



Initiation and Management of Medications for Addiction Treatment in Hard-to-Reach Populations

AFBSS Webinar Series: April 14, 2026

The Assertive Field-Based Substance Use Disorder/Opioid Use Disorder Services Training and Technical Assistance is funded by California Department of Health Care Services (DHCS). This session is presented by Health Management Associates. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, DHCS.



[Slide Image Description: This cover slide introduces the title of this webinar. It contains the logos for Health Management Associates.]

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Faculty	Nature of Commercial Interest
Anika Alvanzo, MD, MS, DFASAM, FACP	Dr. Alvanzo 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.
Andrew Herring, MD	Dr. Herring discloses that he is a Principal Investigator of CA Bridge Connect.
Jeanene Smith, MD, MPH, CME Reviewer	Dr. Smith 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.

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[Slide Image Description: This slide shows Continuing Education disclosures.]

- Anika Alvanzo, MD, MS, DFASAM, FACP: Dr. Alvanzo 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.
- Andrew Herring, MD: Dr. Herring discloses that he is a Principal Investigator of CA Bridge Connect.
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Presenters



**Anika Alvanzo, MD, MS, FACP,
DFASAM**
Physician Principal
Health Management Associates
(HMA)



Andrew Herring, MD
Founder, Principal Investigator
CA Bridge Connect

[HMA](#)

[Slide Image Description: This slide includes images of the presenters of this webinar on a light blue background.]

Dr. Anika Alvanzo is a distinguished health care executive with over 15 years of experience in specialty addiction treatment, behavioral health integration, and quality improvement. At Health Management Associates (HMA) Dr. Alvanzo's consulting has focused on supporting state and local jurisdictions in community needs assessment and strategic planning for behavioral health service delivery; provision of training, technical assistance and coaching to behavioral health providers; implementation of the American Society of Addiction Medicine (ASAM) Criteria; and advancing cultural humility in addiction treatment.

Dr. Andrew Herring is an Attending Emergency Physician and Associate Director of Research at Highland Hospital-Alameda Health System in Oakland, as well as Medical Director of the hospital's substance use disorder treatment program and Attending Physician at its interdisciplinary pain medicine program. His current research focuses on emergency department treatment of opioid use disorders and pain

management. Andrew is an assistant clinical professor at the University of California, San Francisco. He conducted health policy research as a Fulbright Scholar in Central America. He is board-certified in emergency medicine, addiction medicine, and pain medicine. Andrew graduated from Harvard Medical School and completed residency in emergency medicine at Highland Hospital.

Agenda

- » Assertive Field-Based Buprenorphine Initiation
- » Criteria for Tailoring the Approach to the Individual and the Setting
- » Provider Partners
- » Other Logistical Considerations and Dilemmas
- » Question & Answer

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[Slide Image Description: This slide shows the major sections of this webinar on a light blue background.]

Webinar Agenda:

- Assertive Field-Based Buprenorphine Initiation
- Criteria for Tailoring the Approach to the Individual and the Setting
- Provider Partners
- Other Logistical Considerations and Dilemmas
- Question & Answer

Learning Objectives

At the end of the session,
participants will be able to:

- » Describe three different approaches for initiating buprenorphine in individuals using high-potency synthetic opioids.
- » Identify at least three factors to consider when determining the optimal approach for initiating buprenorphine for opioid use disorder in this population.
- » Identify important partners in the care continuum for individuals initiating buprenorphine in non-traditional settings.
- » Describe at least two logistical considerations related to initiation and management of MAT in this population.

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Common Acronyms Used in this Presentation

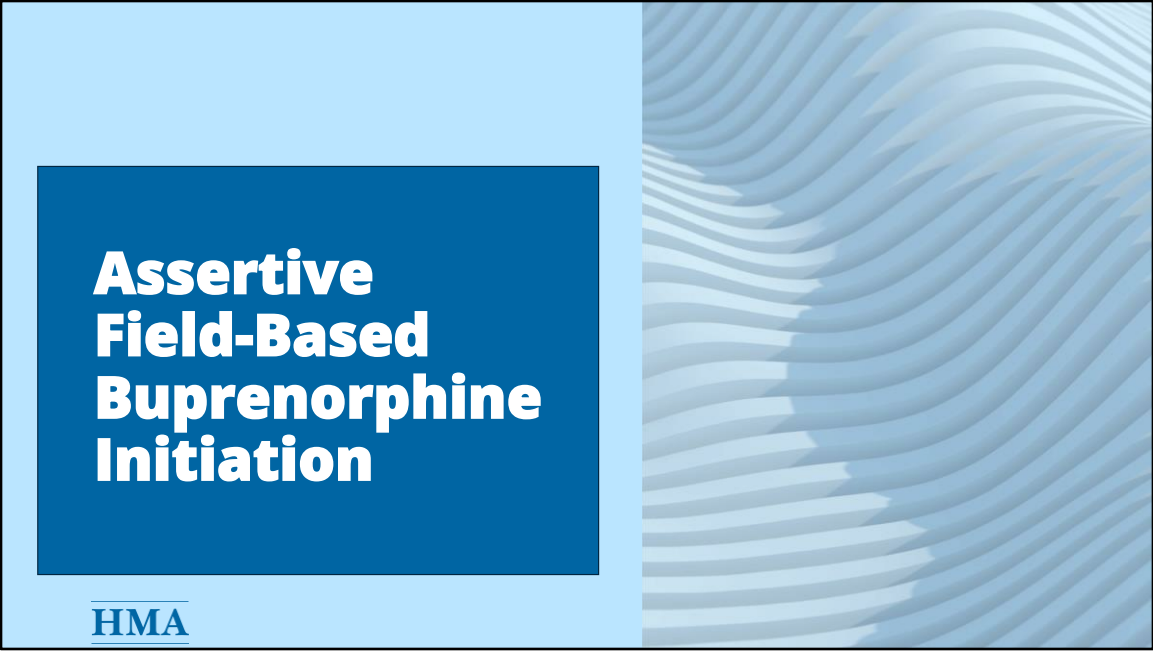
- » **CMS** - Centers for Medicare & Medicaid Services
- » **COWS** - Clinical Opiate Withdrawal Scale
- » **ECM** - Enhanced Care Management
- » **ED** - Emergency Department
- » **FQHC** - Federally Qualified Health Center
- » **FU-7 & 30** - Follow-Up within 7 and 30 Days of ED Visit
- » **HEDIS** - Healthcare Effectiveness Data and Information Set
- » **IET-E** - Engagement of Treatment (for Substance Use Disorder)
- » **IET-I** - Initiation of Treatment (for Substance Use Disorder)
- » **LAI** - Long-Acting Injectable
- » **MAT** - Medications for Addiction Treatment
- » **Medi-Cal** - California's Medicaid Program
- » **MOUD** - Medications for Opioid Use Disorder
- » **NCQA** - National Committee for Quality Assurance
- » **NTP** - Narcotic Treatment Program
- » **OTP** - Opioid Treatment Program
- » **OD** - Opioid Use Disorder
- » **PWUD/PWUO** - People who use drugs/opioids
- » **POD** - Pharmacotherapy for Opioid Use Disorder
- » **SDOH** - Social Determinants of Health
- » **SSP** - Syringe Services Program
- » **SUD** - Substance Use Disorder



[Slide Image Description: This slide includes a list of common acronyms used in this presentation.]

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Assertive Field-Based Buprenorphine Initiation

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[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This first section looks at Assertive Field-Based Buprenorphine Initiation.



[Slide Image Description: This is a sub-section slide with blue boxes.]

First, let's discuss why we are here.

Assertive Field-Based Programmatic Requirements

- » Counties are required to provide rapid access to all FDA-approved medications for addiction treatment (MAT) by strengthening existing and/or standing-up at least one initiative in each of the following three areas that comprise their assertive field-based programs:
 - 1) Data-informed, targeted outreach on an ongoing basis to BHSA-eligible individuals with SUD needs to engage them in SUD services, including MAT, if needed.
 - 2) Mobile field-based programs.
 - 3) Open-access clinics.
- » Field-based programs can work with MAT prescribers directly or refer individuals to providers who are able to rapidly initiate all FDA-approved MAT.

Department of Health Care Services

BEHAVIORAL HEALTH SERVICES ACT COUNTY POLICY MANUAL



SOURCE(S): DHCS, 2025.

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[Slide Image Description: This slide lists assertive field-based programmatic requirements.]

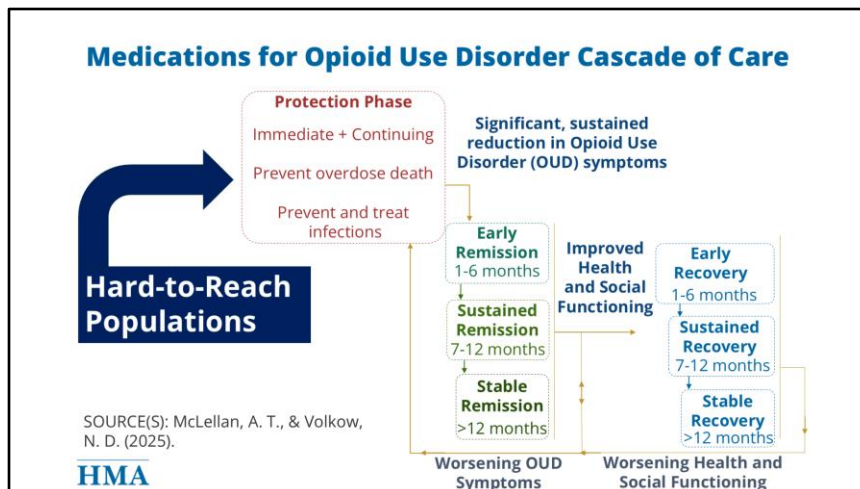
Per the Behavioral Health Services Act County Policy Manual, counties are required to provide rapid access to all FDA-approved medications for addiction treatment (MAT) by strengthening existing and/or standing-up at least one initiative in each of the following three areas that comprise their assertive field-based programs:

1. Data-informed, targeted outreach on an ongoing basis to BHSA-eligible individuals with SUD needs to engage them in SUD services, including MAT, if needed
2. Mobile field-based programs.
3. Open-access clinics.

Counties' assertive field-based programs are required to serve BHSA-eligible individuals living with SUD treatment needs and prioritize those who are at higher risk of overdose, including those known to have experienced overdose reversals, or who are experiencing homelessness and/or justice-involvement.

"To meet this [Rapid Access to MAT] requirement, field-based programs can employ or contract with MAT prescribers directly or refer individuals to providers who are able to rapidly initiate all FDA approved MAT, including CA Bridge programs, Federally Qualified Health Centers (FQHCs), Tribal Health programs, NTPs and medication units."

SOURCE(S): DHCS, 2025.



[Slide Image Description: This slide shows a graphic for a cascade of care for medications for opioid use disorder.]

This Medications for Opioid Use Disorder Cascade of Care presents a key paradigm shift. Traditionally, many folks thought about this concept of when you're ready, entering into treatment, establishing remission, and then recovery.

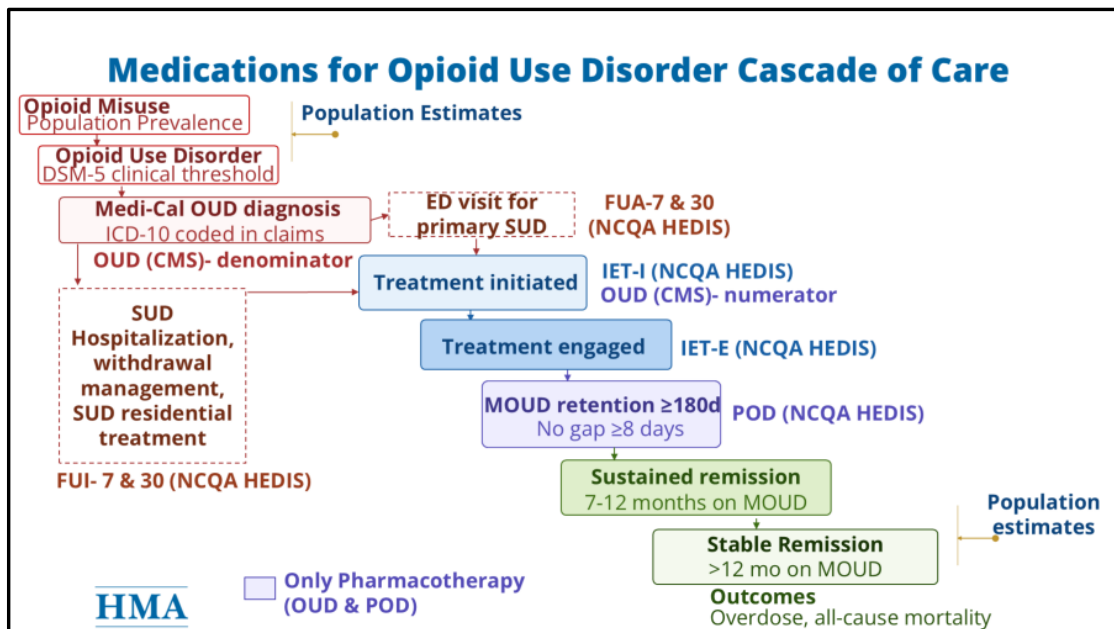
The introduction is this idea of a protection phase, defined as something where treatment contact is immediate, meaning no wait, and it's ongoing. That's assertive and field-based, meaning wherever you're at.

The core is not necessarily long-term recovery in that moment. It is to prevent overdose death, and to prevent and treat associated infections (e.g., HIV, hepatitis C, etc.)

That protection phase is really where the behavioral health system is growing into. It has not been a scale role for the behavioral health system in the past.

And that's what assertive, field-based initiation is looking at.

SOURCE(S): McLellan, A. T., & Volkow, N. D. (2025).



[Slide Image Description: This slide shows a graphic for a cascade of care for medications for opioid use disorder.]

These metrics can feel intimidating. Consider the big picture of who is struggling with opioids. Once people get into care and get a diagnosis, that's where the metrics are really kicking in. The assertive field-based work is at the top of this care cascade, focusing on finding those people who are at high risk and getting them into the care cascade that later then enters into these metric networks.

FUI- 7 & 30 (NCQA HEDIS) = Follow-up after ANY High Intensity SUD visit within 7 & 30 days

IET-I (NCQA HEDIS) = Treatment start within 14 days of NEW episode 180-day (6-month) negative SUD history

OUD (CMS) — denominator: ANY OUD Diagnosis

OUD (CMS) — numerator: ANY OUD pharmacotherapy in last year

IET-E (NCQA HEDIS) = ≥2 visits within 34 days of NEW episode

POD (NCQA HEDIS) = New pharmacotherapy 31-day negative medication history; No gap in medication of 8 or more consecutive days for ≥180 days

- » **Mike** – A 41-year-old electrician with chronic back and knee pain, was started on oxycodone by multiple physicians in 2000 – 2010. Since 2015, he has been using pressed fentanyl tablets daily.
- » He works 40-60 hours a week.

This morning his wife found him unresponsive, called 911, and administered naloxone.



Case Example: Meet Mike



Disclaimer: This is a hypothetical case example. Any resemblance to an actual person is purely coincidental, including race, nationality, and gender.

[Slide Image Description: This slide shows an image of an individual depicting Mike and a description of Mike's situation.]

Let's look at the case example: Mike.

Mike is a 41-year-old electrician with chronic back and knee pain. He was started on oxycodone by multiple physicians in 2000 through 2010. Since 2015, he has been using pressed fentanyl tablets daily. Mike also works 40 – 60 hours a week.

This morning his wife found him unresponsive, called 911, and administered naloxone.

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By the Numbers

- » Drug overdose is the **number one** cause of death in adults under 45 years old.
- » Average years of life lost from a fentanyl overdose is **38 years per death**.
- » Buprenorphine **reduces overdose risk by 60%**.

SOURCE(S): Centers for Disease Control and Prevention, n.d.; Centers for Disease Control and Prevention, 2025; Centers for Disease Control and Prevention, National Center for Health Statistics, n.d.; U.S. Drug Enforcement Administration, n.d.; National Library of Medicine, 2024; National Library of Medicine, n.d.; JAMA Network, n.d.

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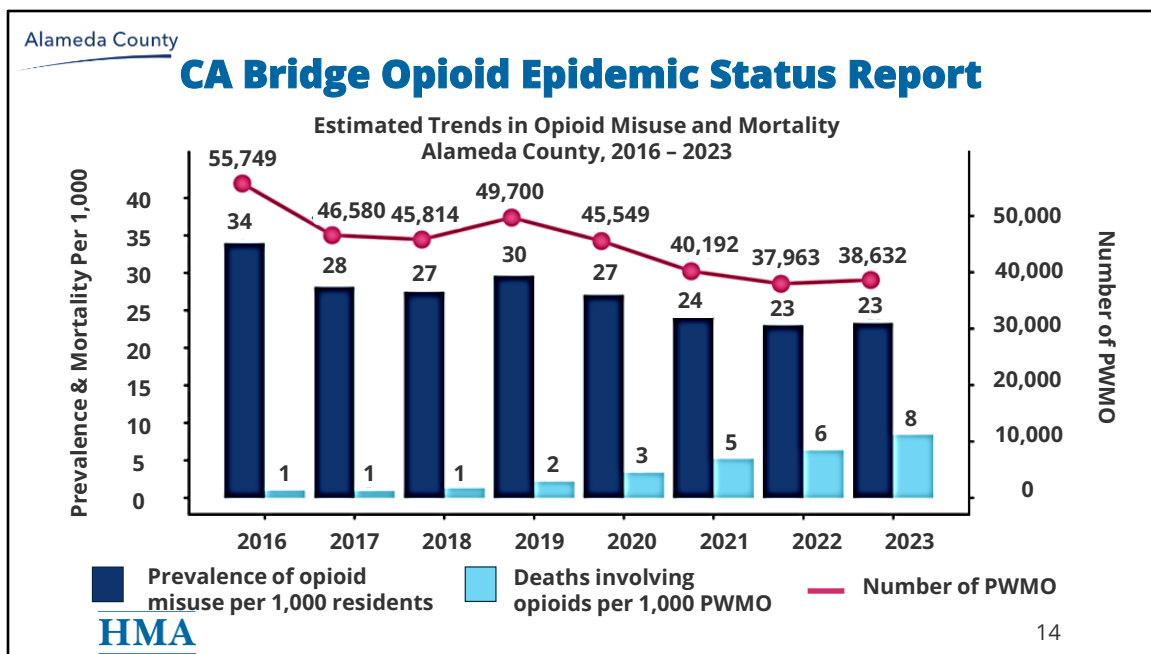
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[Slide Image Description: This slide lists statistics around drug overdose and Buprenorphine.]

By the numbers:

- Drug overdose is the number one cause of death in adults under 45 years old.
- Average years of life lost from a fentanyl overdose is 38 years.
 - Years of Life Lost (YLL) is a measure of premature mortality and represents the difference between the actual age at death and the life expectancy (YLL = Total Deaths x remaining life expectancy at age of deaths).
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SOURCE(S): Centers for Disease Control and Prevention, n.d.; Centers for Disease Control and Prevention, 2025; Centers for Disease Control and Prevention, National Center for Health Statistics, n.d.; U.S. Drug Enforcement Administration, n.d.; National Library of Medicine, 2024; National Library of Medicine, n.d.; JAMA Network, n.d.

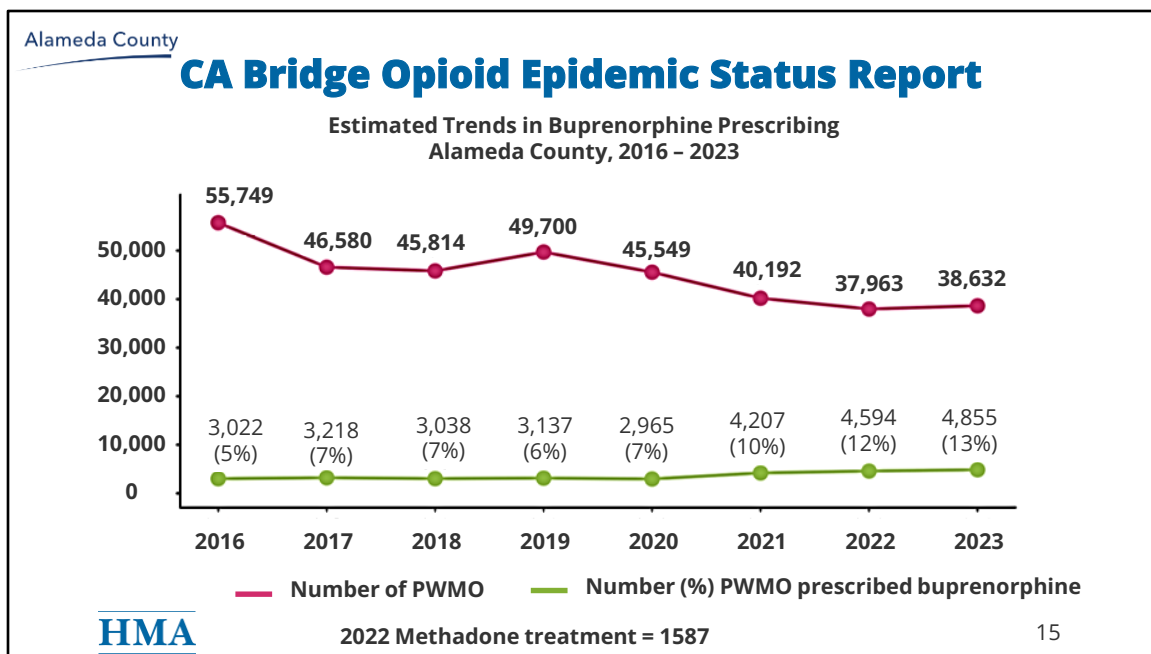


[Slide Image Description: This slide shows CA Bridge Opioid Epidemic Status Report information with data from Alameda County.]

The CA Bridge Opioid Epidemic Status Report, with data from Alameda County, demonstrates estimated trends in opioid misuse and mortality, as well as estimated trends in Buprenorphine prescribing.

Overdose deaths are the leading cause of death in adults under 45 years old. Overdose rates increased 8-fold from 2016 to 2023.

The 2023 MAT Expansion Target in Alameda County was 32,190.



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» **Data informed:**

- Emergency Department (ED) visits for overdose events are a marker of high-risk for opioid-related death.
- Overdose survivor mortality is 5% within 12 months of discharge.
- 85% of Emergency Department patients with opioid use disorder **want** treatment.



**Case Example:
Consider Mike**



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[Slide Image Description: This slide shows an image of an individual depicting Mike and data informed considerations.]

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» **Field-Based:**

- Reaching high-risk patients is most cost effectively done through partnerships.
- Integrating Rapid MAT Access with existing infrastructure—such as EDs, Emergency Medical Services, Street Medicine teams, and shelter medicine teams—can enable rapid scaling of MAT access.



**Case Example:
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» **Open-Access Clinics:**

- The availability of low-barrier MAT is increasing in communities.
- Most people with OUD do not know how to access these services.
- County Behavioral Health Departments can help direct high-risk patients to these services with open-access navigators available by text and phone.



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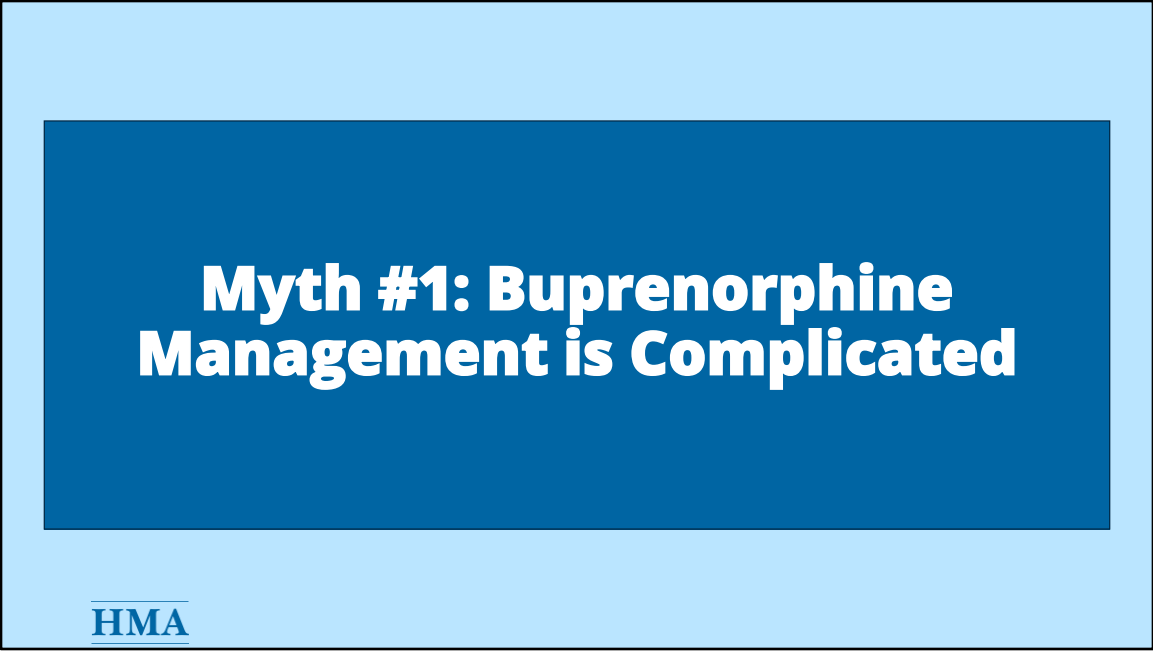
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Starting Buprenorphine

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[Slide Image Description: This is a sub-section slide with blue boxes.]

Let's look at starting buprenorphine.

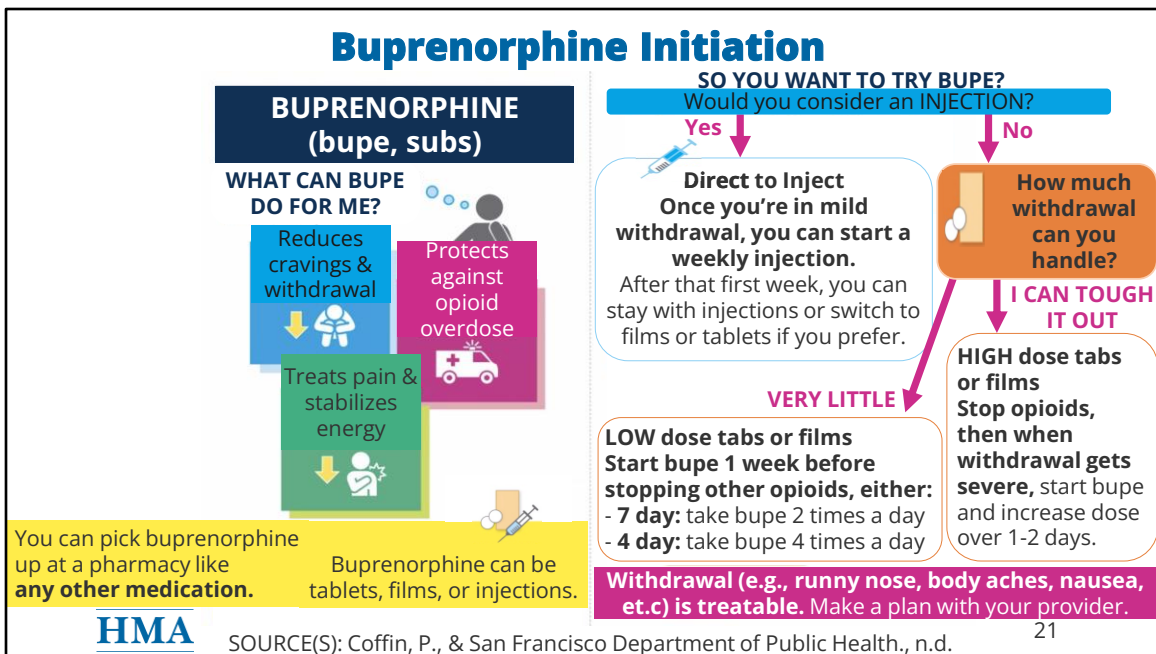


Myth #1: Buprenorphine Management is Complicated

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[Slide Image Description: This is a sub-section slide with blue boxes.]

Let's consider the first myth: Buprenorphine management is complicated.



Withdrawal (e.g., runny nose, body aches, nausea, et.c) is treatable. Make a plan with your provider.

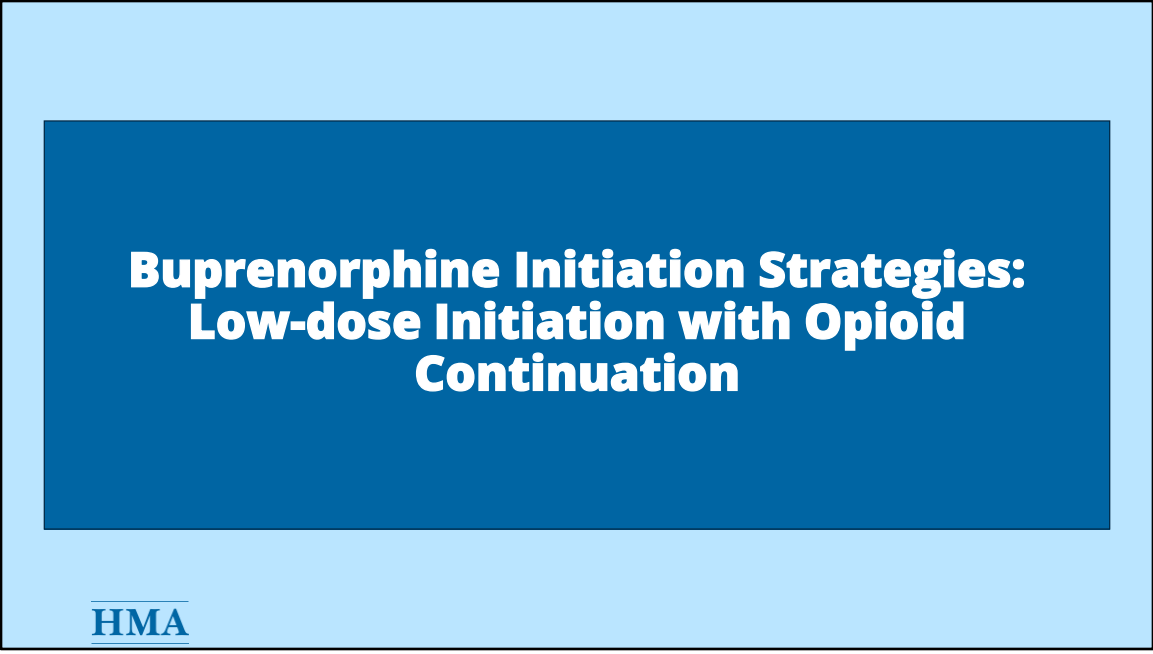
SOURCE(S): Coffin, P., & San Francisco Department of Public Health., n.d.

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[Slide Image Description: This slide shows an image of buprenorphine flyers.]

These buprenorphine flyers from San Francisco Department of Public Health walk individuals through what buprenorphine can do, as well as a decision tree.

SOURCE(S): Coffin, P., & San Francisco Department of Public Health., n.d.



Buprenorphine Initiation Strategies: Low-dose Initiation with Opioid Continuation

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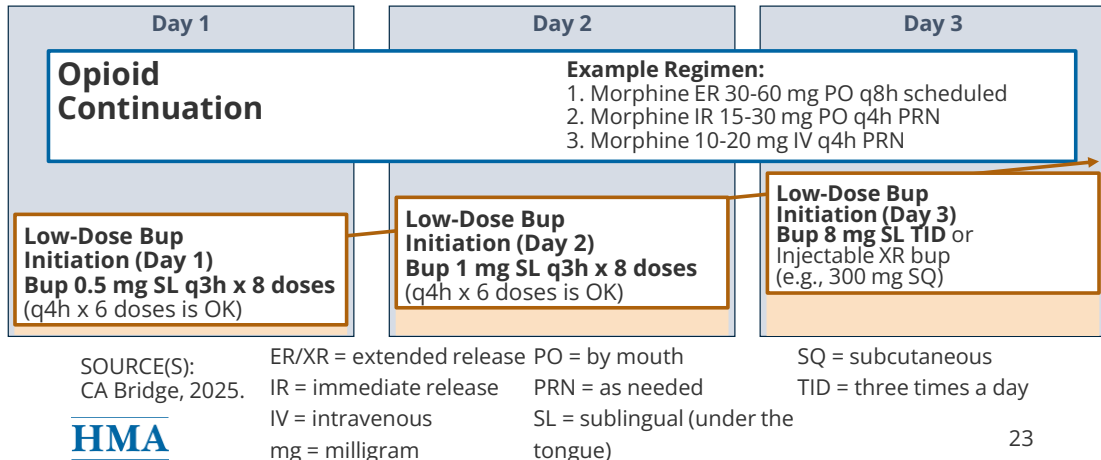
[Slide Image Description: This is a sub-section slide with blue boxes.]

Now we can look at Buprenorphine initiation strategies, including low-dose initiation.

Low-Dose Buprenorphine Initiation with Opioid Continuation

Treatment Bundle Over Three Days

Maximum pain control & withdrawal treatment with opioid analgesics throughout bup initiation.



[Slide Image Description: This slide highlights low-dose buprenorphine initiation with opioid continuation.]

This slide shows low-dose buprenorphine initiation with opioid continuation, using a treatment bundle over three days. This method maximizes pain control and withdrawal treatment with opioid analgesics throughout buprenorphine initiation.

Keep in mind the following:

- A rapid three-day buprenorphine uptitration schedule is presented here that may not be appropriate for some patients, such as patients receiving high-dose methadone. Extend initiation schedule by lengthening the dose interval to q4h, q6h, or q8h+ and/or increasing the number of doses to be given at each step prior to advancing.
- Opioid Analgesic (full agonist) Dosing: The doses presented here assume a very high opioid tolerance. Use clinical judgment to tailor opioid dose to match expected level of opioid tolerance. Morphine doses are presented as a guide for conversion to preferred opioid. Combine opioids with a multimodal analgesic strategy for optimized

comfort and pain control (e.g., NSAIDs, ketamine, and regional anesthesia).

- Bup Dosing: Sublingual (SL) film doses are presented here as a guide for conversion to preferred buprenorphine formulation. If buprenorphine 0.5mg (quartering a 2 mg SL film) is a pharmacy barrier, most patients will tolerate buprenorphine 1 mg SL or an alternative formulation can be used. Example: buprenorphine buccal film 300 mcg, or buprenorphine 0.15 mg IV.
- Bup Frequency: It is OK to hold doses for sleep. Continue dosing when awake. If nursing capacity limits q3h dosing intervals increasing to q4h or q6h is generally well tolerated. Most patients will tolerate one to two missed doses per step.

SOURCE(S): CA Bridge, 2025.

Example of Outpatient Protocol

Initiation Day	3-Day Protocol	
	Buprenorphine	Full Opioid Agonist
Day 1	0.5mg sublingual every 6 hours	Continue
Day 2	1mg sublingual every 6 hours	Continue
Day 3	2mg sublingual every 6 hours	Continue
Day 4	12mg sublingual in AM and follow up with provider	STOP

- » The key to this approach is that **the full agonist opioid must be continued** while the buprenorphine dose is gradually increasing
- » In the **ambulatory setting**, outside of an opioid treatment program, this usually means continued use of **non-medical opioids**
- » Requires shared decision-making and an assessment of risks vs. benefits

SOURCE(S): Cohen et. al., 2022; Suen et. al., 2022.

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[Slide Image Description: This slide shows a table of sample outpatient protocols.]

- At this time, there is no standardized approach to low dose buprenorphine initiation with opioid continuation
- Here is one example of a low-dose protocol from the published literature.
 - This example comes from patients treated at a clinic, which is a partnership between the University of California San Francisco (UCSF) and the San Francisco Department of Public Health.
- This is but one approach and prescribers who want to use this approach with patients must be prepared to adapt and modify as needed.
- The key to this approach is that the full agonist opioid must be continued as the buprenorphine dose is being titrated.
- In the ambulatory setting, outside of an opioid treatment program in which the patient is receiving a stable dose of methadone, continuation of the full agonist opioid usually means continued use of non-medical opioids, such as fentanyl.
- Some prescribers may be less comfortable with this.
- As with any other, this approach requires an assessment of risks vs. benefits and a shared decision-making conversation with the patient.

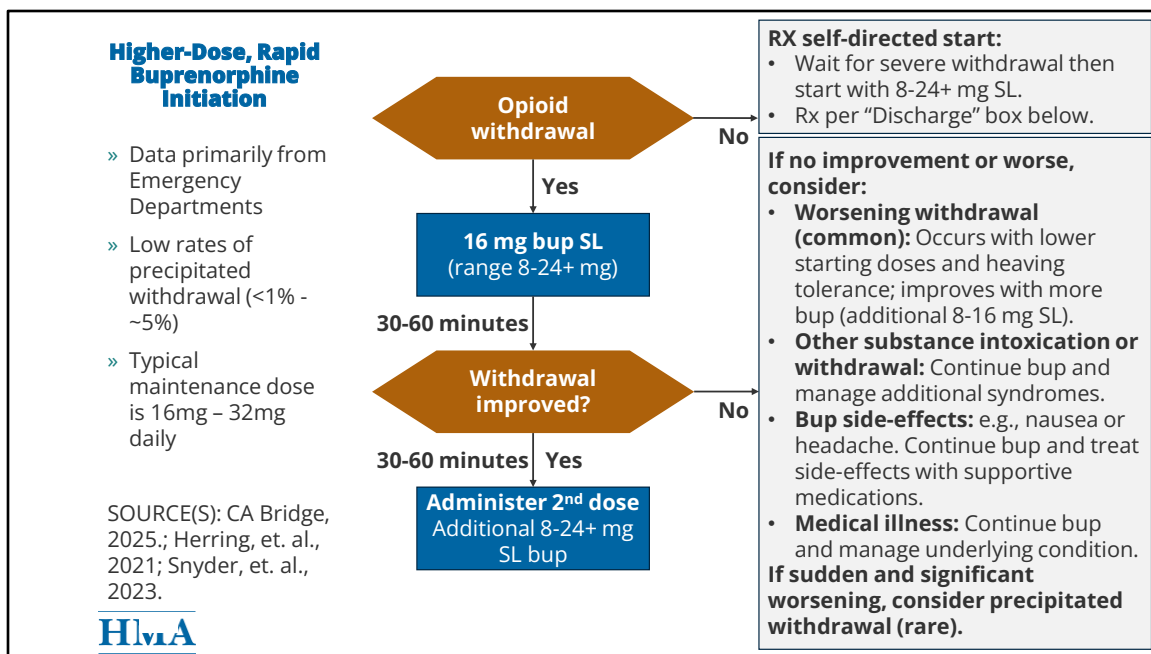
SOURCE(S): Cohen et. al., 2022; Suen et. al., 2022.

Buprenorphine Initiation Strategies: High-Dose Initiation

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[Slide Image Description: This is a sub-section slide with blue boxes.]

Now let's look at high-dose initiation as a buprenorphine initiation strategy.



[Slide Image Description: This slide highlights higher-dose, rapid buprenorphine initiation from the CA Bridge Emergency Department Buprenorphine Quick Start Guide and CA Bridge Buprenorphine Self-Start Guide.]

In contrast to low dose initiation with opioid continuation approaches in which the buprenorphine levels are gradually increased, higher dose initiation approaches allow for more rapid accumulation of buprenorphine at the receptors. Once the patient is in moderate withdrawal, a starting dose between 8 – 24mg is given with administration of additional doses within 30 – 60 minutes until withdrawal symptoms are improved.

If patients are not in withdrawal when seen by the prescriber, patients can be given a prescription and instructions on how to initiate medication on their own for when they can do go into withdrawal. The prescription should allow for a minimum of 16mg of buprenorphine daily until next seen by the provider.

SOURCE(S): CA Bridge, 2025.; Herring, et. al., 2021; Snyder, et. al., 2023.

Higher-Dose, Rapid Buprenorphine Initiation (Continued)

- » Data primarily from Emergency Departments
- » Low rates of precipitated withdrawal (<1% - ~5%)
- » Typical maintenance dose is 16mg – 32mg daily



Buprenorphine Self-Start

Guidance for patients starting buprenorphine outside of hospitals or clinics

1. Plan to take a day off and have a place to rest.
2. Stop using and wait until you feel very sick from withdrawals (at least 12 hours is best, if using fentanyl it may take a few days).
3. Dose one or two 8mg tablets or strips UNDER your tongue (total dose of 8-16mg).
4. Repeat dose (another 8mg-16mg) in an hour to feel well.
5. The next day, take 16-32mg (2-4 tablets or films) at one time.

SOURCE(S): CA Bridge, 2025.; Herring, et. al., 2021; Snyder, et. al., 2023.



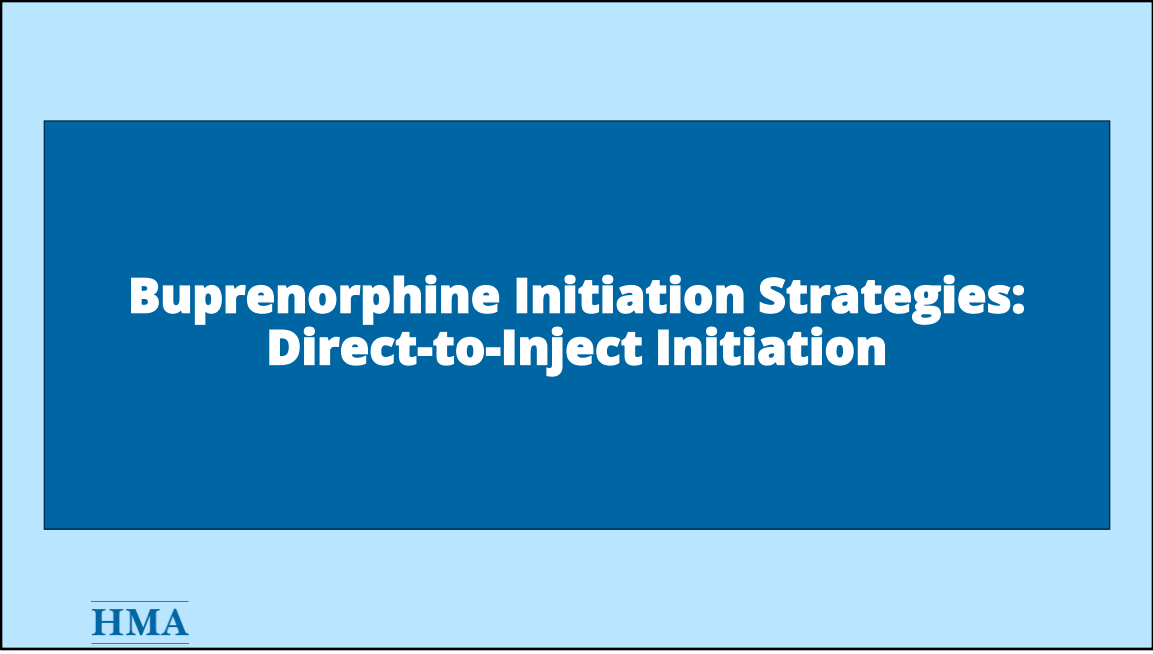
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Buprenorphine Initiation Strategies: Direct-to-Inject Initiation

HMA

[Slide Image Description: This is a sub-section slide with blue boxes.]

Now let's look at direct-to-inject initiation as a buprenorphine initiation strategy.

Long-Acting Injectable (LAI) Buprenorphine Formulations: Brixadi® and Sublocade®

- » Approved for moderate to severe opioid use disorder.
- » Given after a single dose of 4mg sublingual (SL) buprenorphine or if already being treated with buprenorphine.
- » Given in the abdomen, thigh, buttocks or back of the upper arm.
- » Some individuals may need additional SL buprenorphine until steady state levels achieved.

	Brixadi®	Sublocade®
Frequency	Weekly (every 7 days) and Monthly (every 28 days)	Monthly (every 28 days)
Second Injection	As early as 1 – 3 days	As early as 1 week after first injection
Refrigeration	Not required	Can be stored for up to 12 weeks without refrigeration



[Slide Image Description: This slide details long-acting injectable buprenorphine formulations Brixadi and Sublocade with a table.]

There are two FDA-approved formulations of long-acting injectable buprenorphine approved for use in moderate to severe OUD: Sublocade and Brixadi.

Brixadi has both weekly (every seven days) and a monthly (every 28 days) formulations, while Sublocade has two different doses of a monthly (every 28 days) formulations.

Patients currently being treated with sublingual (SL)/transmucosal buprenorphine can go directly to the monthly injection. For those not currently being treated with buprenorphine, the current recommendation is to give a single dose of 4mg SL/transmucosal buprenorphine and proceed to injection if the SL dose is tolerated.

They are subcutaneous injections, meaning they go into the fat right under the skin (e.g., abdomen, thigh, buttocks, back of upper arm), with the second injection being given as early as one to three days for Brixadi or one week after the initial injection for Sublocade.

It's important to know that many patients may need additional doses of SL/transmucosal buprenorphine until the injection reaches a steady state level in the body, which may take a few months.

Please note Brixadi does not require refrigeration, while Sublocade can be stored for up to 12 weeks without refrigeration.

Long-Acting Injectable (LAI) Buprenorphine

Why use long-acting injectable (LAI) buprenorphine?

**Don't have to
remember to take
medication daily.**

**Decreased concerns
for diversion and
safe storage for
medications.**

**Decreased
frequency of office
visits.**

**Ease of
discontinuation, if
patient decides to
discontinue.**

SOURCE(S): California Department of Health Care Services. (n.d.). Medi-Cal Rx contract drug list (CDL). <https://medi-calrx.dhcs.ca.gov/home/cdl/>

HMA

[Slide Image Description: This slide shows long-acting injectable buprenorphine information with colorful boxes.]

Long-acting injectable (LAI) buprenorphine is another potential option for hard-to-reach populations.

Advantages of LAI buprenorphine include:

- Don't have to remember to take medication daily.
 - Adherence to buprenorphine is associated with decreased overdose events.
- Decreased concerns for diversion and safe storage for medications.
- Decreased frequency of office visits.
- Ease of discontinuation, if patient decides to discontinue.

Please note both formulations are on the Medi-Cal-Approved National Drug Code List.

California Department of Health Care Services. (n.d.). Medi-Cal Rx contract drug list (CDL). <https://medi-calrx.dhcs.ca.gov/home/cdl/>

Long-Acting Injectable (LAI) Buprenorphine

Why not use long-acting injectable (LAI) buprenorphine?

Increased cost.

Complicated
pharmacy
logistics.

Decreased
engagement
with treatment
team.

Unclear long-
term benefits.

Pain and
infection risk.

Variability in
drug delivery
experience.

SOURCE(S): DHCS, n.d.

HMA

[Slide Image Description: This slide shows long-acting injectable buprenorphine information with colorful boxes.]

Potential disadvantages of LAI buprenorphine include:

- Increased cost.
- Complicated pharmacy logistics.
- Decreased engagement with treatment team.
- Unclear long-term benefits.
- Pain and infection risk.
- Variability in drug delivery experience.

SOURCE(S): DHCS, n.d.

Direct-to-Inject Studies

- » “Direct to Inject” is the initiations of LAI buprenorphine in patients not currently taking SL buprenorphine
- » Protocols vary:
 - Sample: Day 1: 8mg weekly Brixadi®
 - Day 2: 16mg weekly Brixadi®
 - Day 3: 128mg monthly Brixadi® or 300mg Sublocade®
- » Precipitated withdrawal: 3 – 7%



SOURCE(S): Naren et al., 2025; Waters et al., 2025; Rosenwohl-Mack et al., 2025; D’Onofrio et al., 2024.

HMA

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[Slide Image Description: This slide details four direct-to-inject studies with an image of a person with gloves holding a syringe.]

- Direct-to-inject initiation of long-acting injectable buprenorphine, without first giving a sublingual dose of buprenorphine, is another novel approach to initiating buprenorphine in high-risk populations.
- The literature on this approach is limited, largely based on retrospective case series, and thus, at this time, there is no standardized approach.
- This approach is called direct-to-inject and is typically used in patients who have been unsuccessful in initiating buprenorphine via more traditional approaches and in populations at high-risk for overdose.
- There are four published retrospective case series in which direct-to-inject protocols were used across low-threshold OUD clinics, safety-net public health system sites, and Emergency Departments.
 - Participants ranged from 21 to 129.
- Dosing protocols ranged with three studies starting with an initial weekly injection and one using weekly or monthly injection based upon

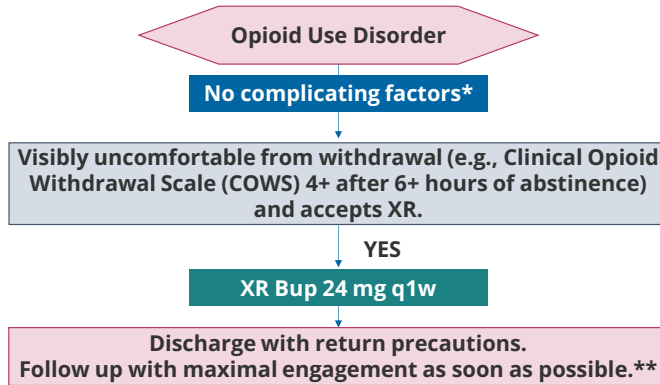
the patient's last use of heroin or other short-acting opioid (notably fentanyl not mentioned in this study).

- Precipitated withdrawal was not common, ranging from 3% to 7%.
- This is another initiation approach in which prescribers are going to have to be flexible and prepared to adapt and modify their approach to find the one that works best, considering their patient population and available resources.
- Similarly, this approach requires an assessment of risks vs. benefits, healthcare costs, and a shared decision-making conversation with the patient.

SOURCE(S): Naren et al., 2025; Waters et al., 2025; Rosenwohl-Mack et al., 2025; D'Onofrio et al., 2024.

Direct-to-Inject Buprenorphine Initiation

Starting weekly long acting injectable buprenorphine (XR Bup) without sublingual (SL) lead-in for patients with opioid use disorder (OUD).



*Complicating factors:

- Altered mental status, delirium, intoxication, recent methadone use (within 1 week).
- Pregnant: Risk/benefit discussion. Risk of untreated OUD generally higher than risk of XR bupe, but only limited studies.
- The only absolute contraindication is known true buprenorphine allergy (exceedingly rare).

**XR BUP does not mean that the team should delay follow up engagement or that patients require less support after discharge.



SOURCE(S): CA Bridge, 2025.

33

[Slide Image Description: This slide highlights direct-to-inject buprenorphine initiation from the CA Bridge Emergency Department Buprenorphine Quick Start Guide.]

More recently, there have been several papers published, largely retrospective case series, in which the authors look back and report on cases of patients who were started on LAI buprenorphine, without first giving a SL/transmucosal dose.

SOURCE(S): CA Bridge, 2025.



[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This second section looks at Criteria for Tailoring the Approach to the Individual and the Setting.

Patient-Level Factors for Consideration in Selecting an Approach

- » Individual preferences of people who are using drugs.
- » Substances being used.
 - Are they using high-potency synthetic opioids (i.e., fentanyl)?
- » Prior experiences of withdrawal.
- » Prior experiences with MOUD, particularly medication initiation.
- » Individual's ability to understand and follow directions.
- » Individual's ability to secure medication.
- » Options for medication continuation.



[Slide Image Description: This slide details patient-level factors for consideration in selecting an approach, with an image of a provider helping a patient.]

Consider the following patient-level factors for consideration in selecting an approach:

- Individual preferences of people who are using drugs.
 - What does the person want and what are they willing to do?
- Substances being used.
 - Are they using high-potency synthetic opioids (i.e. fentanyl)?
- Prior experiences of withdrawal (e.g., inability to tolerate withdrawal).
- Prior experiences with MOUD, particularly medication initiation (e.g., buprenorphine).
- Individuals' ability to understand and follow directions.
- Individuals' ability to secure medication.
- Options for medication continuation.
- Failed attempts at other initiation strategies.

System-Level Factors for Consideration in Selecting an Approach



Prescriber
availability



Prescriber expertise
and comfort



Medication
availability



Insurance/funding
for medications

[Slide Image Description: This slide details system-level factors for consideration in selecting an approach, with various icons.]

Consider the following system-level factors for consideration in selecting an approach:

- Prescriber availability
- Prescriber expertise and comfort
- Medication availability
- Insurance/funding for medications

Ideas in Action



» **Situation:** Mike, a 41-year-old electrician with chronic back and knee pain, was started on oxycodone by multiple physicians in 2000 – 2010. Since 2015, he has been using pressed fentanyl tablets daily. He works 40-60 hours a week. This morning his wife found him unresponsive, called 911, and administered naloxone.

» **Consider which buprenorphine initiation approach you would consider for Mike.**



HMA

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[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

Situation: Mike, a 41-year-old electrician with chronic back and knee pain, was started on oxycodone by multiple physicians in 2000 – 2010. Since 2015, he has been using pressed fentanyl tablets daily. He works 40-60 hours a week. This morning his wife found him unresponsive, called 911, and administered naloxone.

Consider which buprenorphine initiation approach you would recommend for Mike.



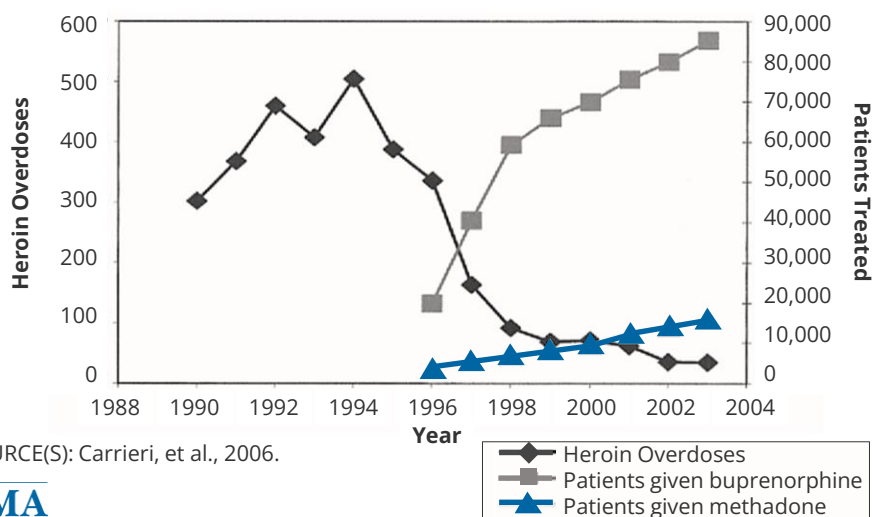
Myth #2: Diverted Buprenorphine is a Public Health Risk

HMA

[Slide Image Description: This is a sub-section slide with blue boxes.]

Let's consider the second myth: Buprenorphine is a public health risk.

Buprenorphine Access Lowers Population Level Opioid Mortality



[Slide Image Description: This slide details shows a chart displaying heroin overdoses and treatment comparisons between buprenorphine and methadone.]

Expanding access to buprenorphine is associated with substantial reductions in population-level opioid overdose mortality, as demonstrated in France, where widespread availability led to a dramatic drop in overdose deaths. By making effective opioid use disorder treatment more accessible, buprenorphine helps stabilize individuals, reduce illicit opioid use, and lower the risk of fatal overdose across populations. Broader access also improves engagement in care—especially in regions facing overlapping opioid and HIV epidemics—further contributing to reduced mortality and better public health outcomes.

SOURCE(S): Carrieri, et al., 2006.



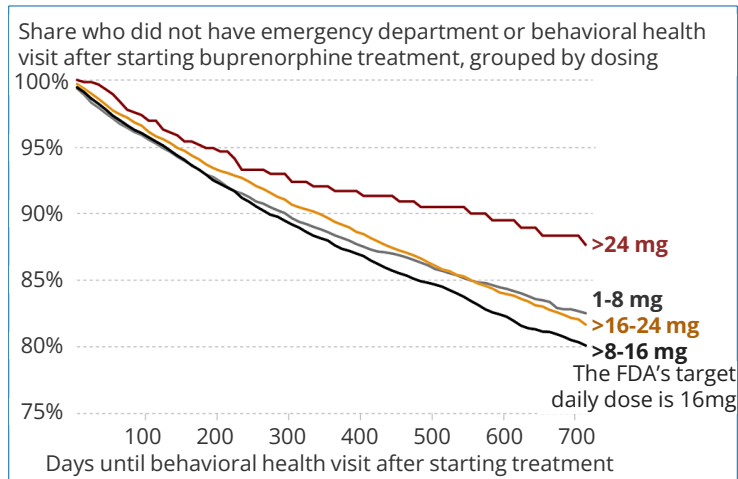
Myth #3: Buprenorphine Treatment is not Recovery

HMA

[Slide Image Description: This is a sub-section slide with blue boxes.]

Let's consider the third myth: Buprenorphine treatment is not recovery.

Higher Buprenorphine Doses Associated with Less Use of Behavioral Health Care



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SOURCE(S): Axeen, et al. 2024; USC Schaeffer Center, 2024.

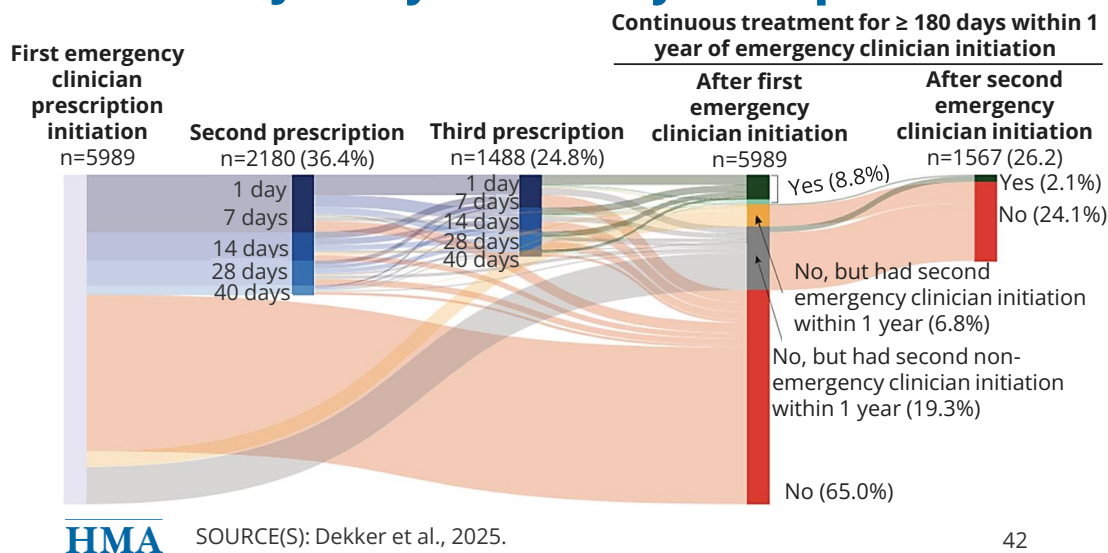
41

[Slide Image Description: This slide details shows a chart displaying how higher buprenorphine doses are associated with less use of behavioral health care.]

A study published in JAMA Network Open found that patients receiving higher-than-recommended doses of buprenorphine were less likely to need emergency department visits or inpatient hospital stays for behavioral health care compared to those on the standard 16 mg dose. Analyzing data from more than 35,000 patients with opioid use disorder, researchers observed that higher doses (above 16 mg) were associated with improved outcomes without increased harm, suggesting better symptom control—especially in the context of potent opioids like fentanyl. These findings indicate that optimizing buprenorphine dosing may reduce the need for intensive behavioral health services over time.

SOURCE(S): Axeen, et al. 2024; USC Schaeffer Center, 2024.

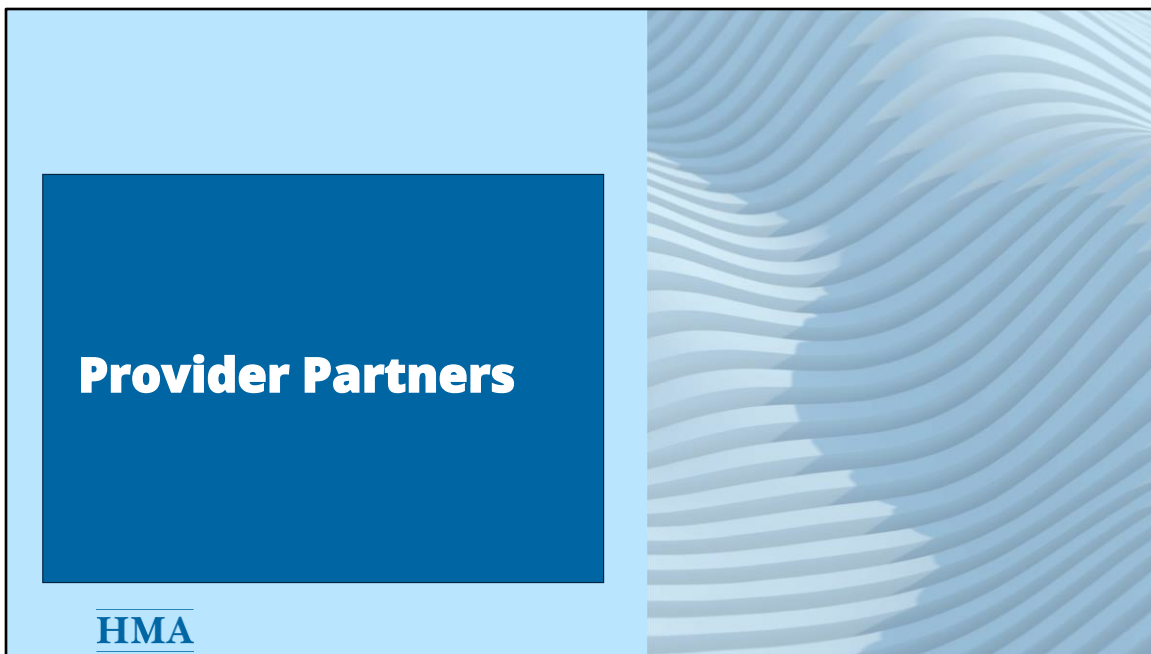
The Journey to Recovery is Complex



[Slide Image Description: This slide details the journey to recovery, with an image from the “Emergency clinician buprenorphine initiation, subsequent prescriptions, and continuous prescriptions” paper.]

This study examined buprenorphine prescriptions in California from 2017 to 2022 and found that emergency clinicians increasingly initiated treatment for opioid use disorder (OUD), with their share of prescribers rising from 2% to 16%. While emergency department initiation expanded access—resulting in thousands of patients receiving their first prescription—only a portion of those patients continued treatment, with about one in nine receiving continuous buprenorphine prescriptions within a year. The findings highlight that although emergency departments can play an important role in starting OUD treatment, the path to sustained recovery is complex and often requires ongoing follow-up and support beyond the initial prescription.

SOURCE(S): Dekker et al., 2025.



[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This third section looks at provider partners for MAT initiation.



Emergency Departments and First Responders

- » Emergency Departments (EDs)
- » Emergency Medical Services (EMS)
 - Post-overdose response
 - Mobile Integrated Health (MIH), Community Paramedicine (CP), and Law Enforcement
 - EMS-initiated buprenorphine
- » Crisis Services

[Slide Image Description: This slide lists first responder partners, with an image of a provider outside of an ambulance.]

- As we have seen from the data that my co-presenter, Andrew, has presented, a substantial proportion of people with untreated OUD, including those who would be appropriate for AFBSS are seen in emergency departments. And the ED encounter is a prime opportunity for getting people started on treatment for their OUD.
- Engaging and partnering with your local emergency departments should be an essential component of any AFBSS intervention.

Emergency departments and first responder partners can include the following:

- Emergency Departments (EDs)
- Emergency Medical Services (EMS)
 - Post-overdose response
 - Mobile Integrated Health (MIH), Community Paramedicine (CP), and Law Enforcement
 - EMS-initiated buprenorphine
- Crisis Services

Harm Reduction: Syringe Services Programs (SSPs)

- » Integration of buprenorphine prescribing into SSP services
 - In person
 - Telehealth
- » Combined with other services
 - Wound care, Hepatitis C Virus testing and treatment
 - Pre-exposure prophylaxis (PrEP)
- » Outcomes
 - 43% buprenorphine treatment retention at 180 days
 - Reduction in substance use
 - Reduction in other HIV risk behaviors

SOURCE(S): Jakubowski, et al., 2023.; Lambdin, et al., 2022.



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[Slide Image Description: This slide details Syringe Service Programs, with an image indicating they save lives.]

Models for integration of buprenorphine prescribing into existing Syringe Service Program (SSP) services include:

- In person
- Telehealth

Typically, buprenorphine prescribing is integrated into service delivery and combined with other services such as:

- Wound care, Hepatitis C Virus (HCV) testing and treatment
- Pre-exposure prophylaxis (PrEP)

Demonstrated outcomes include:

- 43% retention at 180 days
- Reduction in substance use
- Reduction in other HIV risk behaviors

SOURCE(S): Jakubowski, et al., 2023.; Lambdin, et al., 2022.



Street/Shelter Medicine

- » People experiencing homelessness:
 - Higher rates of substance use and substance-related mortality
 - Increased difficulty accessing care
- » These models often incorporate interdisciplinary teams
- » Same day assessment and prescription
- » Harm reduction focused
- » Outcomes are promising:
 - 44% 6-month retention
 - Reduction in high-risk behaviors (e.g., needle sharing)



SOURCE(S): Miler et. al., 2021; Carter et al., 2019.

[Slide Image Description: This slide details street and shelter medicine, with an image of a homeless outreach provider supporting an individual.]

People experiencing homelessness see

- Higher rates of substance use and substance-related mortality
- Increased difficulty accessing care

These models often incorporate interdisciplinary teams who bring treatment directly to people experiencing homelessness (e.g., in encampments). They can also provide same day assessments and prescription, with a focus on harm reduction.

Outcomes are promising:

- 44% 6-month retention
- Reduction in high-risk behaviors (e.g., needle sharing)

SOURCE(S): Miler et. al., 2021; Carter et al., 2019.

Bridge/Open-Access Clinics

- » Offer rapid medication initiation, stabilization, harm reduction services, and linkage to ongoing treatment
- » Low barrier treatment delivered by interdisciplinary teams
- » No defined length of treatment
- » Varying models
 - Hospital/health-system based outpatient clinics
 - Emergency department-based
 - Virtual only
- » Outcomes
 - High engagement
 - Variable linkage



SOURCE(S): Taylor, et al., 2023.

HMA

[Slide Image Description: This slide details bridge/open access clinics, with an image of the Golden Gate Bridge.]

Bridge Clinics are low threshold clinics that are usually based in emergency department or outpatient settings. Bridge clinics provide rapid initiation of MOUD and medications for other SUDs, stabilization during high-risk transitions, harm reduction services, and linkage to long-term providers

Interdisciplinary teams, which may include registered nurse care managers, social workers, psychologists, case managers, patient navigators, peer recovery coaches, pharmacists, addiction medicine physicians, psychiatrists, and nurse practitioners, deliver clinical care and harm reduction services on a scheduled or walk-in basis, with the specific services offered tailored to program size and staffing. There is no defined length of treatment.

Outcomes include high engagement and variable linkage.

SOURCE(S): Taylor, et al., 2023.

FQHC and SUD Partners

- » Federally Qualified Health Centers (FQHCs)
 - Nine-year retrospective study (2007 – 2016) found average yearly interval retention of 69%, with mean time on buprenorphine treatment for OUD of 2.26 years
 - Between 2017 – 2023, the percentage of FQHC patients with OUD who received MOUD increased from 10% to 25%.
 - Negative association with percentage of patients identified as non-white and those experiencing homelessness.
- » Substance Use Disorder Treatment Providers
 - Opioid Treatment Programs (OTPs/NTPs)
 - Telehealth providers



SOURCE(S): Lindenfeld, et al., 2025.; Haddad, et al., 2024.

HMA

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[Slide Image Description: This slide describes FQHCs and SUD partners, with an image of vials.]

FQHCs serve predominantly low-income and uninsured populations and are critical partner in expanding access to buprenorphine for opioid use disorder (OUD), with data indicating FQHCs can deliver long duration of treatment (> 2 years) and high retention rates (69% annually). Between 2017 -2023 the percentage of patients with an SUD who received medication for opioid use disorder increased from 10% to 25%. While the increase is a positive, it also reflects that more work needs to be done to increase MOUD prescribing in this setting, with a need for targeted outreach to FQHCs with larger populations of minoritized and unhoused patients.

Federally Qualified Health Centers (FQHCs)

- Nine-year retrospective study (2007 – 2016) found average yearly interval retention of 69%, with mean time on buprenorphine treatment for OUD of 2.26 years

- Between 2017 – 2023, the percentage of FQHC patients with an SUD who received MOUD increased from 10% to 25%.
 - Negative association with percentage of patients identified as non-white and those experiencing homelessness.

Substance Use Disorder Treatment Providers

- Opioid Treatment Programs (OTPs/NTPs)
- Telehealth providers

Specialty addiction treatment providers, including OTPs and telehealth providers are also important partners for this work.

Community Health Center Inc. (CHCI), a multi-site FQHC with 23 unique buprenorphine prescribers at 14 sites between 7/1/2007 and 12/31/2016. The majority of its patients are racial and ethnic minorities (nearly 50% Hispanic; 15% Black). Approximately two-thirds of CHCI patients are Medicaid-insured, and 90% have income below 200% of the United States federal poverty

Data on FQHCs in all 50 US states (2017 – 2023) using the Uniform Data System(UDS), a publicly available dataset of health center operational information from the Health Resources and Services Administration.

The percentage of patients with an SUD who received MOUD each year, which increased over time from 10.01% in 2017 to 24.75% in 2023.

SOURCE(S): Lindenfeld, et al., 2025.; Haddad, et al., 2024.



Care Management, Community Supports, and Social Determinants of Health (SDOH) Providers

- » Enhanced Care Management (ECM) Providers
- » Peer Support Specialists / Community Health Workers
- » Patient Navigators
- » Community Supports
 - Medical respite
 - Sobering centers
- » SDOH Providers
 - Food banks
 - Transportation services

[Slide Image Description: This slide lists care management and social determinants of health provider partners.]

Additionally, the needs of this population extend beyond medications for addiction treatment and thus engagement and integration of care management, community support, and Social Determinants of Health (SDOH) providers is strongly encouraged.

Consider the following:

- Enhanced Care Management (ECM) is a statewide Medi-Cal managed care plan (MCP) benefit in which high-need individuals are assigned a lead care manager with the goal of improving care coordination and health outcomes while reducing reliance on emergency rooms. Target populations include individuals experiencing homelessness, those with serious mental health or substance use disorders.
- Peer Support Specialists / Community Health Workers
- Patient Navigators
- Community Supports
 - Medical respite
 - Sobering centers
- SDOH Providers
 - Food banks
 - Transportation services
 - Vocational services

Ideas in Action

» Which of these organizations are you currently partnering with:



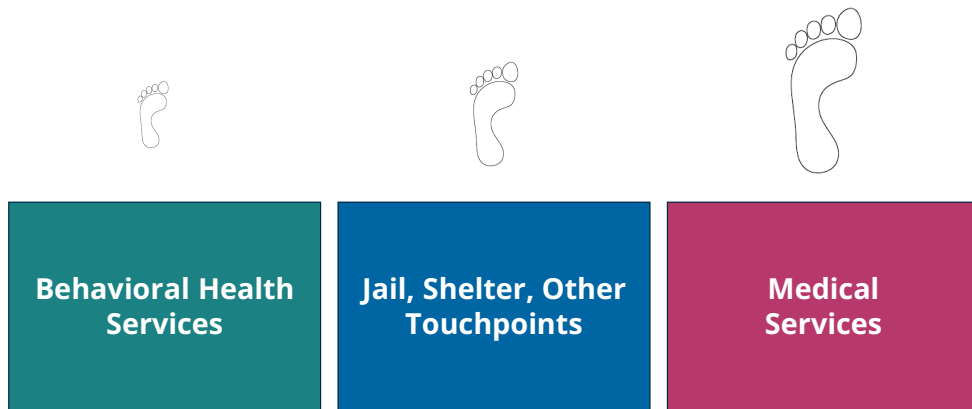
- SSPs
- Street/Shelter Medicine
- Bridge/Open Access Clinics
- FQHC and SUD partners
- First Responders
- Mental Health Organizations/Agencies
- Housing and Homeless Services
- Enhanced Care Management (ECM) Providers
- Community Health Workers
- Peer Support Specialists
- Patient Navigators
- Community Supports (e.g., medical respite, sobering centers)
- SDOH Providers

[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

Which of these organizations are you currently partnering with:

- SSPs
- Street/Shelter Medicine
- Bridge/Open Access Clinics
- FQHC and SUD partners
- First Responders
- Mental Health Organizations/Agencies
- Housing and Homeless Services
- Enhanced Care Management (ECM) Providers
- Community Health Workers
- Peer Support Organizations
- Patient Navigators
- Community Supports (e.g., medical respite, sobering centers)
- SDOH Providers

The Footprint of Partnership Models



[Slide Image Description: This slide describes a partnership model with behavioral health services; jail, shelter, or other touchpoints; and medical services in colorful boxes.]

A strong partnership model for initiating MAT connects behavioral health providers, jails and shelters, and medical services through shared protocols, universal screening, and rapid access to treatment. With shared data systems, cross-agency communication, and a unified harm-reduction approach, the partnership creates a seamless, low-barrier pathway that stabilizes individuals quickly and keeps them engaged in ongoing medical, behavioral health, and social supports.

Most prescribing is outside of the BH setting, demonstrating the need to partner with prescribers.



[Slide Image Description: This slide describes empowering navigators, with images of CA Bridge navigators.]

Empower navigators to reach people in need and link them to available clinicians.



**CA Bridge
Connect**

**We can help you
stop using opioids
like fentanyl.**

Medications like buprenorphine and methadone can quickly stop withdrawals and pain. Connect with our navigators and find support that works for you and what you need:

Overdose prevention | Peer support | Residential treatment | Buprenorphine | Methadone

CA Bridge Connect is an initiative of CA Bridge, a program of the Public Health Institute funded by the California Department of Health Care Services (DHCS).
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Get Connected to Addiction Treatment Today!



Call: 1-800-944-1807
Text: 1-833-308-0461
 Mon – Fri | 9am to 5pm PT
 Currently available in
 El Dorado County.



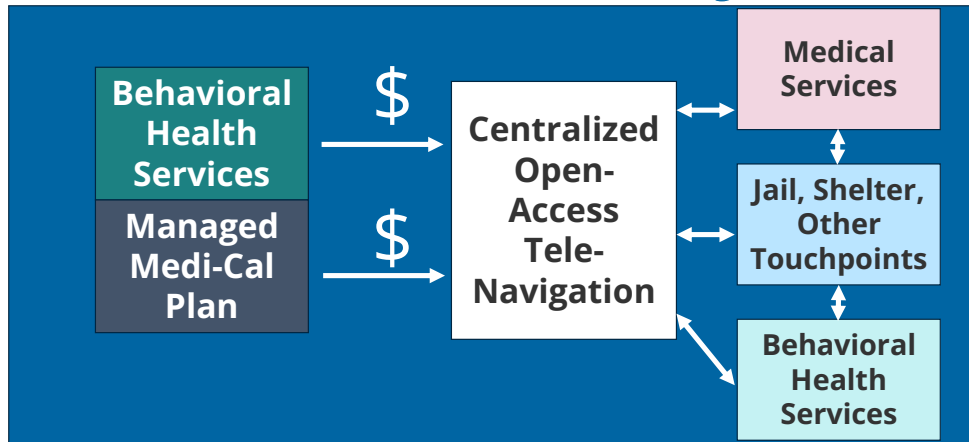



Disclaimer: This is a hypothetical case example. Any resemblance to an actual person is purely coincidental, including race, nationality, and gender.

[Slide Image Description: This slide shows an image of an individual depicting Mike and CA Bridge Connect Resources.]

CA Bridge Connect is an initiative of CA Bridge, a program of the Public Health Institute funded by DHCS. The program provides overdose prevention, peer support, residential treatment, and medications including buprenorphine and methadone.

Centralized Open-Access Through Partnership between Behavioral Health and Managed Medi-Cal



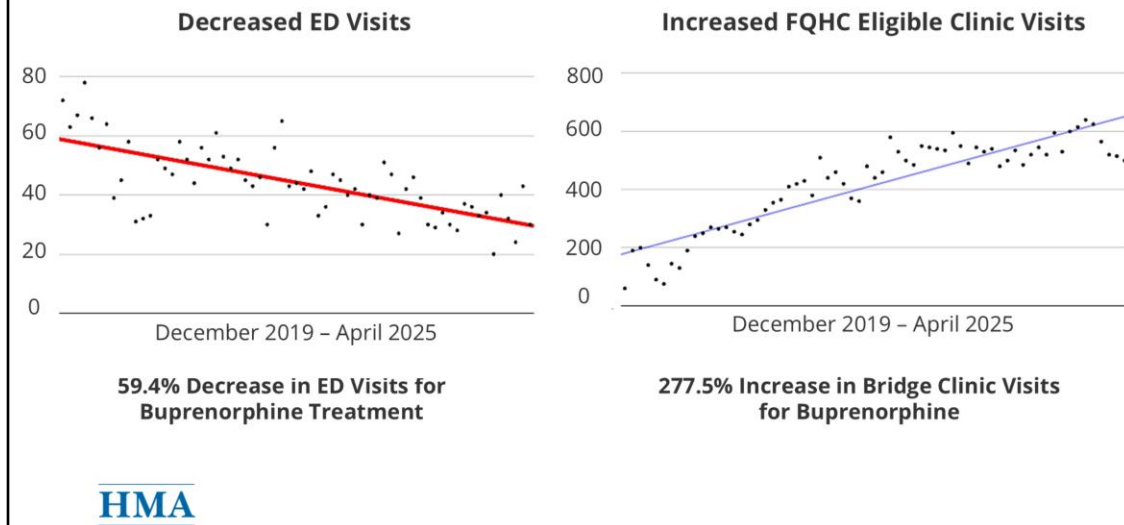
[Slide Image Description: This slide shows a graphic depicting the Alameda Pilot, include colorful boxes.]

For the Alameda Pilot, funds from Behavioral Health Services and Managed Medi-Cal Plans are used for Centralized Open-Access Tele-Navigation, which works in tandem with Medical Services; Jail, Shelter, and other touchpoints; and behavioral health services.

The Alameda Pilot is a win-win situation for everyone involved:

1. Patients and families have someone to call
2. Programs have a streamlined flow of participants

Alameda Pilot Results: Improving Care and Reducing Costs



[Slide Image Description: This slide describes the Alameda Pilot, with graphs showing decreased ED visits and increased FQHC Eligible Clinic Visits.]

The results from the Alameda Pilot indicate improved care and reduced costs.

- 59.4% decrease in emergency department visits for buprenorphine treatment
- 277.5% increase in Bridge Clinic visits for buprenorphine

San Francisco Pilot: Bringing Expanded Access to Medication



» Telehealth Line for MOUD Counseling and Buprenorphine Prescriptions

- 8am-2am, 7 days per week

» In-Person Drop-In Care and Patient Navigator Support

- 9am-5pm, 5 days per week
- Co-located with our DPH behavioral health pharmacy

Courtesy of Dr. Noele Martinez, Medical Director of the BEAM program.



[Slide Image Description: This slide describes the San Francisco Pilot, with images of a telephone and two hands.]

The San Francisco Pilot brought expanded access to medication.

- Telehealth Line for MOUD Counseling and Buprenorphine Prescriptions
 - 8am-2am, 7 days per week
- In-Person Drop-In Care and Patient Navigator Support
 - 9am-5pm, 5 days per week
 - Co-located with the department of behavioral health pharmacy

Courtesy of Dr. Noele Martinez, Medical Director of the BEAM program.

Telehealth BUP is Not Complicated



SSP



Residential Treatment Program



Homeless Outreach



[Slide Image Description: This slide describes telehealth buprenorphine, with images of SSP staff, a house, and homeless outreach staff.]

Telehealth buprenorphine can be easily added to bring MAT to any existing service, including:

- SSPs
- Residential Treatment Program (RTP)
- Homeless Outreach

Telehealth Buprenorphine Saves Lives

» Better retention and fewer overdose deaths:

- A study of 91,914 Medicaid enrollees in Kentucky and Ohio during 2020 found that initiating buprenorphine via telemedicine significantly increased the likelihood that patients remained in treatment for at least 90 days compared with in-person initiation. The study also found no increase in opioid-related nonfatal overdoses among those who initiated treatment through telemedicine.
- During the COVID-19 pandemic, patients receiving opioid use disorder-related telehealth services were more likely to remain on medications for opioid use disorder (27% higher retention) and had significantly lower odds of medically treated overdose (33% reduction) compared with those who did not receive telehealth care.

SOURCE(S): Hammerslag, et al., 2023; Jones, et al., 2022.

HMA

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[Slide Image Description: This slide describes results from two studies around telehealth buprenorphine.]

Evidence from large Medicaid and Medicare cohorts shows that telehealth access to buprenorphine improves treatment engagement and helps prevent overdose among people with opioid use disorder. A study of 91,914 Medicaid enrollees in Kentucky and Ohio during 2020 found that initiating buprenorphine via telemedicine significantly increased the likelihood that patients remained in treatment for at least 90 days compared with in-person initiation. Retention in treatment is a key predictor of survival for people with opioid use disorder, because consistent use of medications like buprenorphine reduces cravings, withdrawal, and relapse risk. Importantly, the study also found no increase in opioid-related nonfatal overdoses among those who initiated treatment through telemedicine, demonstrating that remote initiation is a safe and effective pathway to start lifesaving care.

Complementary findings among 175,778 Medicare beneficiaries further demonstrate the life-saving impact of telehealth. During the COVID-19

pandemic, patients who received opioid use disorder–related telehealth services had significantly higher retention in medications for opioid use disorder (MOUD) and substantially lower odds of medically treated overdose compared with those who did not receive telehealth care. Specifically, telehealth use was associated with a 27% increase in the likelihood of staying on treatment and a 33% reduction in overdose risk. Together, these studies show that telehealth expands access to buprenorphine and other MOUD while improving retention in care and reducing overdose risk—key mechanisms through which telehealth policies help save lives.

SOURCE(S): Hammerslag, et al., 2023; Jones, et al., 2022.

Key Take-Home Points

1

Behavioral Health Departments are the essential catalyst to drive system change.

2

Most MAT will be provided OUTSIDE the Behavioral Health System—seek partners.

3

Empowering open-access to navigators using telehealth is the #1 most cost-effective strategy to reach high risk populations.

[Slide Image Description: This slide describes key take-home points, with a list in blue boxes.]

Consider the Following Key Take-Home Points:

1. Behavioral Health Departments are the essential catalyst to drive system change.
2. Most MAT will be provided OUTSIDE the Behavioral Health System—seek partners.
3. Empowering open-access to navigators using telehealth is the #1 most cost-effective strategy to reach high risk populations.



[Slide Image Description: This is a section divider slide to indicate a major section of this webinar.]

This fourth section looks at Other Logistical Considerations and Dilemmas.

Other Logistical Factors to Consider

- » Health Coverage
 - What processes do you have or will you need to develop to facilitate Medi-Cal enrollment?
- » Competing survival priorities
- » Building relationships and trust
- » Medication access
 - Pharmacy
 - Relationship building, specific processes or methods for medication delivery
- » Medication safety and storage
- » Recovery Supports

[Slide Image Description: This slide describes other logistical factors to consider.]

- Health Coverage
 - What processes do you have or will you need to develop to facilitate Medi-Cal enrollment?
- Competing survival priorities
- Building relationships and trust
- Medication access
 - Pharmacy
 - Relationship building, specific processes or methods for medication delivery
- Medication safety and storage
- Recovery Supports

Additional Questions for Consideration

- » Can you say a little more about the use of direct-to-inject in unstably housed populations?
 - Are there protocols that seem to be more effective than others?
- » Is MAT effective for individuals dependent on kratom?

[Slide Image Description: This slide describes other logistical factors to consider.]

- Can you say a little more about the use of direct-to-inject in unstably housed populations?
 - Are there protocols that seem to be more effective than others?

There are four published retrospective case series in which direct-to-inject protocols were used across low-threshold OUD clinics, safety-net public health system sites, and Emergency Departments. Participants ranged from 21 to 129. This approach is called direct-to-inject and is typically used in patients who have been unsuccessful.

Dosing protocols ranged with three studies starting with an initial weekly injection and one using weekly or monthly injection based upon the patient's last use of heroin or other short-acting opioid (notably fentanyl not mentioned in this study).

Retention ranged from 65% - 73% at 30 days, and 57% at 90 days.

- Is MAT effective for individuals dependent on kratom?

Case reports and case series used buprenorphine to control symptoms. More commonly in persons with current or past history of concurrent opioid use disorder.

Ideas in Action

- » What are you finding as the most challenging logistical factors, and the strategies you are using to address them?



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[Slide Image Description: This is an Ideas in Action slide that provides an opportunity for participants to practice using the information. It contains a checkbox and an arrow.]

What are you finding as the most challenging logistical factors, and the strategies you are using to address them?

Questions?

info@afbsstraining.org

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[Slide Image Description: This slide shows the AFBSS email address.]

We are here to support you and provide you with those opportunities to connect and hear about implementing AFBSS. The website is [INSERT](#) and our email address is info@afbsstraining.org.

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