

Update in HIV Treatment

Wendy Armstrong MD FIDSA

November 6, 2026

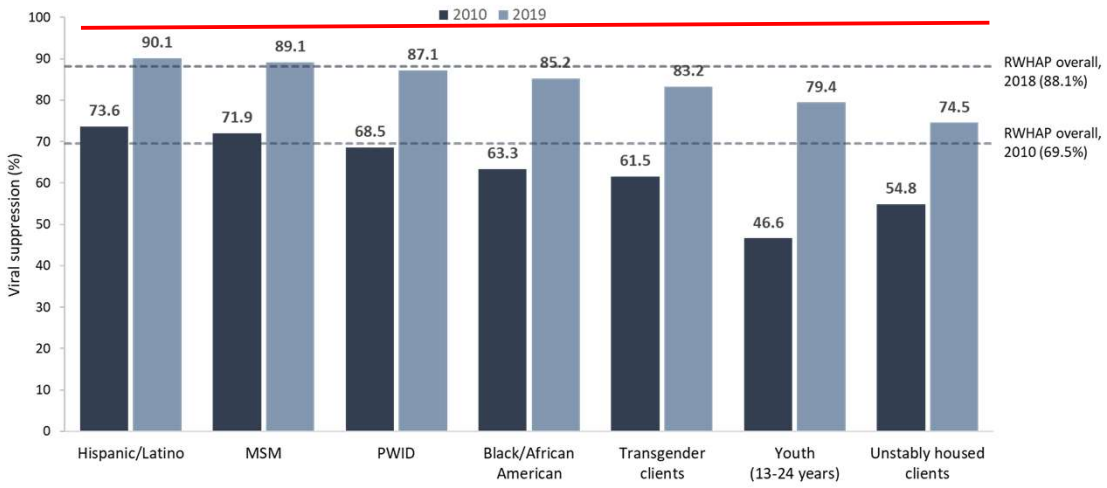
COI/Disclosures

- No financial conflicts of interest to report
- I serve on the DHHS ART Guidelines Committee
- I will talk about off-label use of medications and will make that explicit

Outline

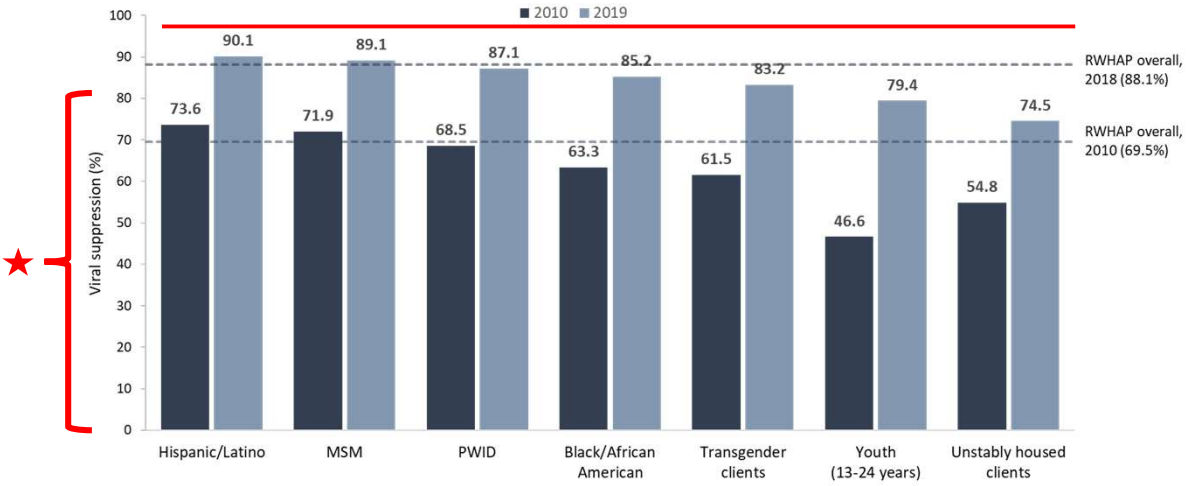
- New Therapies
  - Long acting injectable therapies
  - New oral therapies
- Innovative health care delivery

Viral Suppression among Key Populations Served by the Ryan White HIV/AIDS Program, 2010 and 2019—United States and 3 Territories[a]



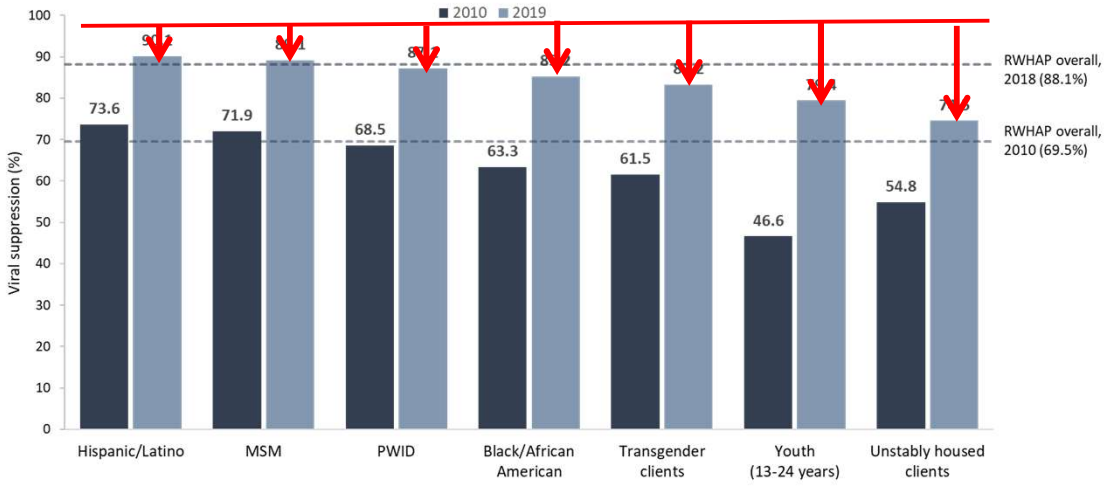
Hispanics/Latinos can be of any race.
Viral suppression: ≥1 OAHS visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.
[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

Viral Suppression among Key Populations Served by the Ryan White HIV/AIDS Program, 2010 and 2019—United States and 3 Territories[a]

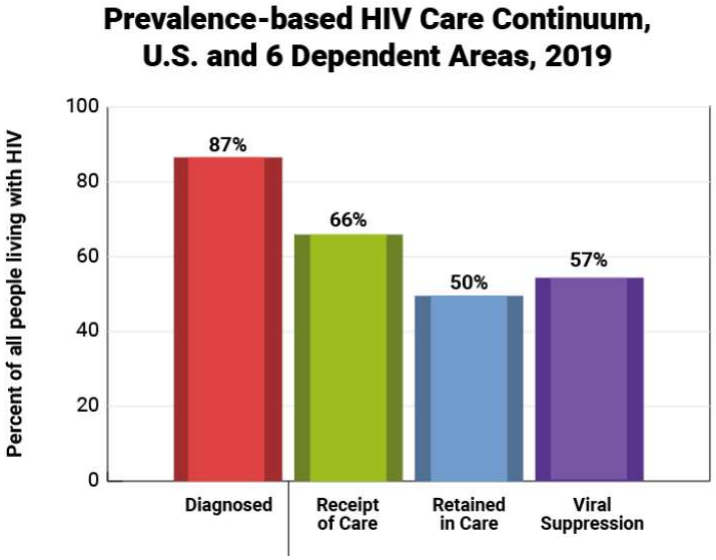


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Viral Suppression among Key Populations Served by the Ryan White HIV/AIDS Program, 2010 and 2019—United States and 3 Territories[a]



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UNAIDS goal

90-90-90

(VS of 72%)

or

95-95-95

(VS of 86%)

Long-Acting (Injectable) Therapy





Long-Acting Cabotegravir/Rilpivirine (CAB/RPV)

--- INDICATIONS AND USAGE----------
CAB/RPV … is indicated as a complete regimen for the treatment of HIV-1 infection in adults to replace the current antiretroviral regimen in those who are virologically suppressed (HIV-1 RNA less than 50 copies per mL) on a stable antiretroviral regimen with no history of treatment failure and with no known or suspected resistance to either cabotegravir or rilpivirine.

Injectable CAB/RPV: Pooled analysis

- Among 1651 participants in ATLAS, ATLAS-2M, and FLAIR trials, 1.4% (23) developed virologic failure (VF) through 152 weeks

Three Baseline Factors:
RPV RAMs, Subtype A6/A1, and BMI ≥30 kg/m^2

Baseline Factors (Number)	Virologic Suppression, n (%)[b]	CVF, n (%)[c]
0	844/970 (87.0)	4/970 (0.4)[d]
1	343/404 (84.9)	8/404 (2.0)[e]
≥2	44/57 (77.2)	11/57 (19.3)[f]
TOTAL	1231/1431 (86.0)	23/1431 (1.6)
(95% CI)	(84.1–87.8)	(1.0–2.4)
		18/1224 (1.47)[j]

Orkin C et al, Clin Infect Dis, 2023

The Promise of Long-Acting ART

ACTG A5359 LATITUDE: Long-acting Cabotegravir + Rilpivirine vs. Oral ART in People Living with HIV with Adherence Challenges

Patients randomized to LA CAB/RPV vs continued oral therapy once VL < 200. Stopped early by the DSMB. 17% of patients randomized to LA CAB/RPV arm actually had VL > 200 at the time of medication start, one-third with VL > 10,000 copies/cc

Secondary Outcomes	LA CAB/RPV	Oral ART	Difference (%)
Virologic failure (n, %)	6 (7 %)	28 (25%)	-18.2 (-31.1 to -5.4)
Treatment-related failure (n, %) • Viral failure • Treatment discontinuation 2/2 AEs	9 (9.6 %) 6 3	29 (26%) 28 1	-16.6 (-29.9 to -3.3)

Rana et al, Abstract 212, CROI 2024

Slide 11

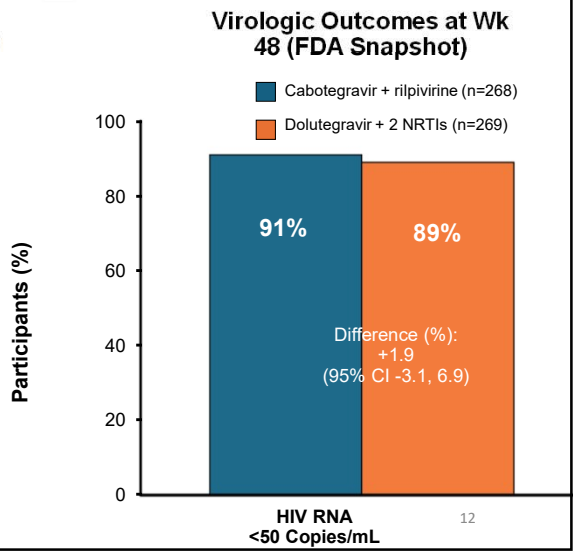
Long-Acting HIV Therapy in African Adults with Adherence Challenges

The NEW ENGLAND JOURNAL of MEDICINE

Authors: Fiona V. Cresswell, M.B., Ch.B., Ph.D., Jonathan Kitonsa, M.B., Ch.B., Claire Norcross, M.B., B.S., Victoria Tumusiime, M.Sc., Loice Achieng Ombajo, M.Med., Nigel Garrett, Ph.D., Sheetal Kassim, M.B., Ch.B., +25, for the IMPALA Study Group* Author Info & Affiliations

Published October 14, 2026 | N Engl J Med 2026;395:1505-1518 | DOI: 10.1056/NEJMoa2518753

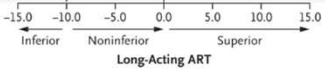
- PWH in Africa with difficulties adhering to oral ART (n=540)
- During screening phase, all achieved HIV RNA <200 on Dolutegravir + 2 NRTI
- Randomized to CAB/RPV every 2 months or daily oral DTG + 2 NRTI
- 94% preferred injectable therapy



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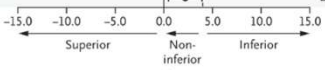
A Primary End Point

Analysis Population	Long-Acting ART	Oral Therapy	Adjusted Risk Difference (95% CI)
	no. of participants with event/ total no. (%)		*percentage points*
ITT-exposed population: primary analysis	244/268 (91.0)	240/269 (89.2)	1.9 (−3.1 to 6.9)
ITT population	248/271 (91.5)	240/269 (89.2)	2.4 (−2.6 to 7.3)
ITT-exposed population with last viral load measured ≤48 wk	248/268 (92.5)	245/269 (91.1)	1.5 (−3.1 to 6.1)
Subgroups of the ITT-exposed population			
CD4 level			
<500 cell/mm³	81/89 (91.0)	76/86 (88.4)	3.5 (−5.5 to 12.5)
≥500 cells/mm³	163/179 (91.1)	164/183 (89.6)	2.0 (−4.0 to 8.1)
Body-mass index			
<30	180/200 (90.0)	194/218 (89.0)	1.1 (−4.8 to 6.9)
≥30	64/68 (94.1)	46/51 (90.2)	4.2 (−5.2 to 13.8)
Per-protocol population	229/244 (93.9)	223/248 (89.9)	4.0 (−0.8 to 8.8)



B Key Secondary End Points

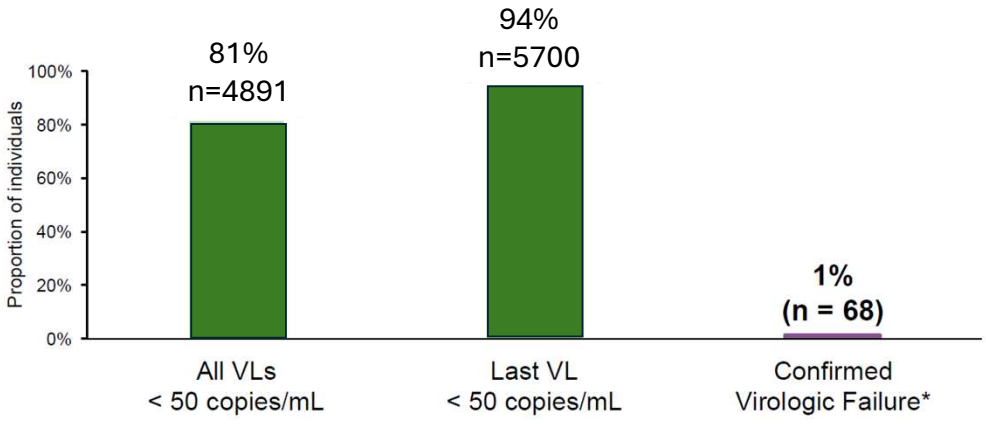
Antiviral Activity	Long-Acting ART	Oral Therapy	Adjusted Risk Difference (95% CI)
	no. of participants with event/ total no. (%)		*percentage points*
Virologic nonresponse, ITT-exposed population	17/268 (6.3)	21/269 (7.8)	−1.5 (−5.8 to 2.8)
Virologic nonresponse, ITT-exposed population with last viral load measured ≤48 wk	17/268 (6.3)	22/269 (8.2)	−1.9 (−6.2 to 2.5)
Confirmed virologic failure, ITT-exposed population	5/268 (1.9)	0/269	1.9 (0.3 to 3.5)
Confirmed virologic failure, sensitivity analysis in the ITT-exposed population	7/268 (2.6)	18/269 (6.7)	−4.1 (−7.6 to −0.6)
Confirmed virologic failure, ITT population	6/271 (2.2)	0/269	2.2 (0.5 to 3.9)



OPERA Cohort (IDWeek 2026)

Virologic Outcomes

Among 6,058 Complete Initiators with Baseline VL < 50 copies/mL and Follow-Up VL(s)



*2 VL ≥200 or 1 VL ≥200 discontinuation within 4 months

What about initiating LA-ART in patients with viremia?

- Increasing published experience with good success rates in viremic patients
  - **Ward 86 at UCSF:** 129 viremic, 88% CD4 < 200, 97% VS at 24 weeks, 98% at week 48, median VL 45,600
  - **UMississippi:** 12 patients with viremia in the South, all achieved VS, median VL 153,000
  - **OPERA cohort:** 368 patients, median VL 120 [IQR 61-2535], 63% from Southern US, median CD4 578 cells [IQR 365-808]. 331 initiated, 258 on CAB LA with median f/u 12 months. 88% suppression to <50, 36 (12%) had non-response

JAMA. 2025 Mar 6;333(16):1451–1453. doi: 10.1001/jama.2025.0109

Clin Infect Dis. 2023;78(1):122-124.

IAS 2025, Kigali, Abstract OAS0105LB

The use of lenacapavir with LA-CAB, RPV or both

Not addressed in the guidelines but increasing anecdotal and published series.

Potential reasons

- Often in the setting of NNRTI resistance (CAB+LEN), less often INSTI resistance
- Sometimes with high level viremia to potentially decrease risk of developing RPV resistance

Pitfalls

- Lower barrier to resistance
- CAUTION re: adding this to other oral agents in patients with difficulty with adherence

Open Forum Infect Dis. 2024 Apr 16;11(4)

Long-Acting Cabotegravir/Rilpivirine, Lenacapavir, and Ibalizumab Use Among Persons With HIV-1 Viremia at a Ryan White-Funded Clinic in the Urban US South

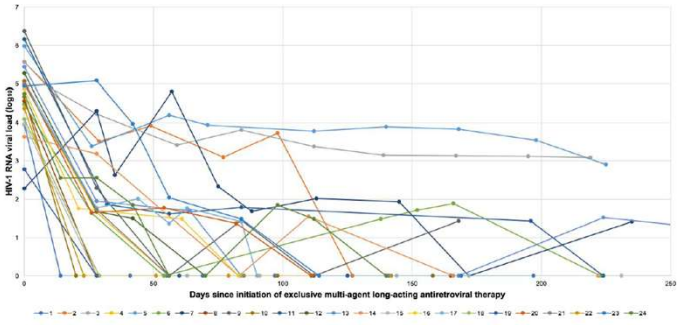
Jonathan A. Colasanti,[1,2,3] Amalia Aldredge,[1,2] Larisa V. Niles-Carnes,[1] Eudiah Ochieng,[1] Priyasha Pareek,[2] Vickie Robinson,[1] Erica Anderson,[1] Mary Castaneda,[1] Hilary Spralling,[1] Bradley L. Smith,[1] Jeri Sumitani,[1] Eric Paul Leue,[1] Caitlin A. Moran,[1,2] Meredith Lora,[1,4] Wendy S. Armstrong,[1,2] and Lauren F. Collins[1,2]

- 361 pts initiated on LA-ART in this urban safety net population with significant barriers to care,
- 88 (22%) with viremia **[NOW approx. 200 – personal communication]**
  - 51% food insecurity, 35% housing instability, 25% unmet transportation needs
  - 51% with CD4<200, median VL 4.0 log, 16% with VL > 5 log , 46% with prior OIs
  - 9 perinatal infection
- 69% CAB/RPV, 27% with CAB +/- RPV + LEN, 4% CAB +/-RPV + LEN + IBA

Clinical Infectious Diseases, ciaf425, https://doi.org/10.1093/cid/ciaf425

Results

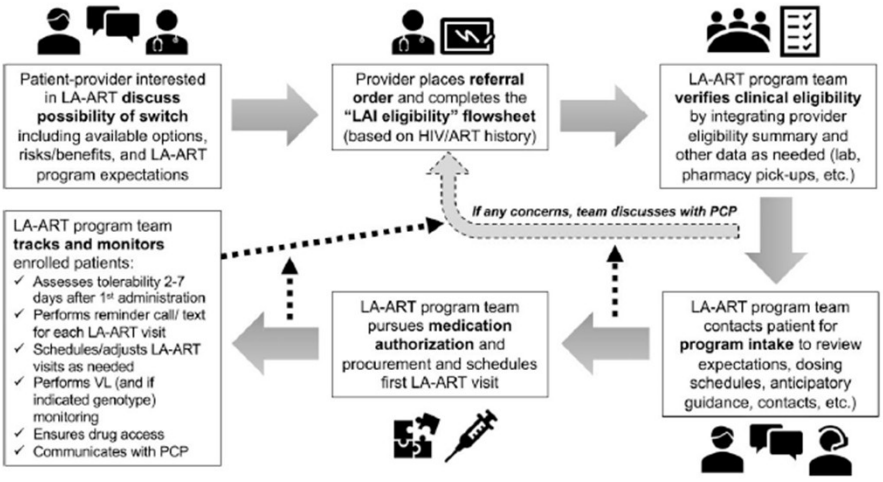
- 2 lost to follow-up
- 98% on time injections for CAB/RPV, 100% on time for LEN and IBA
- 92% with VS
  - 2 with LLV (50-200 copies/cc)
  - 2 with VL >200 and no resistance
  - 2 with VF with resistance
    - Both with dual class resistance (NNRTI + INSTI)



ViiV HEALTHCARE'S LONG-ACTING HIV TREATMENT *CABENUVA* (CABOTEGRAVIR + RILPIVIRINE) MEETS PRIMARY ENDPOINT OF SUPERIOR VIRAL SUPPRESSION VS. DAILY ORAL THERAPY IN PEOPLE WITH VIREMIA

- Press release October 6, 2026
- Phase IIIb study
- Enrolled approximately 326 subjects across 8 countries and 85 sites
- Randomized to LA CAB/RPV vs daily oral therapy in patients with detectable virus at study entry
- 6-month outcomes show superior VS in those on LA therapy

"Results to be presented at an upcoming meeting"



JAMA | Special Communication

Antiretroviral Drugs for Treatment and Prevention of HIV in Adults: 2024 Recommendations of the International Antiviral Society-USA Panel

Rajesh T. Gandhi, MD; Raphael J. Landovitz, MD; Paul E. Sax, MD; Davey M. Smith, MD; Sandra A. Springer, MD; Huldrych F. Günthard, MD; Melanie A. Thompson, MD; Roger J. Bedimo, MD; Constance A. Benson, MD; Susan P. Buchbinder, MD; Brenda E. Cra[illegible] Carlos del Rio, MD; Ellen F. Eaton, MD; Joseph J. Eron Jr, MD; Jennifer F. Hoy, MBBS; Clara Lehmann, MD; Jean-Michel Donna M. Jacobsen, BS; Michael S. Saag, MD

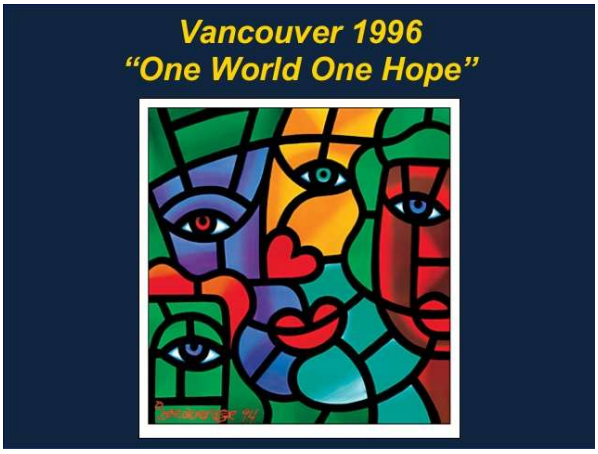
Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents With HIV

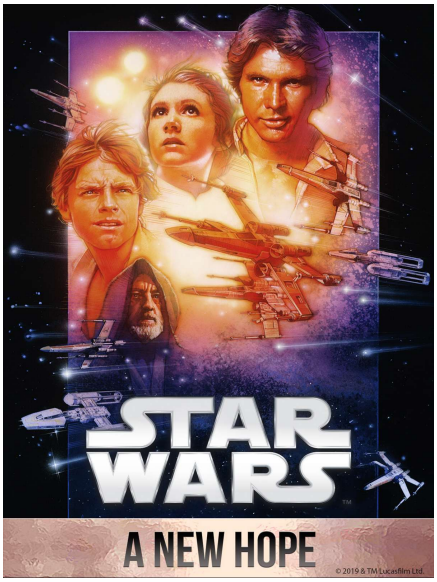
Developed by the HHS Panel on Antiretroviral Guidelines for Adults and Adolescents—A Working Group of the NIH Office of AIDS Research Advisory Council (OARAC)

When supported by intensive follow-up and case management services, LA-CAB+RPV may be considered in people with viremia meeting the following criteria:

- Unable to take oral ART consistently despite efforts and support
- High risk of HIV disease progression (CD4 <200)
- Virus susceptible to both CAB and RPV ****

doi:10.1001/jama.2024.2985





Special cases: Pregnancy

- Concern for lower RPV levels in pregnancy – one case report and pk data
- Need more data
- Shared decision-making: If not suppressed pre-CAB LA, may be riskier to change back to orals

	n	VL <20 at first ANC	VL <20 at delivery
On CAB/RPV prior to pregnancy	16		
Stayed on CAB/RPV	13	11 (85%)	12 (92%)
Switched to CAB/RPV during pregnancy (at median 22w)	6	1 (17%) Remainder 590-111K	5 (83%) Remainder 2K

22 pregnancies, no vertical transmissions

Abstract 1015, Short et al, CROI 2025

Special Cases: Hepatitis B co-infection

Scenario 1

- Pt is virologically suppressed on oral therapy with 1-2 active HBV drugs
- HBsAg +, cAb +
- Generally, not recommended to switch to CAB-LA. Pt would have to take additional oral meds for this HBV

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Scenario 2

- Pt is not virologically suppressed on oral therapy with 1-2 active HBV drugs
- HBsAg+, cAb+, HBV DNA > 10^5
- My take: at least get his HIV under control with LAI, prescribe TXF/XTC separately

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- HBsAg+, cAb+, HBV DNA > 10^5
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Scenario 3

- Pt is not virologically suppressed on oral therapy with 1-2 active HBV drugs
- HBsAg-, cAb+, sAb +/-, HBV DNA UD
- OK to switch, risk of reactivation is very low, but monitor and counsel patient
- Vaccinate if sAb neg

2025 +

INSTIs
- GS-1720 oral qWk Phase 2
- VH 184 LA inj, Phase 2
- ULA CAB q4mo Phase 1
- GS-6212 q3mo Phase 1
- GS-1219 q6mo Phase 1
- GS-3242 q6mo Phase 1
- ULA BIC q6mo Preclin
- ULA pro-CAB ≥ q6mo Preclin
- DTG implant Preclin

NRTTIs
- Islatravir
- MK 8527 oral qMo PrEP
- GS 1614 ISL prodrug - injection q3mo Ph 1

Protease Inhibitors
- GS 9770 oral qWk, unboosted; Preclin

Capsid Inhibitors
- VH 289 Phase IIa
- VH 499 Phase IIa
- GS 4182 oral pro-LEN Phase 1

NNRTIs
- MK 8507 (ULO) oral weekly
- GS 5894 oral weekly Ph 1

Coformulations
- DOR/ISL daily
- LEN/ISL weekly
- New: LEN/BIC and ISL/DOR

bNAbs/anti-CD4 Ab
- N6LS (+CAB)
- ZAB, TAB (+ LEN)
- VRC07-523 LS (+CAB or +TMB 365)
- PGDM1400 + PGT 121 + VRC07-523 LS
- UB-421 anti CD4 Ab in pts w MDR
- Other bi-specific, tri-specific bNAbs

>26 Unique Agents
- Multiple potential regimens for oral daily or weekly
- Injectable q3mo, q4mo, ≥ q6mo; Implants?

Courtesy of Melanie Thompson, MD

2025 +
>26 unique agents

INSTIs
- Ultra long-acting CAB/RPV q4mo

NRTTIs
- Islatravir
- GS 1614 ISL prodrug - injection q3mo Ph 1

Protease Inhibitors

Capsid Inhibitors

NNRTIs
- MK 8507 Uloniviring oral weekly

Coformulations
- LEN/ISL weekly
- ISL/ULO weekly
- DOR/ISL daily
- LEN/BIC daily

bNAbs/anti-CD4 Ab
- N6LS (+CAB)
- ZAB, TAB (+ LEN)
- And many others



Adapted from Melanie Thompson, MD

Islatravir plus …

- Initially developed as a longer acting drug (esp once/monthly for PrEP), development stopped due to reduced cell counts
- DOR/ISL co-formulated as a daily pill – FDA, April 2026
- Ulonovirine (ULO)/ISL – once weekly – Phase 2b at IAS but trial stopped (20 mg ISL) now new trial with a 2 mg ISL dose going forward.
- GS1614 (ISL prodrug) + LEN: quarterly dosing. Phase 1
- And then….

Phase 3 Trial of Weekly Oral Islatravir–Lenacapavir for HIV-1 Treatment

Authors: Jürgen K. Rockstroh, M.D., Moti N. Ramgopal, M.D., Adrian Curran Fàbregas, M.D., Malcolm Hedgcock, M.D., Kimberly A. Workowski, M.D., Sylvie Ronot-Bregigeon, M.D., Isabel Cassetti, M.D., +18 , for the ISLEND-1 Study Team* Author Info & Affiliations

Published July 29, 2026 | N Engl J Med 2026;395:1299-1309 | DOI: 10.1056/NEJMoa2607973 | VOL. 395 NO. 13

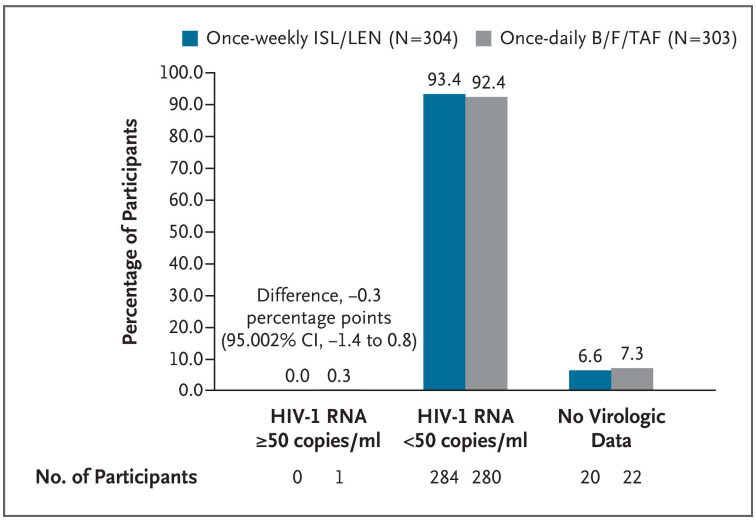
- Pts on stable B/F/TAF for at least 6 months with viral suppression
- Randomized 1:1 to continuation vs switch to once weekly ISL (2 mg)/ LEN (300 mg) orally [after a load]
- Primary endpoint HIV RNA >50 at week 48

ISLEND 1

The NEW ENGLAND JOURNAL of MEDICINE

50% white
98% cisgender men
50% > 50y
mean CD4 739
Hx of AIDS in 4%
Median of 14y w/ HIV

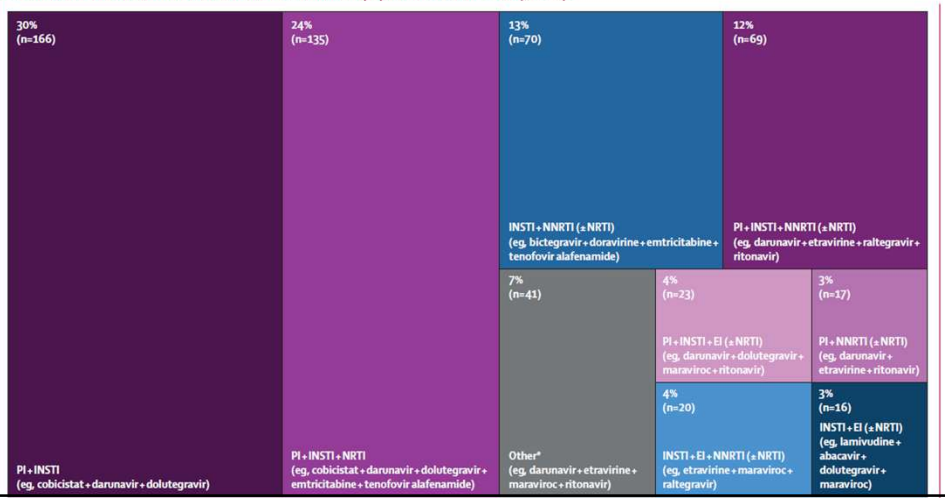
Once weekly oral ISL/LEN was noninferior to once daily B/F/TAF in maintaining VS



Switch to single-tablet bictegravir–lenacapavir from a complex HIV regimen (ARTISTRY-1): a randomised, open-label, phase 3 clinical trial

Chloe Orkin, Peter J Ruane, Malcolm Hedgcock, Cyril Gaultier, Marcelo H Losso, Benoit Trottier, Thomas Lutz, Mark O'Reilly, Mark Bloch, Jihad Slim, Moti Ramgopal, Simiso Sokhela, Karam Mounzer, Hung-Chin Tsai, Jorge Santana Bagur, Xu Zhang, Keith Aizen, Kwanza Price, Nicolas Margot, Jairo M Montezuma-Rusca, Peter Sklar, Martin Rhee, Pedro Cahn, on behalf of the ARTISTRY-1 Study Group

Lancet 2026; 407: 1249–58



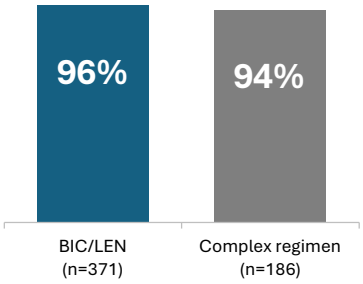
ARTISTRY-1: Switch from a complex regimen to BIC/LEN

60 yrs
median age – oldest registrational HIV trial population

81%
on a complex regimen because of ARV resistance

28 yrs
median time on ART; median 3 pills/day

HIV-1 RNA <50 copies/mL at Week 48



Randomised 2:1 · open-label · 48 weeks

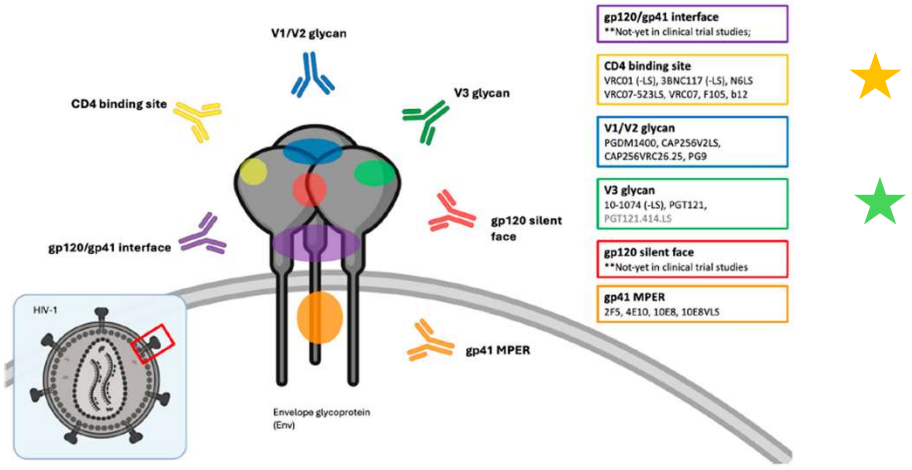
Takeaways

- **Non-inferior:** viral load ≥50 in 1% vs 1%
- **No resistance** emerged on BIC/LEN
- **Higher satisfaction** after switching (HIVTSQs +7 vs 0)
- **Similar AE rates** (82% vs 84%); drug-related AEs 14% vs 2%

One daily tablet can replace a multi-pill regimen without losing suppression

Orkin C, et al. Lancet 2026;407:1249–58. Phase 3, randomised 2:1, open-label, 48 weeks, n=557. Snapshot analysis.

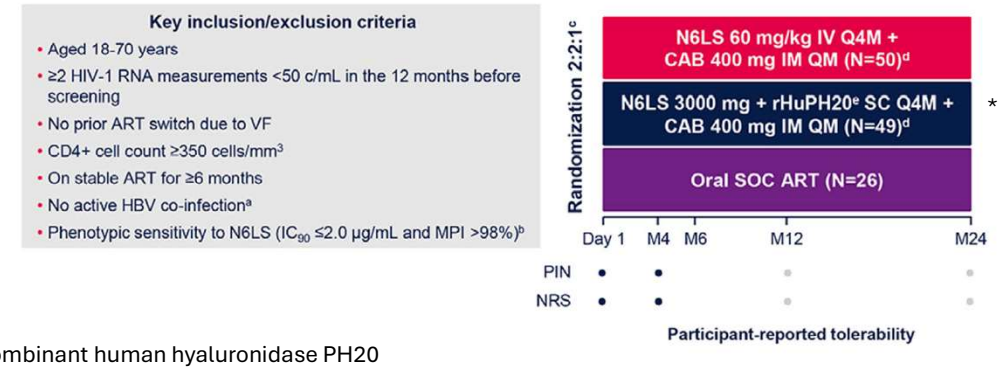
Broadly Neutralizing Antibodies (bnAbs)



Viruses 2024, *16*, 911. https://doi.org/10.3390/v16060911

Broadly neutralizing Abs: EMBRACE

Figure 1. EMBRACE Q4M study design.



*recombinant human hyaluronidase PH20

Griesel, EACS2025 PS09.1

LEN + teropavimab (TAB) + zinlirvimab (ZAB)

Key inclusion/exclusion criteria
- Age 18-65
- VL<50 x 12 months +
- Stable oral ART for 12 months
- CD4>=200 cells/mm3
- No HBV infection
- Pheno susc to TAB, ZAB

LEN 927 mg sc q6m + 2550 mg IV TAB q6m + 2550 mg IV ZAB q6m
n=53

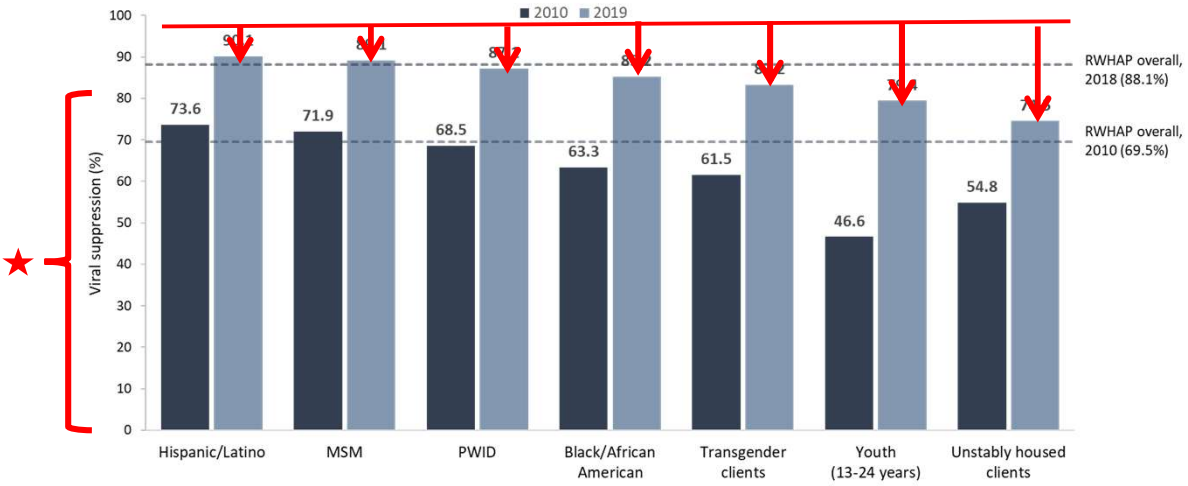
stable baseline oral therapy
n=27

Wk 26 Wk 52

- Well-tolerated, 36 pts in the LEN/TAB/ZAB arm with ISRs to LEN, mostly Grade I
- No infusion related reactions
- 3 virologic failure in LEN/TAB/ZAB arm, none in oral therapy arm

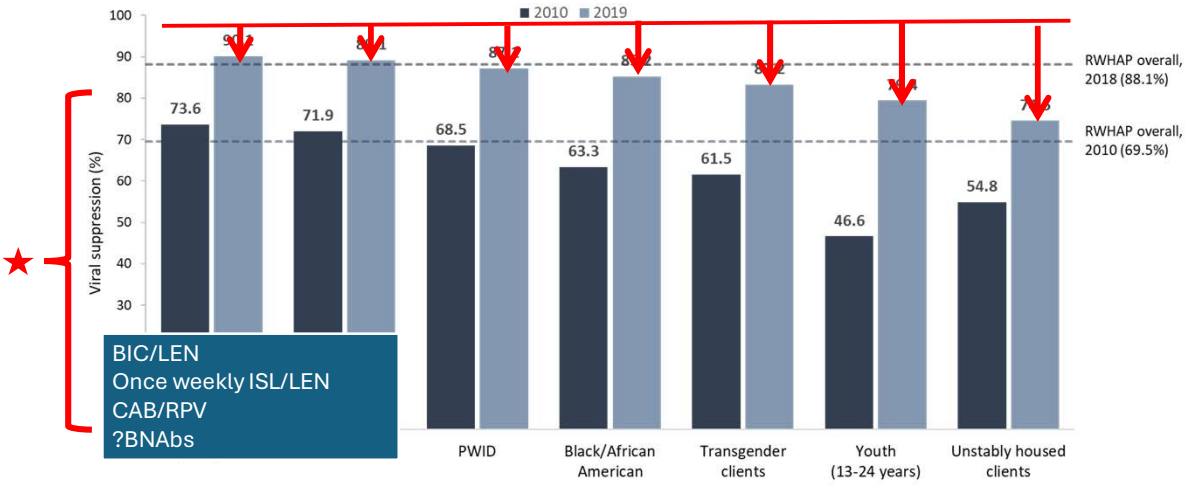
Ogbuagu, EACS 2025, Abs PS09.2

Viral Suppression among Key Populations Served by the Ryan White HIV/AIDS Program, 2010 and 2019—United States and 3 Territories[a]



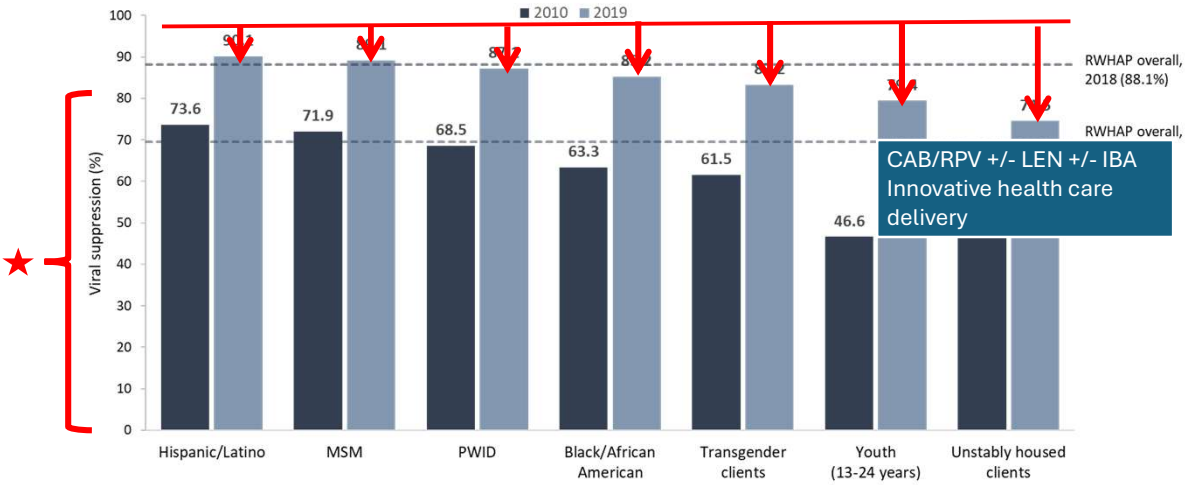
Hispanics/Latinos can be of any race.
Viral suppression: ≥1 OAHS visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL.
[a] Guam, Puerto Rico, and the U.S. Virgin Islands.

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NIH National Institute on Drug Abuse

JAMA® The Journal of the American Medical Association

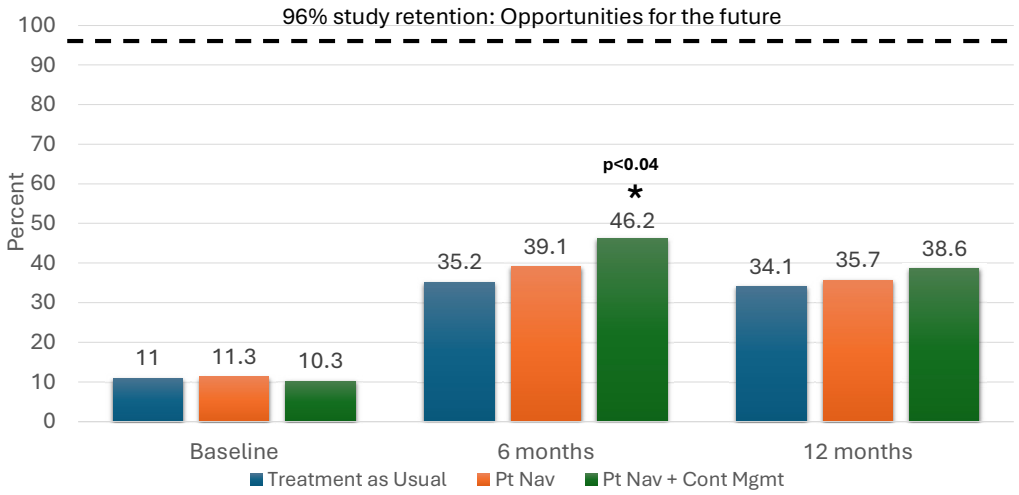
Original Investigation

Effect of Patient Navigation With or Without Financial Incentives on Viral Suppression Among Hospitalized Patients With HIV Infection and Substance Use
A Randomized Clinical Trial

Lisa R. Metsch, PhD; Daniel J. Feaster, PhD; Lauren Gooden, PhD; Tim Matheson, PhD; Maxine Stitzer, PhD; Moupali Das, MD; Mamta K. Jain, MD; Allan E. Rodriguez, MD; Wendy S. Armstrong, MD; Gregory M. Lucas, MD, PhD; Ank E. Nijhawan, MD; Mari-Lynn Drainoni, PhD; Patricia Herrera, MD; Pamela Vergara-Rodriguez, MD; Jeffrey M. Jacobson, MD; Michael J. Mugavero, MD; Meg Sullivan, MD; Eric S. Daar, MD; Deborah K. McMahon, MD; David C. Ferris, MD; Robert Lindblad, MD; Paul VanVeldhuisen, PhD; Neal Oden, PhD; Pedro C. Castellón, MPH; Susan Tross, PhD; Louise F. Haynes, MSW; Antoine Douaihy, MD; James L. Sorensen, PhD; David S. Metzger, PhD; Raul N. Mandler, MD; Grant N. Colfax, MD; Carlos del Rio, MD

JAMA. 2016;316(2):156-170. doi:10.1001/jama.2016.8914

Treatment Success (% VS among those alive)



Offers opportunity to get out of the clinic and to give DOT using mobile health units or utilize other community venues



Clinical Infectious Diseases
IDSA FEATURES

Policy Recommendations to Support Equitable Access to Long-Acting Injectables for Human Immunodeficiency Virus Prevention and Treatment: A Policy Paper of the Infectious Diseases Society of America and the HIV Medicine Association

Julia L. Marcus,[1] Andrea Weddle,[2,©] Colleen F. Kelley,[2,3] Allison Agwu,[2,4] Sheila Montalvo,[5] Elizabeth Sherman,[2,5] Tara Vijayan,[2,6] Jose Gutierrez,[7] Matthew D. Hickey,[8] Samantha E. Dilworth,[9] Douglas Krakower,[1] Teaniese L. Davis,[10] Lauren F. Collins,[3,©] Moira C. McNulty,[11] Jonathan A. Colasanti,[3,a,©] and Katerina A. Christopoulos[8,a]

Clin Infect Dis. 2025 Jan 28:ciae648. doi: 10.1093/cid/ciae648.

Low barrier clinics

AIDS PATIENT CARE and STDs
Volume 32, Number 4, 2018
© Mary Ann Liebert, Inc.
DOI: 10.1089/apc.2017.0313

The Max Clinic: Medical Care Designed to Engage the Hardest-to-Reach Persons Living with HIV in Seattle and King County, Washington

Julia C. Dombrowski, MD, MPH,[1–3] Meena Ramchandani, MD,[1,3] Shireesha Dhanireddy, MD,[1] Robert D. Harrington, MD,[1] Allison Moore, BS,[3] and Matthew R. Golden, MD, MPH[1–3]

Clinical Infectious Diseases® 2023;77(2):252–7

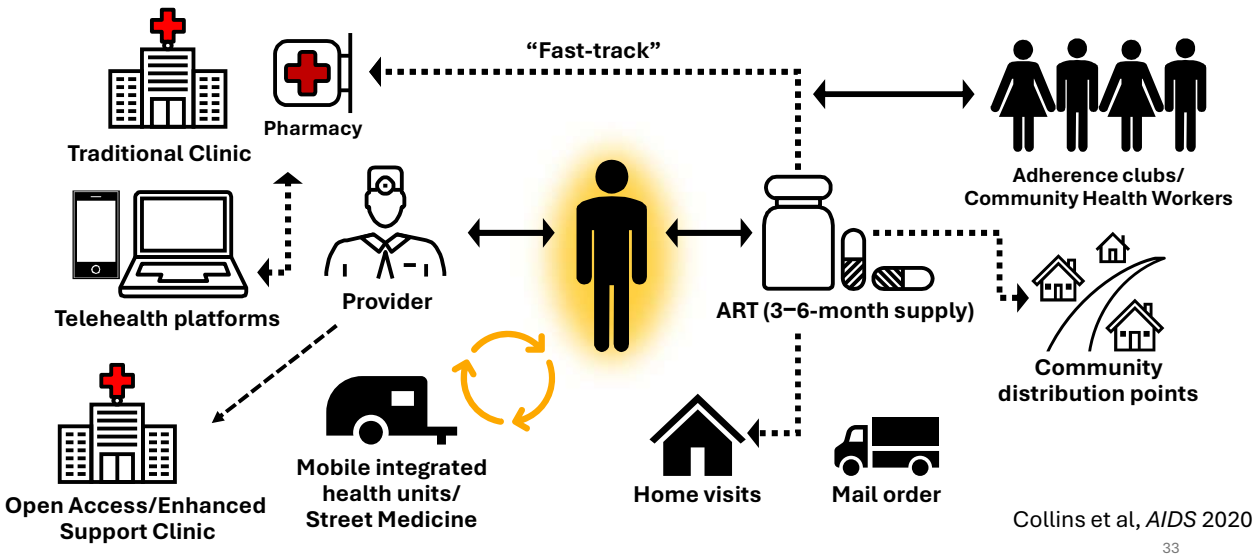
0% virally suppressed

86% drugs or alcohol
72% psychiatric illness
65% unstable housing

80% reached viral suppression, 54% with continuous viral suppression

	COMPONENT	EXAMPLE
Structural Elements	Walk In Access to Care	All visits for medical care and case management available without scheduled appts
	Integrated Care Team with Case Managers	Case managers know pts, low caseload
	Incentives	Gift cards, food, clothing, hygiene items
Process of Care Elements	Low Barrier to Care Philosophy	Creative treatment plans when guideline adherent care not possible
	Multisector Coordination	Methadone treatment, behavioral health programs
	Commitment to Rapid Modification	Pilot and iteratively improve

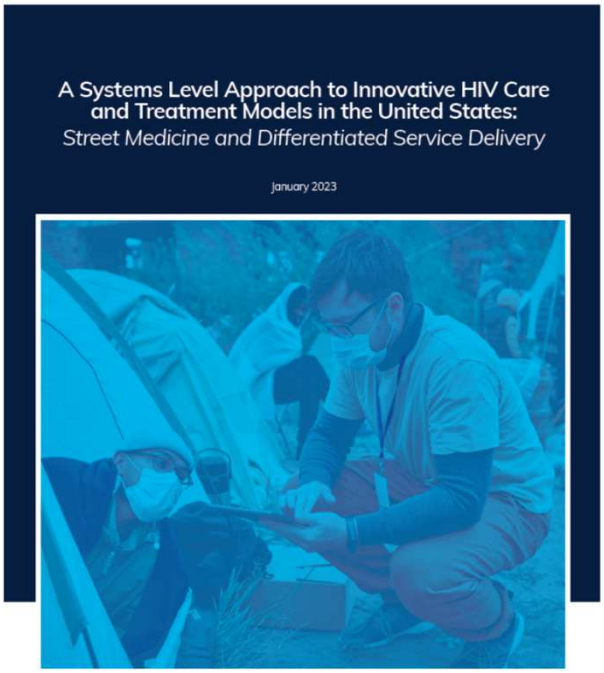
Differentiated Service Delivery
(need to learn what works and for whom?)



Collins et al, *AIDS* 2020

CMS POS (Place of Service) 27 - eff 10/23

A non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals.



hivma
hiv medicine association

The IDEA Exchange: Integrated Service Delivery

- Lobbied Florida legislature to change law to allow for syringe exchange – dirty for clean needles

We exist to provide the tools necessary to **reduce the spread of HIV, Hepatitis C, and other blood-borne diseases** through harm reduction in South Florida to keep people healthy.

Safe Injection packs, Naloxone packs, Harm reduction packs, HIV and hepatitis C testing, linkage to rehab and treatment

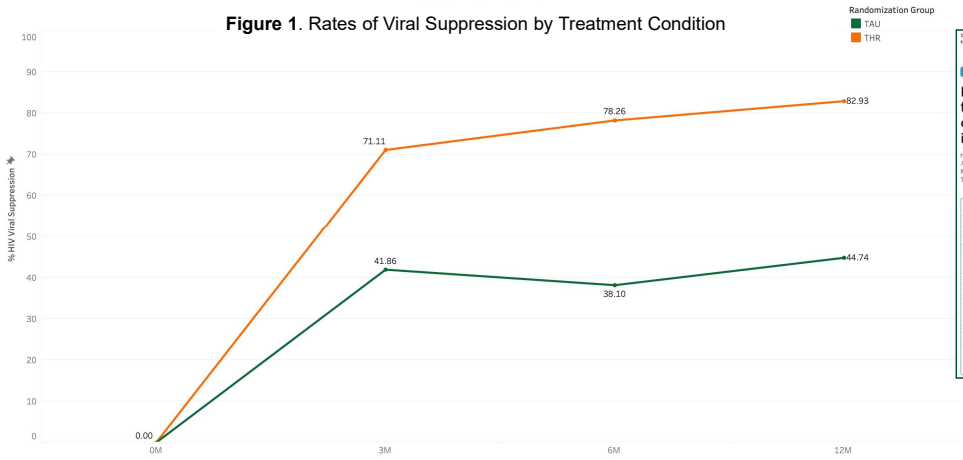
https://
ideaexchangeflorida.or...



Hansel Tookes MD

Telehealth Solution for HIV and Addiction Related Problems (T-SHARP) Trial

Figure 1. Rates of Viral Suppression by Treatment Condition





STUDY PROTOCOL Open Access

Project T-SHARP: study protocol for a multi-site randomized controlled trial of tele-harm reduction for people with HIV who inject drugs

Note. Total sample size (N = 100)
Primary Outcome is defined as HIV RNA <200
Retention rates across 3M, 6M, and 12M were 88%, 89%, 81%, respectively

QR code for protocol paper

*Preliminary results shown. Data analyses are ongoing per protocol. This work was supported by the National Institute of Drug Abuse (NIDA) DP2DA053720. The content is solely the responsibility of the authors and does not necessarily represent the official views of NIH.

MIAMI MILLER SCHOOL of MEDICINE

My take on New Therapies

- Exciting times – more options, longer acting and simpler!!
- We need to think again about personalization (like we used to pre B/F/TAF and other newer pills)
- The people we are failing have complex lives and if we meet that moment with curiosity and compassion, we can make a difference
- Health Care Delivery including Integrated Care Delivery are critical. We can do this in the current system and overcome a lot of SDOH even when we cannot fix them