Integrating Buprenorphine Opioid Abuse Treatment Into HIV Primary Care: Webinar Series
Agenda

- Brief introduction to the new SPNS IHIP project (Sarah Cook-Raymond, Impact Marketing + Communications)

- Overview of the “Innovative Methods for Integrating Buprenorphine Abuse Treatment in HIV Primary Care Settings Initiative” including:
  - Its synergy with the National HIV/AIDS Strategy (Adan Cajina, Chief – Demonstration Branch SPNS Program)
  - Findings from the Initiative (Linda Weiss, PhD, New York Academy of Medicine)
  - Addressing misconceptions (Cindy MacLeod, ACRN, The Miriam Hospital Immunology Center)
  - Patient testimony (Arthur, Miriam Hospital Immunology Center)

- Q &A
Introducing IHIP...

- SPNS has launched the “Integrating HIV Innovative Practices” (IHIP) project.

- IHIP takes innovative findings from SPNS Initiatives and assists health providers in replicating proven models of care.

- The result? Improved care delivery and healthier patients.
Findings from the Buprenorphine Initiative have been translated into:
- A training manual
- A curriculum
- A Web site and online wiki (forthcoming) to share lessons learned and provide a virtual community of providers.
- A Webinar series
  - This is the first of three focusing on buprenorphine
  - Subsequent Webinars will review the clinical aspects of delivering buprenorphine and how to build capacity within your clinic.
- All IHIP products and a buprenorphine monograph can be accessed at www.careacttarget.org.

The Buprenorphine Initiative is the first initiative in the IHIP series. Outreach and retention are next, with more to come.
Questions about the IHIP project can be directed to
Sarah Cook-Raymond, Managing Director
Impact Marketing + Communications (www.impactmc.net)
scook@impactmc.net
Innovative Methods for Integrating Buprenorphine Opioid Abuse Treatment in HIV Primary Care:
A Critical HIV/AIDS Bureau Initiative

August 28, 2012

Adan Cajina
Chief – Demonstration Branch SPNS Program
U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau
Part F: Special Projects of National Significance

- Mission: Respond to emerging HIV primary care needs of individuals receiving assistance under the Ryan White HIV/AIDS Program
  - Development of innovative models of HIV care
  - Evaluation of program effectiveness
  - Build capacity by promoting dissemination and lessons learned
  - Replication of successful models
National HIV/AIDS Strategy

- White House releases the NHAS & Implementation Plan – July, 2010

- Nation’s first comprehensive coordinated HIV/AIDS roadmap with clear, measurable goals for 2015

- Refocuses existing efforts to maximize available resources and make the case for new investments

- **Reduce new infections** (25%), lower transmission rate (30%), and increase to 90% awareness of HIV+ serostatus

- **Improve access to and outcomes of care** by linking 80% of PLH to care w/in 3 mo of diagnosis, increase to 80% RW clients in continuous care, and increase to 86% RW clients with permanent housing

- **Reduce HIV-related health disparities** by increasing by 20% the number of men who have sex with men (MSM), Blacks, and Latinos with undetectable viral load
Part F: SPNS Initiatives

- NHAS tasked HAB: “To collaborate with States and localities on pilot initiatives for expanding the most promising models for integrating HIV testing, outreach, linkage and retention in high risk communities”.

- SPNS initiatives have and continue to promote the strategy through innovative models related to access, health care integration and optimization, and re-engagement and retention.
Current SPNS Initiatives

- Enhancing Linkages to Primary Care & Services in Jail Settings
- Enhancing Access to and Retention in Quality HIV/AIDS Care for Women of Color
- Hepatitis C Treatment Expansion
- HIT Capacity Building Initiative for Ryan White HIV/AIDS Program AIDS Drug Assistance Program (ADAP)
- Systems Linkage and Access to Care for Populations at High Risk of HIV Infection
- Retention and Re-engagement Project
New Initiatives

- Enhancing Access to and Retention in HIV Primary Care for Transgender Women of Color
- Integrated HIV Care, Mental Health and Substance Abuse Treatment for Homeless populations
- HIT Capacity Building Initiative for Ryan White Program Providers
- Replication of a Public Health Information Exchange to Support Engagement in HIV Care
Recently Closed High–Impact Initiatives

- Oral Health
- Prevention with Positives
- Outreach
- Electronic Networks of Care
- YMSM
- Others found at: [http://hab.hrsa.gov/abouthab/special/previousinitiatives.html](http://hab.hrsa.gov/abouthab/special/previousinitiatives.html)

- And the Buprenorphine Initiative funded from 2004–2009.
Catalyst to fund this initiative:

- Approximately one-third of all AIDS cases are directly or indirectly linked to injection drug use.
- Opioids are among the most frequently abused drugs.
- Nonmedical opioid pain medication abuse is on the rise.
- Mortality among illicit opioid users is estimated at approximately 13 times that of the general population.
Innovative Methods for integrating Buprenorphine Opioid Abuse Treatment in HIV Primary Care Initiative

- Catalyst to fund this initiative:
  - HRSA–SAMHSA Collaboration
  - Licensing of Buprenorphine (DATA 2000)
  - Need to bridge the two cultures of substance abuse treatment and HIV primary care by building capacity for both medication-assisted treatment (MAT) and the supportive services that are critical to its success.
  - Ryan White HIV/AIDS Program providers were seeing opioid dependent patients already; integration of buprenorphine offered one more way to create a comprehensive medical home.
Innovative Methods for integrating Buprenorphine Opioid Abuse Treatment in HIV Primary Care Initiative

- First of its class demonstration project piloted in real-world clinical settings

- 5-year initiative comprised of 10 demonstration sites across the Nation and coordinated by an Evaluation and Technical Assistance Center – The New York Academy of Medicine – in collaboration with Yale University School of Medicine.

- Lessons learned adding to the knowledge base and expansion of substance abuse treatment into not just HIV primary care, but primary care more generally.
Contact Information

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Integration of Buprenorphine into HIV Care: Findings from the BHIVES Collaborative

Linda Weiss, PhD
Center for Evaluation and Applied Research

August 2012
Presentation Objectives

1. Describe the HIV, drug use, and quality of life outcomes for integrated HIV and buprenorphine treatment at BHIVES sites.

2. Describe promising practices for integration of buprenorphine treatment into an HIV primary care clinic

3. Describe common challenges faced by providers offering buprenorphine treatment to their HIV patients, as well as effective responses to those challenges
Buprenorphine Overview

• An opioid replacement therapy that has been shown to be as effective as methadone in reducing opioid use.

• Approved by the FDA in 2002 for office based treatment of addiction.

• Can be prescribed by physicians that complete buprenorphine training and register with the DEA.

• Offers a unique opportunity to integrate drug treatment for opioid use into HIV care settings.

• Provides an alternative to patients who are uninterested in or unsuccessful with methadone programs.
BHIVES Initiative

BHIVES INITIATIVE

• Starting in 2005, HRSA/SPNS funded 10 sites to design and implement programs that integrate primary HIV care and the office-based treatment of opioid addiction using buprenorphine.

• Sites designed their own integrated models consistent with clinic characteristics, including staffing and patient population.

• The initiative included an Evaluation and Support Center based at The New York Academy of Medicine to coordinate a multi-site evaluation, provide clinical and evaluation technical assistance, and promote dissemination of findings.

• Clinical support provided by Yale University School of Medicine.

Multisite Evaluation

Objectives

• Assess the feasibility and effectiveness of integrating buprenorphine treatment and HIV primary care.

• Identify best practices for integrated care.

• Promote the replication of these practices.
Model Demonstration Sites

- EL Rio Santa Cruz Neighborhood Health Center (Tucson, AZ)
- OASIS (Oakland, CA)
- Oregon Health & Sciences University (Portland, OR)
- Montefiore Medical Center, (Bronx, NY)
- University of Miami Medical School (Miami, FL)
- The Miriam Hospital (Providence, RI)
- UCSF Positive Health Program (San Francisco, CA)
- Johns Hopkins University (Baltimore, MD)
- CORE Center (Chicago, IL)
- Yale University School of Medicine (New Haven, CT)

Evaluation & Support Center (BHIVES)

- The New York Academy of Medicine (evaluation)
- Yale University Medical School (clinical expertise)
- Weill Cornell Medical College (cost analysis)
Multisite Evaluation Methods: Patient Data

• Study participants were assessed at baseline, 30 days and quarterly for one year

• Assessments included interview and chart abstraction data focused on:
  • Sociodemographics
  • Substance use
  • Health status
  • HIV clinical indicators
  • Quality of life
  • Service utilization

• Validated measures incorporated into the assessments included:
  • Addiction Severity Index (ASI)
  • SF-12
  • CES-D
  • Brief Symptom Inventory
  • NAIDS Symptom Distress Module

• Qualitative interviews were conducted with a convenience sample of 33 patients from 7 BHIVES sites. Interviews focused on:
  • Drug use cessation and buprenorphine treatment
  • Experience with other treatment modalities, including methadone
  • Advantages and disadvantages of integrating substance abuse treatment into HIV care.
Multisite Evaluation Methods: Provider Data

- Provider surveys were administered three times during the study period and focused on:
  - HIV and substance use treatment experience
  - Patient characteristics
  - Knowledge regarding buprenorphine treatment
  - Factors affecting willingness to prescribe buprenorphine

- A survey of providers examining the quality of opioid prescribing was administered at the midpoint of the study. Topics included:
  - Adherence to recommended guidelines for opioid prescribing
  - Concern around substance abuse and the misuse of prescriptions opioids
  - Confidence in ability to recognize opioid analgesic abuse

- Individual and group interviews with providers and staff were conducted during the first and fifth year of the study covering:
  - Program implementation
  - Best practice recommendations
  - Lessons learned
BHIVES Sample (N=303)

- Most participants were over 40 years of age (71%); had been HIV+ for >10 years (61%) and had been using opioids for an average of 17 years.

- Just over half of the sample were African-American/Black (52%)

- At baseline, most of the participants reported being unemployed (74%) and a quarter (25%) were homeless

<table>
<thead>
<tr>
<th>Participant Characteristics</th>
<th>%</th>
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<tbody>
<tr>
<td>Age (mean)</td>
<td>45.2</td>
</tr>
<tr>
<td>Years HIV+ (mean)</td>
<td>12</td>
</tr>
<tr>
<td>Years using heroin (mean)</td>
<td>17</td>
</tr>
<tr>
<td>Unemployed</td>
<td>74.3</td>
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<tr>
<td>Homeless</td>
<td>25.1</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>67.7</td>
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<tr>
<td>Female</td>
<td>32.3</td>
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<tr>
<td>Race/ethnicity</td>
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<tr>
<td>African-American/Black</td>
<td>51.5</td>
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<tr>
<td>Latino/a</td>
<td>22.4</td>
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<tr>
<td>White</td>
<td>22.7</td>
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<tr>
<td>Other</td>
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<td>Education</td>
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<tr>
<td>&lt; HS</td>
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<tr>
<td>HS/GED</td>
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<tr>
<td>College</td>
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</table>
Findings: Treatment Retention

- We found moderate retention in buprenorphine treatment over 12 months

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Retained in Buprenorphine</th>
<th>Not Retained in Buprenorphine</th>
<th>Lost to Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Baseline</td>
<td>303</td>
<td>100.0</td>
<td>0</td>
</tr>
<tr>
<td>Quarter 1</td>
<td>225</td>
<td>74.3</td>
<td>30</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>204</td>
<td>67.3</td>
<td>35</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>179</td>
<td>59.1</td>
<td>43</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>149</td>
<td>49.2</td>
<td>52</td>
</tr>
</tbody>
</table>
Findings: Heroin and Other Opioid Use Outcomes

There were significant decreases in heroin and other opioid use over time

- “Any opioid use” decreased from 84% at baseline to 42% at year 4.
- On average participants were 52% less likely to use any opiates for each quarter of participation in the intervention (OR = .659, p ≤ .001).

- Heroin use decreased from 70% at baseline to 27% at year 4.
- On average participants were 59% less likely to use heroin for each quarter of participation in the intervention (OR = .629 p ≤ .001)

### Opioid Use Outcomes

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opioids</td>
<td>70.5</td>
<td>35.6</td>
<td>28.7</td>
<td>26.5</td>
<td>27.7</td>
</tr>
<tr>
<td>Heroin</td>
<td>84.4</td>
<td>43.8</td>
<td>38.8</td>
<td>41.6</td>
<td>42.4</td>
</tr>
</tbody>
</table>
Findings: HIV Outcomes

- Patients initiating buprenorphine were significantly more likely to start or remain on ART and improve CD4 levels.

- For patients not on ART at baseline, retention in buprenorphine treatment for 3 or more quarters was associated with starting ART and reduced viral load.

**FIGURE 2.** Mean CD4 count at baseline and throughout 12 months of observation. Compared with baseline, $P < 0.05$ for each subsequent quarter of follow-up observation.
Findings: Health Related Quality of Life

• Baseline normalized SF-12 scores were lower than the general US population (mean of 50) for all HRQOL domains

• Average composite mental HRQOL improved from 38.3 to 43.4 over 12 months

• Average composite physical HRQOL remained unchanged over 12 months (varied between 42.1 and 43.9)

• In multivariate analysis, continued buprenorphine treatment across all 4 quarters was associated with improvements in both physical and mental HRQOL
Findings: Qualitative Patient Interviews

Patient perspectives regarding buprenorphine and integrated care were positive

- **Satisfaction & Perspectives on Effectiveness**
  - Effective in controlling opioid use and blocking cravings; buprenorphine treatment resulted in decreased substance use
  - Greatly improved quality of life: feel “normal”

- **Impact on Health & HIV care**
  - Improved health
  - Increased engagement with health and HIV care

- **Self Management & Withdrawal**
  - Nuanced ability to manage treatment
  - Less fear of withdrawal

- **Integrated Care: Benefits & Concerns**
  - Benefits include convenience, improved quality of care, improved treatment environment
  - Concerns include confidentiality issues and time saving (too much saved)

- **Counseling**
  - Substance abuse treatment is complicated – needs more than just buprenorphine
Findings: Qualitative Patient Interviews

“I love it. Absolutely. This stuff’s like a frigging gift from God, Suboxone, it is, I love it. The shit works so good.”

“It was like a big yoke being lifted off my shoulders. It means freedom to me.”

“With buprenorphine you just feel like you’re just normal…it’s kind of like, it takes me back to before I had ever done opiates.”

“Actually I don’t feel like I’m on any drug when I take the Suboxone [compared to methadone]. I don’t nod. I’m not speedy. I’m not sleeping. I feel good when I’m on the Suboxone.”

“Now they know I got [HIV], and it’s like nothing to them, you know what I mean. They treat me nice, you know. I mean they’re all, you know, here to help you.”

“For me having it in the same place worked out well. I can get everything right here in this one facility, without having to run over here and over there.”
Findings: Provider and Staff Interviews

- Integrated buprenorphine and HIV treatment successfully introduced into community and hospital based-clinics under the direction of ID, psychiatry, and general internal medicine physicians

- At virtually all sites, providers and staff were highly satisfied with integrated care
  - Anticipated continued provision of the service after the end of the grant period

- Multiple prescribers necessary to ensure sufficient coverage

- A “buprenorphine coordinator” (e.g. nurse, counselor) was seen as essential to the provision of quality care

- Ongoing challenges included:
  - Multi-substance use and mental health issues among patients
  - Limited adoption of buprenorphine treatment among colleagues
  - Necessity of incorporating new procedures (e.g. urine toxicology) testing into established practice
Findings: Provider and Staff Interviews

Positive perceptions of buprenorphine and integrated care

• “Is it worth it? Absolutely…. it expanded our capacity to take care of folks who were previously on the margins of engaging in health care. So, it ended up bringing in folks who haven't been previously engaged in HIV care, and it gave us tools to better take care of the ones who were engaged in some fashion, in our practices already, but not doing well from an addiction standpoint… it also had this spill-over effect of raising our awareness of addiction issues in general.”

• “One of the beauties of office based buprenorphine is really embracing a harm reduction model. I’m not going to stop their buprenorphine if they have a positive drug screen.”

Buprenorphine coordinator

• “I think they really benefit from closer follow-up than I could give them, like phone contacts and those sorts of things, and in person with their counselor, and addressing some of the mental health issues that I just can't get to in a 25 minute visit.”

• “It's more like somebody to … stay on top of what's going on with the patients and then to actually work with them—that has the experience and training to know how to work with substance abusers and counsel them individually and run a group, for example. I think those are, by far, the more important components of the job.”
Findings: Provider and Staff Interviews

Challenges to integrated care

• “These patients are really complex. On one hand, treating the substance abuse is basically just opening the [door] to all the other sorts of problems that are going on with these folks.”

• “[For induction] we have to assess the patient, give them the prescription, they go down [to the pharmacy], get the medication and bring it on up. So on the first days, you’re often dealing with one or two visits and then that first week, you’re dealing with three to five visits and then two visits after that. So it’s just so many visits that it’s just hard.”

• “We had this precipitated withdrawal, we brought the patient back to this area we call the treatment room where we have a few stretchers … and this nurse, and I never would have expected it, but before we brought the patient back she said, “I just hate dealing with these kinds of patients.” And I mean she works in the treatment room of the HIV clinic, I mean she sees a lot of-- but as soon as she heard it was somebody in withdrawal. And that sort of struck me that, if we were asking existing staff, if we came to them and said, ‘Hey, we got this new exciting thing, but you need to put in some effort on it’ I don't know exactly how well it would go over.”
Other Findings

- **Costs:** Implementing buprenorphine treatment is associated with some increased costs.
  - Integrated HIV and buprenorphine treatment require different resources; buprenorphine treatment has costs that are not third-party reimbursed.

- **HIV quality of care:** Buprenorphine treatment was associated with improvement in HIV quality of care indicators (QI) at 12 months (46% of QIs at baseline, compared to 52% at 6 months).
  - Improvements primarily in preventive and monitoring care domains

- **Safety:** Buprenorphine did not produce measurable hepatic toxicity or pharmacodynamic interaction with atazanavir in HIV-infected opioid-dependent patients.

- **Policy considerations:** Financing issues, workforce and training issues are barriers to the full integration of buprenorphine treatment into HIV care.
  - Recommendations include changes to financing and reimbursement policies, as well cross training between the fields of addiction medicine, drug treatment, and HIV medicine
Limitations

- Diversity in programs
  - Staffing, intervention and patient population differed across sites. Impossible to determine (statistically) the impact of program characteristics
- Primary mandate was service delivery
  - Essentially no one was excluded
  - Although most sites had control arms, they permitted patient choice and cross-over
  - Use of clinical judgment regarding frequency of VL, CD4, urine toxicology. Data available for the evaluation were in some cases sparse
- Sample size smaller than anticipated
- A portion of the sample was lost to follow-up
Conclusions/Discussion

- Integrated buprenorphine and HIV care proved feasible and acceptable in almost all BHIVES sites

- Buprenorphine treatment provided in HIV care settings resulted in
  - reduced heroin/opioid and other substance use
  - improved self-reported mental and physical health over time
  - some improvement in HIV treatment

- The longer participants were in the intervention the better their self-reported outcomes

- The opioid use findings are consistent with those observed with buprenorphine treatment among HIV-negative patients in specialty and office-based treatment settings
For More Information

• Integrating Buprenorphine/Naloxone Treatment into HIV Clinical Care, JAIDS Volume 56, Supplement 1, March 1 2011. (http://journals.lww.com/jaids/toc/2011/03011)


• Linda Weiss: lweiss@nyam.org, 212-822-7298
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• The Evaluation and Support Center Staff: D Fiellin (Yale University Medical School), R Finkelstein, L Weiss, J Netherland, J Gass, and M Botsko, J Egan (NYAM)

• The BHIVES Principal Investigators: K Carmichael (EL Rio Santa Cruz Neighborhood Health Center, Tucson, AZ), D Sylvestre (OASIS, Oakland, CA), P T Korthuis (Oregon Health & Sciences University, Portland, OR), C Cunningham (Montefiore Medical Center, New York, NY), M Fischl (University of Miami Medical School, Miami, FL), FLANNIGAN (The Miriam Hospital, Providence, RI), P Lum (UCSF Positive Health Program, San Francisco, CA), G Lucas (Johns Hopkins University, Baltimore, MD), J Watts (CORE Center, Chicago, IL), R Altice (Yale University School of Medicine, New Haven, CT), and L Sullivan (Yale University School of Medicine, New Haven, CT),

• HRSA/SPNS Project Officers: Adan Cajina, Pamela Belton, and Katherine McElroy

• This initiative was funded by the U.S. Health and Human Services/Health Resources and Services Administration Grant Number H97HA03793
“RUBBER”, PLEASE MEET THE “ROAD…”

Integrating buprenorphine treatment in a Rhode Island HIV primary care clinic
WHY OUR CLINIC FELT THAT BUPRENORPHINE INTEGRATION WOULD MESH WITH OUR MISSION:

- Our years of adherence research among active drug users showing link between addiction treatment and improved HIV/health outcomes
- Existing primary care model
- Medical and substance abuse treatment ‘silos’ in community
- Serve many active users of opiates and other substances
- Strong bonds between patients and physicians, staff
- Many patients had hx of long term use and social instability
- Patients actively seeking alternatives to methadone maintenance
- 5 MDs became certified to prescribe buprenorphine
- Willingness to dedicate nurse to co-manage buprenorphine clinic
MISCONCEPTIONS (AKA, REALITY BITES...)

What we thought:

1. Successful management of opiate craving attenuates use of other substances

2. Patients pleading for ‘bup’ would also do “whatever it takes” to promote long term recovery (self-help meetings, counseling).

What we learned:

1. Addictive focus may change to another drug or behavior

2. Once the pharmacological treatment began, many patients avoided developing recovery network, preferring to rely on “the pill.”
<table>
<thead>
<tr>
<th>What we thought...</th>
<th>What we learned...</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Imposing highly structured and restrictive protocol for referral and induction was necessary.</td>
<td>3. With experience, we were able to merge clinical competency with expediency. We learned the value of flexibility within a structured model.</td>
</tr>
<tr>
<td>4. Buprenorphine would not be adequate to treat any patients with mixed pain and addiction disorders.</td>
<td>4. Some patients responded well and stabilized, something they were not able to do with full agonist opiates. Others were referred for methadone or pain management.</td>
</tr>
</tbody>
</table>
What we thought...

5. Patients would taper from buprenorphine and successfully utilize their recovery support networks.

What we learned...

5. Some did. Many relapsed and often returned for multiple re-inductions. The same relapse-recovery cycles prevailed as for all treatments. A good number have remained on treatment for up to 7 years, since our program began.
6. Could we safely transition patients from methadone to buprenorphine?

6. Our physician mentors (PCSS) were invaluable in talking us through challenges such as methadone transfers, precipitated withdrawals, emergency/trauma care and pre/postoperative care.
7. This addition to our already busy practice would be too burdensome for, and unsupported by, clinic staff.

7. In fact, the MDs and ‘bup nurse’ have a good reputation for immediate intervention with active substance users. The nurse case manages her clients and has the capacity to do community outreach and linkage to Miriam Hospital, social services and other resources as well as linkage to clinical HIV and primary care.
8. Be tough!

8. *Our HIV patients are, until the cure, our patients for life. We choose to take a long view and a harm reduction approach. We build on the patient-physician bonds and leverage these to promote the patient’s optimal treatment plan. Our door is always open.*
9. We are not substance abuse treatment specialists!

9. We can reduce harm and promote recovery with a relatively safe opiate replacement. We can collaborate with our community treatment specialists. We can bridge addiction treatment and HIV care. We can do this!
ARTHUR, a 48-YEAR-OLD MAN WHO STARTED BUPRENORPHINE TREATMENT IN 2005.
Visit www.careacttarget.org to view IHIP products and visit www.hab.hrsa.gov/abouthab/partfspns.html to learn more about the SPNS program.