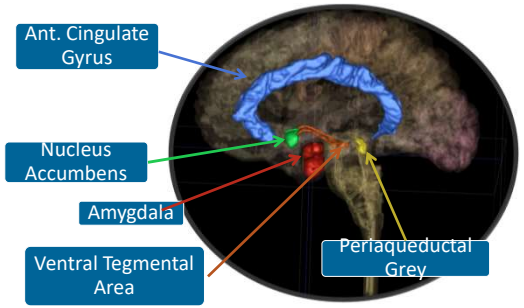


NATURAL REWARDS RELEASE DOPAMINE

Dopamine: Often referred to as the "feel good" chemical contributing to feelings of pleasure and motivation

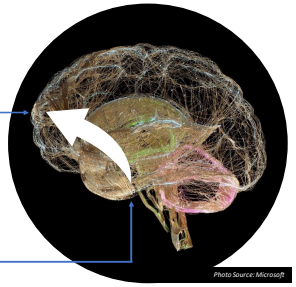


SCIENCE OF ADDICTION



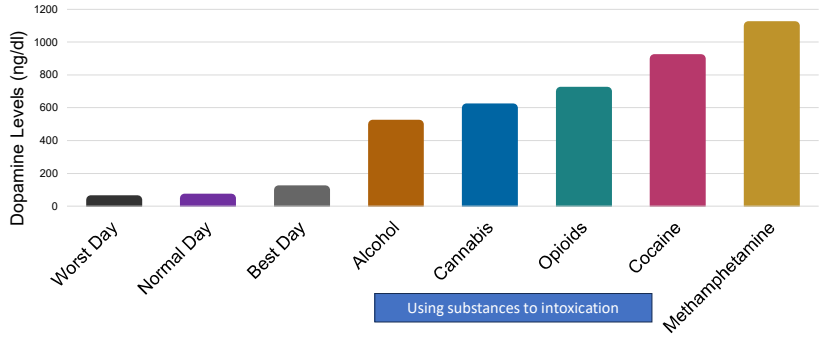
HOW ADDICTIVE SUBSTANCES AFFECT THE BRAIN

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



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

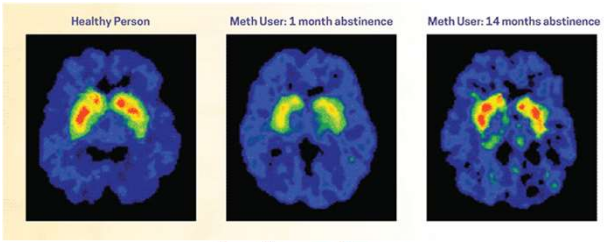
DSM-5: DIAGNOSIS OF OPIOID USE DISORDER (OUD)

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

DOPAMINE DEPLETION EFFECTS RECOVERY: IT TAKES TIME FOR YOUR BRAIN TO RECOVER

- Prolonged drug use changes the brain in long lasting ways
- Changes are both functional and structural
- Return to normal dopamine production is under study (takes over 1 year)
- Discontinuing treatment before brain recovery may affect outcomes



Source: Volkow (2001)

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.

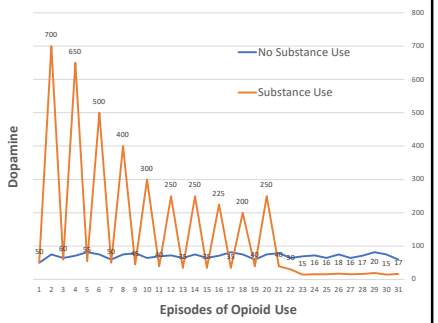
How the Brain Changes and Recovers from Drug Use

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

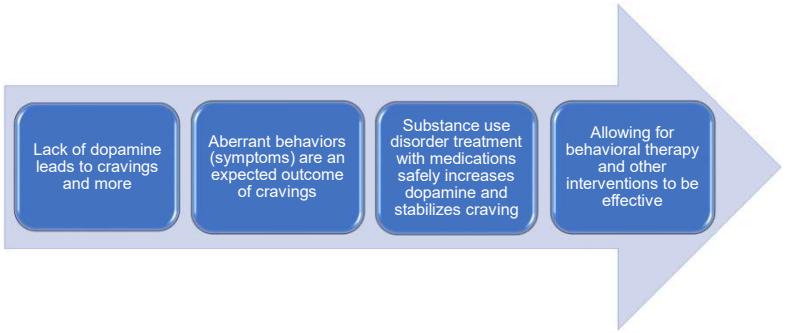
DOPAMINE DEPLETION EFFECTS RECOVERY

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?

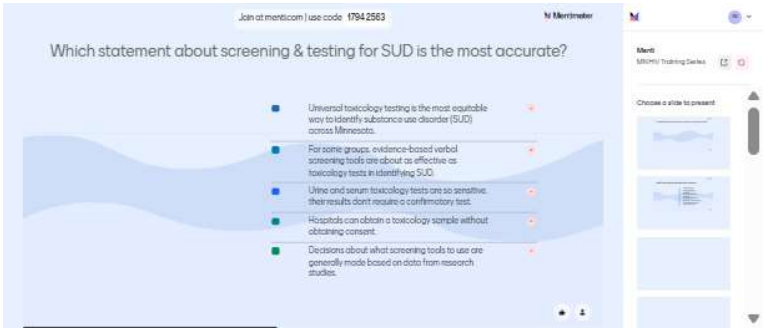
a) Personal choice and behaviors

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



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)

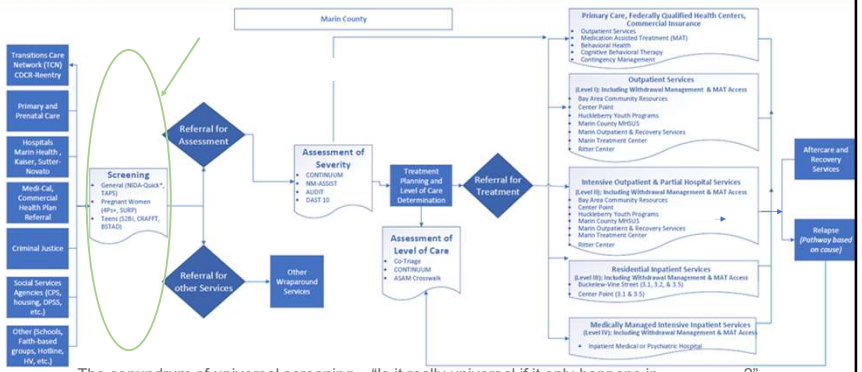
Level of Care Determination:

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) + *Patient History Questionnaire (PHQ-9)* + *General Anxiety Disorder (GAD-7)* + *PTSD Checklist (PCL-5)* + *Columbia Suicide Severity Rating Scale (C-CCRS)*	+ 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) + *Perinatal Mood and Anxiety Disorder (PMAD) – Edinburgh, PHQ-9*	+ 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* + *Patient History Questionnaire (PHQ-9) for adolescents*

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).
  - *Make sure you know what is covered by your toxicology panel*
- 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).
  - *Knowing your lab cutoff values can avoid action on false positives (e.g., poppy seeds, oxycodone and hydrocodone)*

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?

A. Universal toxicology testing is the most equitable way to identify substance use disorder (SUD) across Minnesota.

B. For some populations, screening for SUD using an evidence-based verbal screening tools is about as sensitive as using toxicology testing in identifying SUD.

C. Urine and serum toxicology tests are so sensitive, their results don't require a confirmatory test.

D. Hospitals can obtain a toxicology sample without obtaining consent.

E. Decisions about what screening tools to use are generally made based on data from research studies.

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

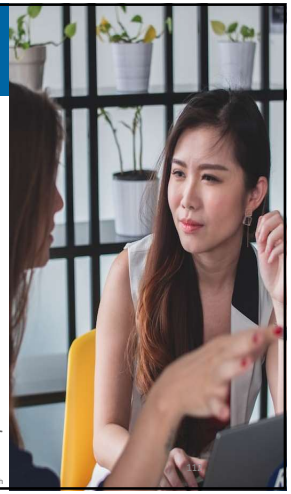
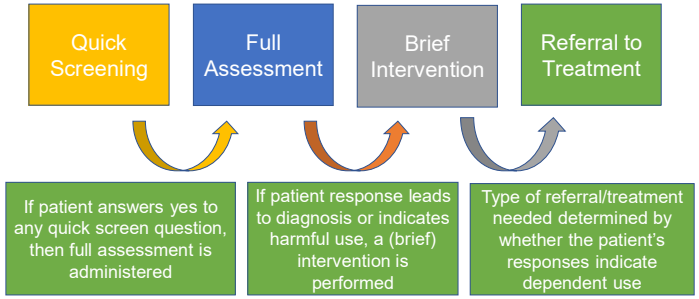


Photo Source : Mimi Thian on Unsplash

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 Psychiatric and Cognitive
4 Substance Use Related Risks
5 Recovery Environment Interactions
6 Person-Centered Considerations

DECISION RULES

LEVEL OF CARE

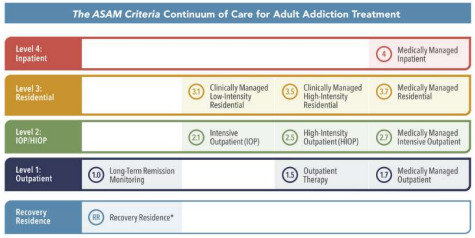
1 Outpatient | 2 Intensive / High-Intensity Outpatient | 3 Residential | 4 Inpatient Services (Medically Managed)

FOURTH EDITION ASAM LEVEL OF CARE CHANGES

Third Edition	Fourth Edition
1 Acute Intoxication and/or Withdrawal Potential	1 Intoxication, Withdrawal, and Addiction Medications
2 Biomedical Conditions and Complications	2 Biomedical Conditions
3 Emotional, Behavioral, or Cognitive Conditions and Complications	3 Psychiatric and Cognitive Conditions
4 Readiness to Change	4 Substance Use-Related Risks
5 Relapse, Continued Use, or Continued Problem Potential	5 Recovery Environment Interactions
6 Recovery/Living Environment	NEW 6 Person-Centered Considerations

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

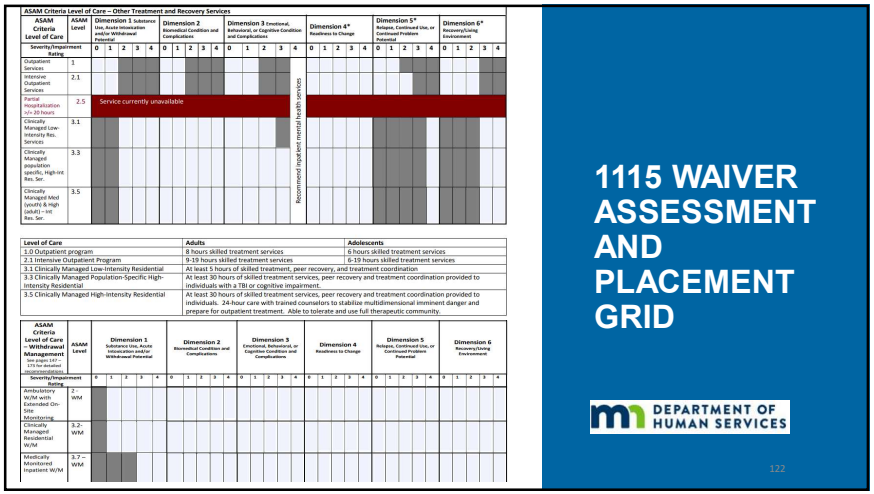
MN Medicaid Section 1115 Waiver and related legislation requires that providers of SUD services use the ASAM Level of Care criteria

- 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 Statues 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

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



1115 WAIVER ASSESSMENT AND PLACEMENT GRID

DEPARTMENT OF HUMAN SERVICES

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
- Reisfieled, 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, AACC 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

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SESSION 2

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

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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

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 general, no specific informed consent or pre-test counseling is required in MN
- Informed consent must be obtained, EXCEPT in cases of an EMS exposure
- Mandatory provision of HIV education materials for clients in chemical dependency treatment programs

Photo Source : CDC on Unsplash

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?

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 24 hours (any reactive test) and to the health commission within 30 days of diagnosis
  - "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

Would a HIV+ virally suppressed individual need to disclose their status to the partner?

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.

DISCUSSION

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

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

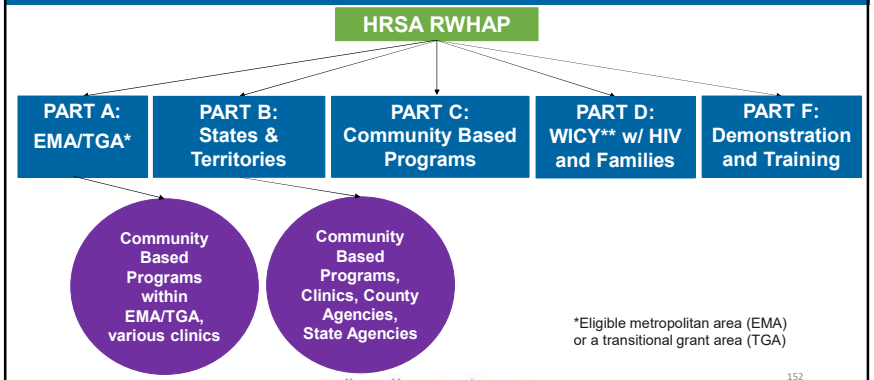
- Funding to support family-centered HIV primary medical and support **services for women, infants, children, and youth** living with HIV
- Competitive grants to local public and private health care entities, including hospitals, and public agencies
- Includes services designed to engage **youth with 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

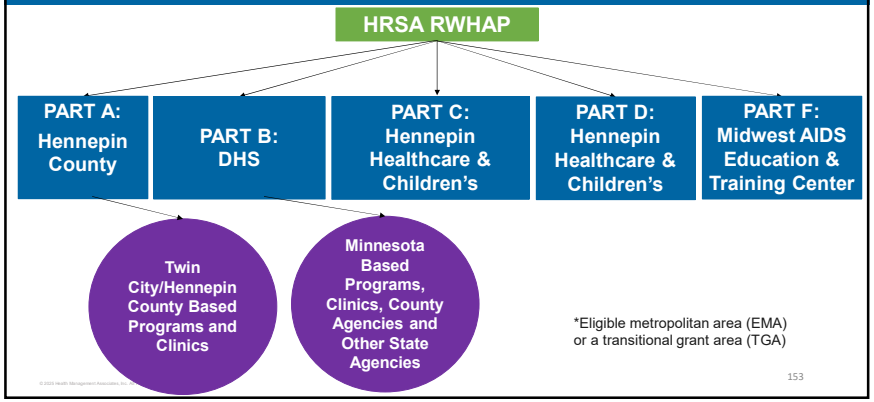
- Funds support **clinician training, dental services, and dental provider training.** In addition, Part F funds the development of innovative models of care to improve health outcomes and reduce HIV transmission.
- Funds Minority AIDS Initiative (MAI)
- Funds Special Project of National Significance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



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

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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.

Diagnose all people with HIV as early as possible.

Treat people with HIV rapidly and effectively to reach sustained viral suppression.

Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).

Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.

HEALTH MANAGEMENT ASSOCIATES

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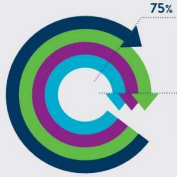
END HIV MN IS OUR COMPREHENSIVE STRATEGY TO END HIV IN MINNESOTA.

END HIV MN provides a roadmap for coordinating efforts and resources to end HIV in Minnesota. The strategy contains goals, tactics, and action steps geared toward four specific outcomes.

END HIV MN

How Minnesota will measure success

The Minnesota Legislature has identified four ambitious—but attainable—outcomes for END HIV MN. Timelines to achieve these outcomes were set by the END HIV MN Advisory Board.



75%

4. Reduce the annual number of new HIV diagnoses in Minnesota by at least 25% by 2025 and at least 75% by 2035 (which requires successful achievement of outcomes 1, 2, and 3)

90%

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

90%

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

90%

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

Our Vision is Clear

By 2025, Minnesota will be a state where new HIV diagnoses are rare and all people living with HIV—and those at high risk of HIV infection—will have access to high quality health care and the resources they need to live long healthy lives, free from stigma and discrimination.

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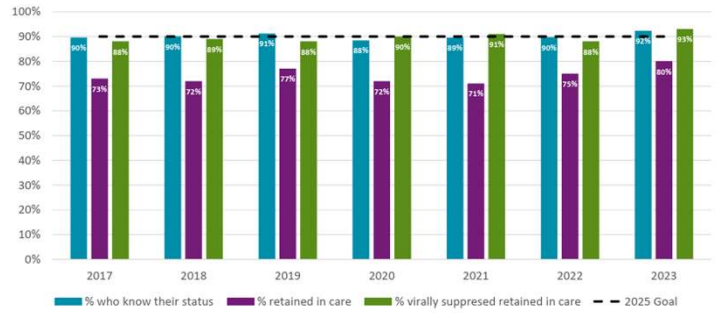
MINNESOTA'S STRATEGY TO END HIV

- 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%	90%	90%	75%
Increase the percentage of Minnesotans living with HIV who know their HIV status to at least 90% by 2025	Increase the percentage of Minnesotans diagnosed with HIV who are retained in care to at least 90% by 2025	Of individuals retained in care increase the percentage of Minnesotans who are virally suppressed to at least 90% by 2025	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

President Biden's Fiscal Year 2024 Budget Request Includes $850 Million for the Ending the HIV Epidemic Initiative

EHE was developed under President Trump's first administation

President Trump's leaked budget for HHS EHE would be eliminated as well as HIV research

FUNDING CONT.

State Opioid Response Grants: $1.5 Billion over 2 Years

The SAMSHA program aims to address the opioid crisis by increasing access to medication-assisted treatment using the three FDA-approved medications for the treatment of opioid use disorder, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including illicit use of prescription opioids, heroin, and fentanyl and fentanyl analogs).

This program also supports evidence-based prevention, treatment and recovery support services to address stimulant misuse and use disorders, including for cocaine and methamphetamine.

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/endhiv/index.html
- MN Department of Health End HIV MN Resources: https://www.health.state.mn.us/endhivmn#:~: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
- Antiretrovial advances
  - Viral suppression (U=U)
  - PrEP and PEP

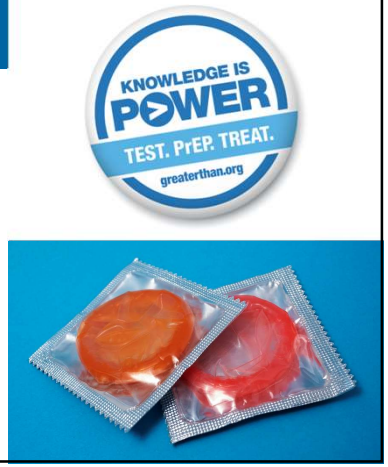


Photo Source : greaterthan.org and Reproductive Health Supplies Coalition on Unsplash

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.

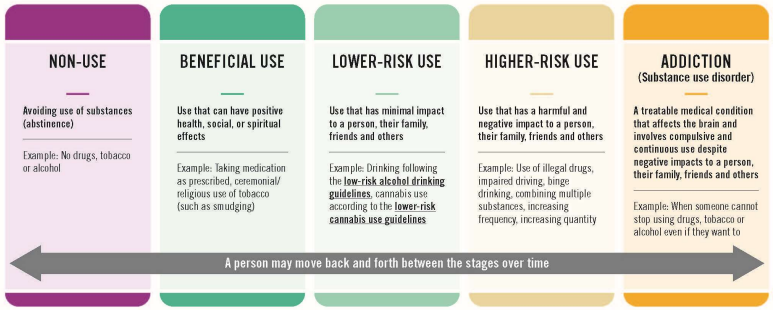
National Harm Reduction Coalition

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, such as **controlled and illegal drugs**, **cannabis**, **tobacco/nicotine** and **alcohol** for different reasons, including medical purposes; religious or ceremonial purposes; personal enjoyment; or to cope with stress, trauma or pain. Substance use is different for everyone and can be viewed on a spectrum with varying stages of benefits and harms.



Source: Health Canada

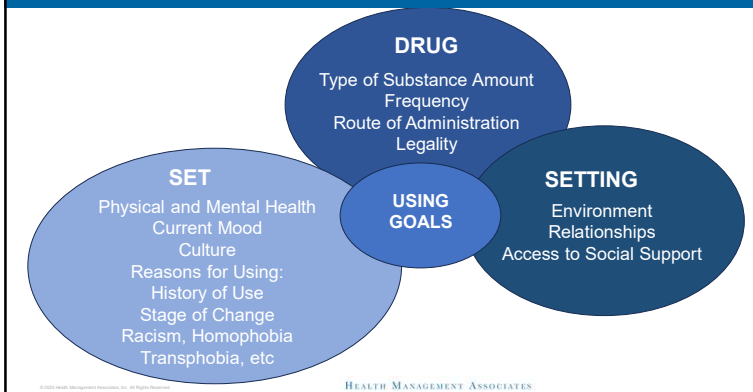
SUBSTANCE USE SPECTRUM

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

Non-use	Beneficial Use	Lower Risk Use	Higher Risk Use	Addiction
Avoiding use of substances	Use that has positive health, social or spiritual effects	Use that has minimal impact to a person, their family, friends and others	Use that has a harmful and negative impact to a person, their family, friends and others	A treatable medical condition that affects the brain and compulsive and continuous use despite negative impacts on the person, family, friends and others

Source: Health Canada

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 CHOKE 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
- 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

Photo Source: NEXT Distro on Unsplash

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

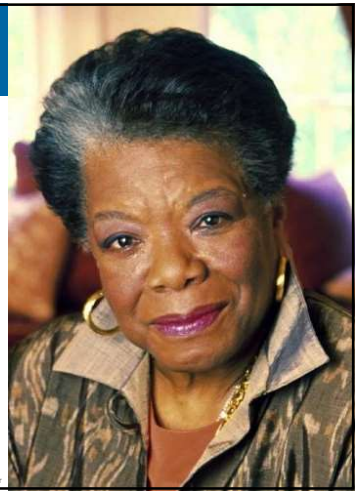


Photo Source : Montana State University/Dwight Carter

HOW DO WE DEFINE STIGMA?

CATEGORIES OF STIGMA

Category (group)
+ Generalization
Stereotype (label)
+ Judgment
Prejudice (attitude)
+ Action
Discrimination (behavior)
+ Power
Oppression/ "Isms" (process, system)

S. Harrell, Ph.D.

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

https://supportdontpunish.org/

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

MOTIVATIONAL INTERVIEWING

LEARNING OBJECTIVES: MOTIVATIONAL INTERVIEWING

- Define and explain Motivational Interviewing (MI) and how it can be utilized with clients contemplating behavior change
- Explain the stages of change and how they relate to unders tanding and supporting clients
- Identify the principles and spirit of MI
- Explain OARS (Open-Ended Questions, Affirmations, Reflections and Summaries)

Look at the chart and say the COLOR not the word

YELLOW BLUE ORANGE
BLACK RED GREEN
PURPLE YELLOW RED
ORANGE GREEN BLACK
BLUE RED PURPLE
GREEN BLUE ORANGE

Left – Right Conflict
Your right brain tries to say the color but your left brain insists on reading the word

THIS IS YOUR BRAIN ON CHANGE

PERSUASION EXERCISE

- Choose one person near you to work with
- One will be the speaker, one will be the listener

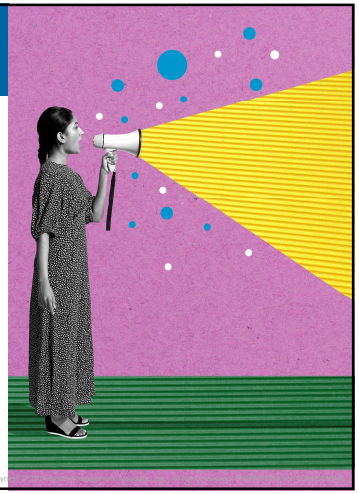
PERSUASION EXERCISE

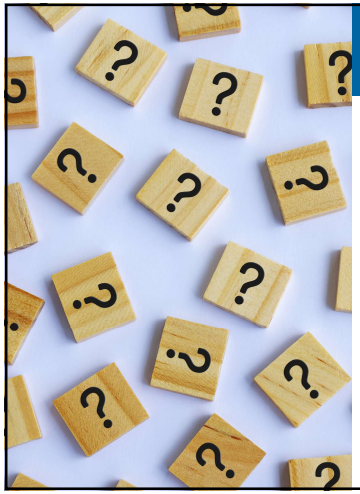
- Speaker Topic
- Something about yourself that you
  - Want to change
  - Need to change
  - Should change
  - Have been thinking about changing

But you haven't changed yet!!!

PERSUASION EXERCISE

- Listener's Job
  - Explain, in depth, *why* the person should make this change
  - Give at least 3 specific *benefits* of making this change
  - Tell the person *how* they could change
  - Emphasize that it's *important* to change
  - Persuade the person to do it and do it NOW!
  - If the person becomes resistant, repeat the above steps until they get it!





PERSUASION EXERCISE

- How did it go?
  - Thoughts?
  - Reactions?

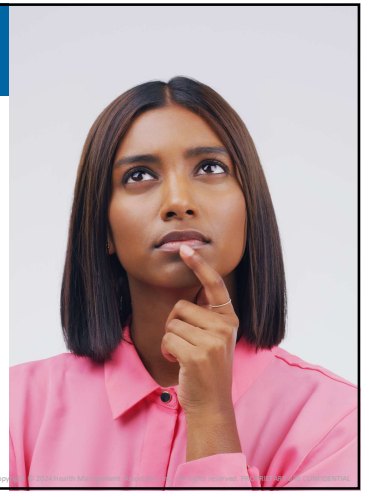
COMMON REACTIONS

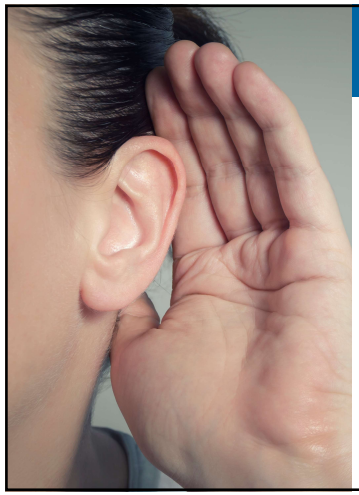
- Anger
- Agitation
- Oppositional
- Discounting
- Justifying
- Feeling not understood
- Feeling not heard
- Procrastination
- Fear
- Helpless
- Overwhelmed
- Ashamed
- Trapped
- Disengaged
- Avoidant (may not talk to you again)
- Uncomfortable
- Misunderstood

PERSUASION EXERCISE

- Let's Try Again!
  - Same roles
- Speaker Topic
  - Something about yourself that you
    - Want to change
    - Need to change
    - Should change
    - Have been thinking about changing

But you haven't changed yet!!!





PERSUASION EXERCISE

- Listener's Job:
  - Listen carefully with goal of understanding the dilemma
  - GIVE NO ADVICE
  - Ask these 4 open-ended questions
    - Why would you want to make this change?
    - How might you go about it to succeed?
    - What are the 3 best reasons to do it?
    - On a scale of 0-10, how important is it for you to make this change?
      - Follow up: "Why are you at _____ instead of 0?"
    - Give a short summary/reflection of the speaker's motivation for change
    - Ask, "What do you think you'll do?" and just listen

PERSUASION EXERCISE

- How did it go?
  - Thoughts?
  - Reactions?

COMMON REACTIONS

- Feeling understood
- Want to talk more
- Liking the listener
- Feeling open
- Feeling accepted
- Feeling respected
- Feeling engaged
- Feeling able to change
- Safe
- Empowered
- Hopeful
- Comfortable
- Interested
- Want to come back
- Cooperative

WRITING ACTIVITY

Photo Source : Nathan Dumlao on Unsplash

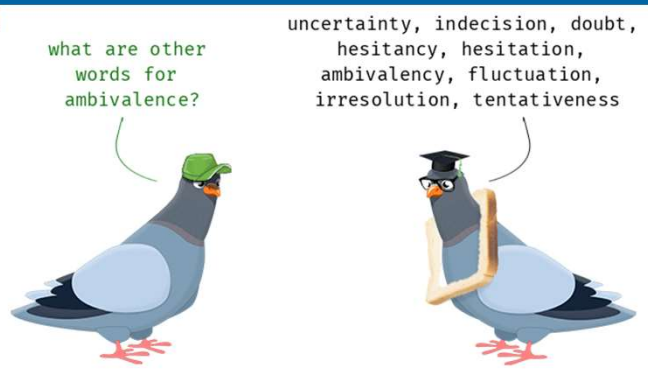
INSTRUCTIONS – WRITING ACTIVITY

Take 5 minutes to:

- Think about a behavior change you have been considering.
- Think about the benefits and challenges of making this behavior change. Jot them down.
- Describe the feelings that come up for you when considering the pros and cons of behavior change.
- Please raise your hand if you'd like share.

"To change or not to change"

WHAT IS AMBIVALENCE?



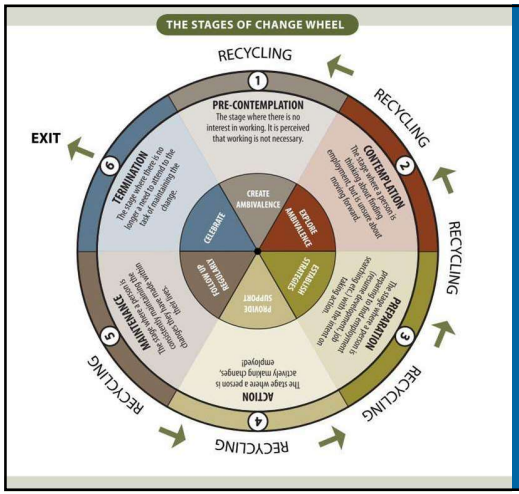
AMBIVALENCE

- Many people are **ambivalent** about change.
- Providers who push for specific change create conflict which reduces motivation for change.
- Conflict perpetuates ambivalence.
- **Evoking** the client's own **change talk** will enhance behavior change.
- We don't have the power to make someone change – we can develop skills to **engage in and tolerate** conversations about the **possibility** of change.
- People are usually motivated for something, find what that is and start there.

WHAT IS MOTIVATIONAL INTERVIEWING?

"MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."

(Miller & Rollnick, 2013, p. 29)



TRANSTHEORETICAL MODEL OF CHANGE

Prochaska J, DiClemente C. Changing for Good: A Revolutionary Six Stage Program for Overcoming Bad Habits and Moving Your Life Positively Forward. New York, Avon Bools. 1995

MOTIVATIONAL INTERVIEWING (MI) WORKS BEST WHEN…

- **Ambivalence is high** and people are stuck in mixed feelings about change
- **Confidence is low** and people doubt their abilities to change
- **Desire is low** and people are uncertain about whether they want to make a change
- **Importance is low** and the benefits of change and disadvantages of the current situation are unclear

THE PROCESS OF MOTIVATIONAL INTERVIEWING

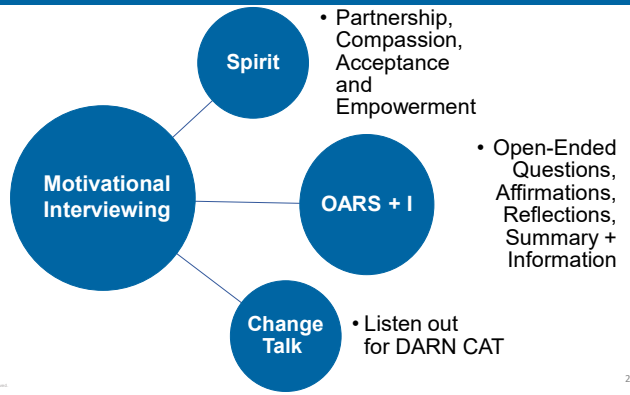
Engaging: Can we talk together?

Focusing: Where are we going?

Evoking: Why would you go there?

Planning: How will you get there?

CORE ELEMENTS OF MOTIVATIONAL INTERVIEWING



SPIRIT OF MOTIVATIONAL INTERVIEWING

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OARS + I

- **O**pen-Ended Questions
- **A**ffirmations
- **R**eflections
- **S**ummary

+

- **I**nformation Exchange

Photo Source : Jake Lorefice on Unsplash

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OPEN OR CLOSED?

- How is your back pain impacting your overall life?
- Do you have any concerns about the stress in your life?
- Is it important for you to serve your children healthy food?
- Do you use cannabis or other street drugs?
- Will you remember to do your exercises every day?
- What do you like about drinking?
- How, if at all, does your alcohol use affect your parenting?
- How is your meth use improving your sex life?
- Upon reflection, how does cannabis help reduce your anxiety?
- If you were to stop using heroin, how would your days be different?
- What would you spend your money on if you stopped drinking?
- Can I ask you something?

Open or closed?

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AFFIRMATIONS

What are they?

- Strengths and attributes
- Successes
- Hopes
- Desires
- Efforts to improve things
- Humanity
- Compassion

What are the results?

- Strengthen the relationships
- Build trust
- Support confidence and self-esteem
- Build a meaningful working alliance

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AFFIRMATIONS

These statements should show appreciation for a client's challenges and achievements, however they are not meant to be "cheers" and shouldn't start with "I am".

"You really thought clearly about your next steps"
"Wow, that must've taken a lot of courage"
"You applied some self-care and it helped you stay calm"
"You've achieved so much this week"
"You are determined and continue to search for answers"

Stepping it Up – Affirmation + building experience and confidence

- "You are staying alcohol-free in the face of many challenges", tell me how that feels...
- "You are not avoiding difficult conversations, what is helping you do that?"

REFLECTIONS

Reflective Listening:

When people are ambivalent, MI helps organize and integrate our mind, helping to create congruent decisions that make change possible.

Simple: Express that you understand what the client is saying and that you are listening

Complex: Step it up a notch by providing feedback or expanding on a feeling

Tips:

- Avoid using the pronoun "I" (i.e., making the reflection about the listener)
- Avoid negating change talk by using "and" instead of "but". Both realities exist at once.
- Should be brief

REFLECTIONS

Reflective Listening:

Tips:

- Avoid negating change talk by using **"and"** instead of **"but"**. Both realities exist at once.

"You are terrified of ending the relationship and you know it's the right thing to do"

"You want to stop using and you fear that you will not be able to succeed"

" You know that using could impact your housing and you keep using"

"You are motivated to stay healthy and you find it hard to take your meds"

EXAMPLES OF REFLECTIONS

For the following scenario, suggest open-ended questions the provider could ask next.

Client: I like to party; I don't see a problem as long as I'm at home. It's when I leave the house that things get out of hand.

Provider: Things are fine when you party at home. Partying is different when you leave the house.

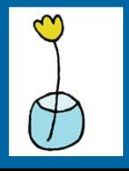
(What Open-ended question could you follow with here?)

Please raise your hand if you'd like to share

SUMMARIES

- Summaries allow us to keep track of the session, ask more questions and find out if we are really understanding the client's unique situation.
- After you state a summary ask:
  - "Did I get that right?"
  - "Did I miss anything?"
- Encourage the client to "Use the **edit** button". If your reflection is not accurate, say "edit me".

A SUMMARY IS A BOUQUET FILLED WITH ALL THE MATERIAL THE CLIENT HAS PROVIDED



INFORMATION EXCHANGE

Elicit-Provide-Elicit

Ask-Tell-Ask

Explore-Offer-Explore

- Ask an open-ended questions
- Reflect on the client's response
- Ask for permission to give information or advice
- Provide information
- Ask open-ended question
- Reflect-affirm-summarize

Always ask for permission

SUSTAIN TALK	CHANGE TALK
Client speech which favors maintaining and not changing a specific behavior	Client speech which favors changing a specific behavior

	Change talk	Sustain talk
Desire	"I *want to* quit smoking."	"I really *enjoy* smoking."
Ability	"I think it's *possible* for me to quit."	"I don't think I *could* stand the withdrawal."
Reasons	"My children are begging me to quit."	"It's the only way I have to relax."
Need	"I've *got to* quit smoking."	"I *need to* be able to smoke."
Activation	"I'm *willing to* give it another try."	"I *plan to* keep on smoking."
Commitment	"I'm *going to* quit."	"I have *decided to* keep on smoking."
Taking steps	"I bought some nicotine gum today."	"I bought two cartons of cigarettes today."

Source: Motivational Interviewing: Helping People Change And Grow, Fourth Edition

LISTEN FOR DARN CAT

Preparatory Change Talk

Desire: I want to…

Ability: I can…

Reasons: There are good reasons to….

Need: I really need to…

Mobilizing Change Talk

Commitment: I'm going to, I will…

Activation: I'm ready to…

Taking steps: I did…

Follow up when you hear change talk...

DARNCAT Cheat sheet

DESIRE	*I want to… I would like to… I wish…*
Ask evocative questions Ask for elaboration Ask for examples Look back/look forward Link behavior with values to develop discrepancy	• *Why do you want to make this change?* • *Why else might you want to make this change?* • *Tell me about some times over the last month when you really felt a strong wish to make this change.* • *What may happen if things continue as they are? –OR- If you were 100% successful in making the change you want, what would be different?* • *You have said that [value] is really important to you. How do you think [current behavior] impacts [value].*
ABILITY	*I could… I can… I would like to be able to…*
Ask evocative questions Ask for elaboration Ask for examples Affirm small steps Readiness ruler	• *How might you go about this change in order to succeed?* • *What other supports might help you be successful? How might others support you?* • *Give me an example of a time you made a change in your life. What strengths might you draw on to make a change? - OR - Tell me about a time in the past when you were able to make a change in your life.* • *Tell me about how this change could be broken down into some smaller steps.*
REASON	*Specifies a particular rationale, basis, incentive, justification or motivation for the change*
Ask evocative questions Ask for elaboration Ask for examples Look back/look forward Link behavioral with values to develop discrepancy Decisional balancing Query extremes Readiness ruler	• *What are the reasons for making this change?* • *Why else might you consider this change?* • *Give me an example of how this change would affect your life.* • *Tell me about a time before [the target behavior] emerged. How were things better/different?* • *What may happen if things continue as they are? –OR- If you were able to make the change you want, what would be different?* • *You have said that [value] is important to you. How do you think [current behavior] impacts [value]?* • *What are the pros and cons of making this change?* • *What are the worst things that might happen if you don't make this change? What are the best things that might happen if you make this change?*
NEED	I ought to… I have to…. I should….
Ask evocative questions Ask for elaboration Look back/look forward Query extremes Link behavior with values to develop discrepancy	• *How important is it for you to make this change?* • *Why is it so important to make this change?* • *Tell me about a time before [the target behavior] emerged. How were things better/different?* • *What may happen if things continue as they are? OR If you were 100% successful in making the change you want, what would be different?* • *What are the worst things that might happen if you don't make this change? OR What are the best things that might happen if you do make this change?* • *You have said that [value] is really important to you. How do you think [current behavior] impacts [value]?*

HMA generated handout

RESIST THE "FIXING REFLEX"

- Fix things
- Set things right
- Use shock tactics
- Give advice
- Get someone to face reality
- Shame into change

RESIST THE "RIGHTING REFLEX"

"People are more persuaded by what they hear themselves say than what someone else tells them"

(self-perception theory, 1972).

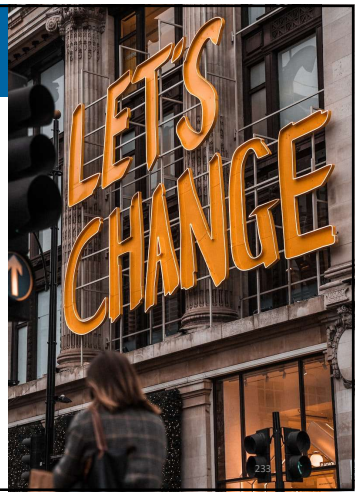


Photo Source : Brad Starkey on Unsplash

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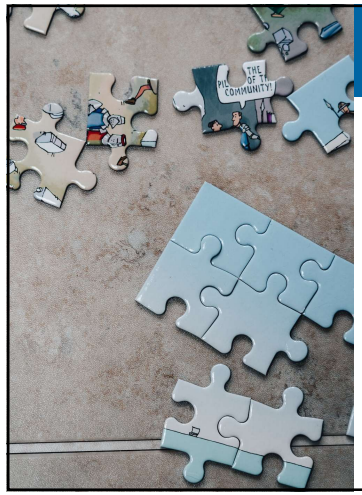

GOLDEN RULE

80/20

REMEMBER THE GOLDEN RULE

The client should be talking more than the provider and open-ended questions are an ideal way to keep the conversation going.

Photo Source : Jonny Gios on Unsplash

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TOOLS FOR MI

- Circle Chart
- Decision Matrix
- Scales or Rulers

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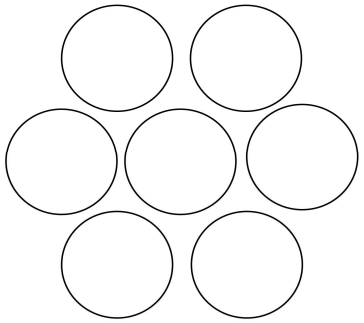
Agenda Map

Fill in the circles with topics to explore.



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DECISION MATRIX – SOCIAL MEDIA

	GOOD	NOT SO GOOD
NOT CHANGING BEHAVIOR		
CHANGING BEHAVIOR		

USING THE READINESS RULER

ABILITY TO CHANGE – CONFIDENCE

On a scale of 0 to 10 how confident you are you can make this change?

Why are you a ____ [insert # reported] and not a zero?

What would it take for you to get from ____ [insert # reported] to ____ [the next higher number]?

0	1	2	3	4	5	6	7	8	9	10
Not at all (*Important or Confident*)										Extremely (*Important or Confident*)

Figure 3: An Example of an Importance or Confidence Ruler

REASON OR NEED TO CHANGE – IMPORTANCE

On a scale of 0 to 10 how important is to make this change?

Why are you a ____ [insert # reported] and not a zero?

What would it take for you to get from ____ [insert # reported] to ____ [the next higher number]?

EXPLORING VALUES

From an idea to a belief to a value

"Smoking is unhealthy and I enjoy it" to

"I believe not smoking will improve my life" to

"I value health and wellbeing for myself and therefore don't want to smoke anymore".

WAYS TO INCORPORATE MI PRACTICE INTO YOUR WORK

- Post-it notes in your workspace or find posters on Pinterest
- Organize MI skills meetings once a month (many online curricula can guide you)
- Send a MI video to the team and spend 10 min discussing it before a meeting.
- Focus on one skill each week. It's Affirmations week!!!
- Find films or shows with ambivalent characters and discuss what skills you could use.
- Have a MI book club.
- Practice with songs (Still, Should I stay or should I go, Please don't leave me, A million reasons).
- Lift up good examples for recognition and review
- Take advantage of cases with challenging patients or outcomes to review and role play as part of routine workflow such as
  - During case reviews
  - On rounds
  - During supervision

Developing proficiency in MI is like learning to play a musical instrument. Some initial instruction is helpful, but real skill develops over time with practice, ideally with feedback and consultation from knowledgeable others. As with other complex skills, gaining proficiency is a lifelong process.

- WILLIAM MILLER, 2008

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REFERENCES: STIGMA

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- Mom and Baby Substance Exposure Initiative (MBSEI) Toolkit, Best Practice #37. nastoolkit.org
- National Academies of Sciences, Engineering, and Medicine. Ending discrimination against people with mental and substance use disorders: the evidence for stigma change. Washington, DC: The National Academies Press. https://www.nap.edu/catalog/23442/ending-discrimination-against-people- with-mental-and-substance-use-disorders. Published 2016. Accessed December 19, 2019.
- Stangl, A.L., Earnshaw, V.A., Logie, C.H. et al. The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. BMC Med 17, 31 (2019). https://doi.org/10.1186/s12916-019-1271-3

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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://inpud.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/

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REFERENCES: MOTIVATIONAL INTERVIEWING

- Center for Substance Abuse Treatment. Enhancing Motivation for Change in Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 35. HHS Publication No. (SMA) 13-4212. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999 (revised, 2013). Retrievable at https://store.samhsa.gov/system/files/sma13-4212.pdf
- Case Western Reserve Center for Evidence-based Practices – The Spirit of MI. https://www.centerforebp.case.edu/resources/tools/the-spirit-of-mi
- Frey J, Hall A. Motivational Interviewing for Mental Health Clinicians: A Toolkit for Skills Enhancement. PESI Publishers. May 2021.
- MBSEI Toolkit, Best Practice #6 – Appendix A is an abbreviated MI curriculum with several useful internet links. nastoolkit.org
- Motivation Interviewing Network of Trainers (MINT). https://motivationalinterviewing.org/
- Miller, W. R., & Rollnick, S. (2002). Motivational interviewing: Preparing people to change addictive behavior (2nd ed.). New York, NY: The Guilford Press.
- Prochaska J, Norcross J, and DiClemente C. Change for Good: A Revolutionary Six Stage Program for Overcoming Bad Habits and Moving Your Life Positively Forward. New York Avon Books 1995.
- "An Example of an MI 'Session'" from the work of WR Miller and S Rollnick
- Sobell & Sobell. (2008.) Motivational Interviewing Strategies and Techniques: Rationalesand Examples

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QUESTIONS?

AGENDA FOR TRAINING SERIES

Session	Topics
#1 **WEDNESDAY,** **MAY 28** 9:00 am to 12:00 pm	❑ Understanding HIV ❑ HIV Testing, Treatment and Prevention ❑ The Science of Addiction ❑ Screening and Assessment
#2 **WEDNESDAY,** **MAY 28** 12:30 pm to 4:00 pm	❑ Ethical and Legal Issues ❑ Funding and Policy Considerations ❑ HIV Risk Reduction ❑ SUD Harm Reduction ❑ HIV and Stigma ❑ Motivational Interviewing
#3 **THURSDAY,** **MAY 29** 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 **THURSDAY,** **MAY 29** 12:30 pm to 4:00 pm	❑ **Cultural, Racial and Sexual Identities** ❑ **Pregnancy and HIV, SUD/OUD** ❑ **Accessing, Obtaining, and Integrating Services for Individuals with HIV and SUD in Minnesota**

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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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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

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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
OUD – 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