



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.



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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.
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Presenters



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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.

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

Assertive Field-Based Buprenorphine Initiation

Why are we here?

Assertive Field-Based Programmatic Requirements

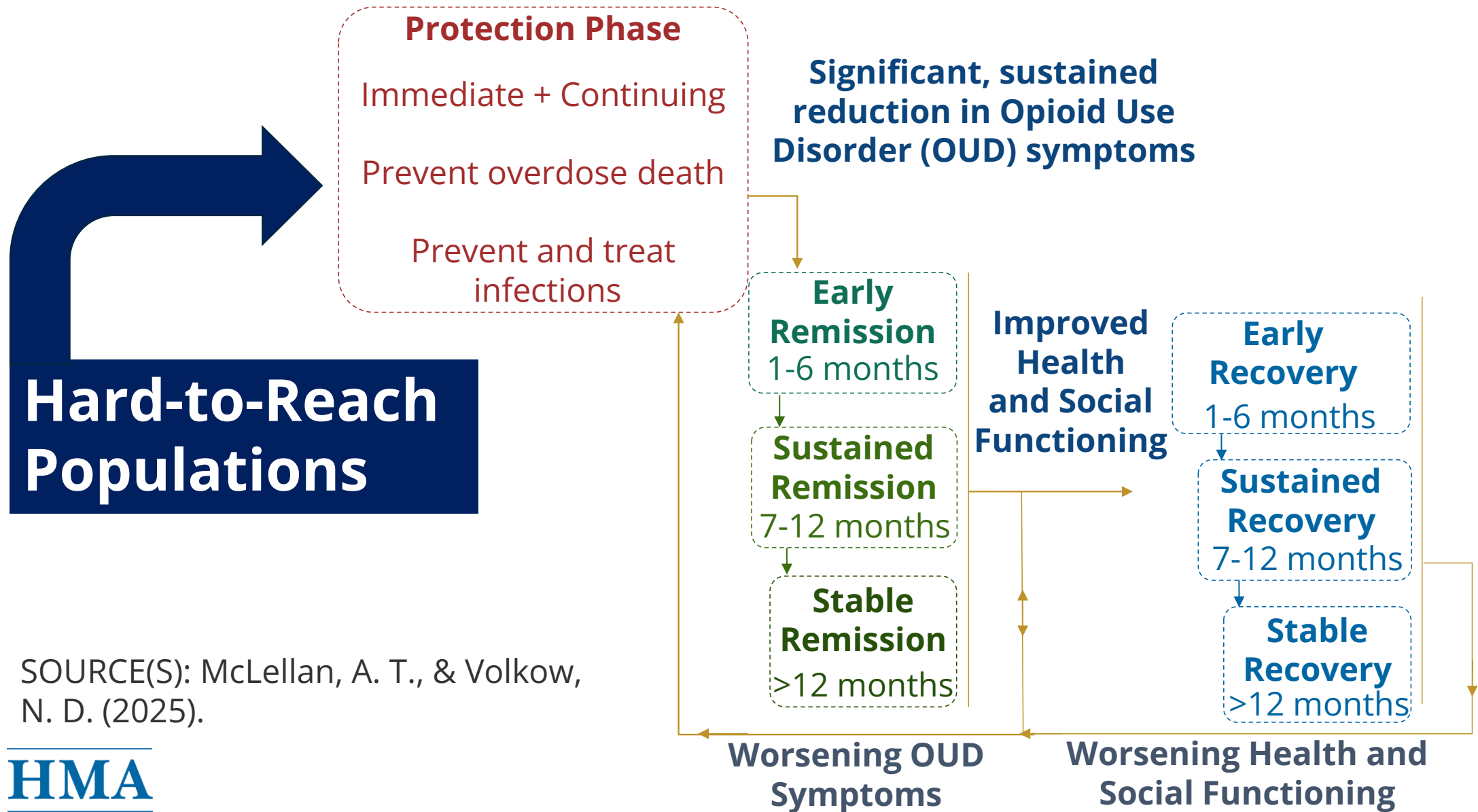
- » Counties are required to provide rapid access to all FDA-approved medications for addiction treatment (MAT) by strengthening existing and/or standing-up at least one initiative in each of the following three areas that comprise their assertive field-based programs:
 - 1) Data-informed, targeted outreach 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

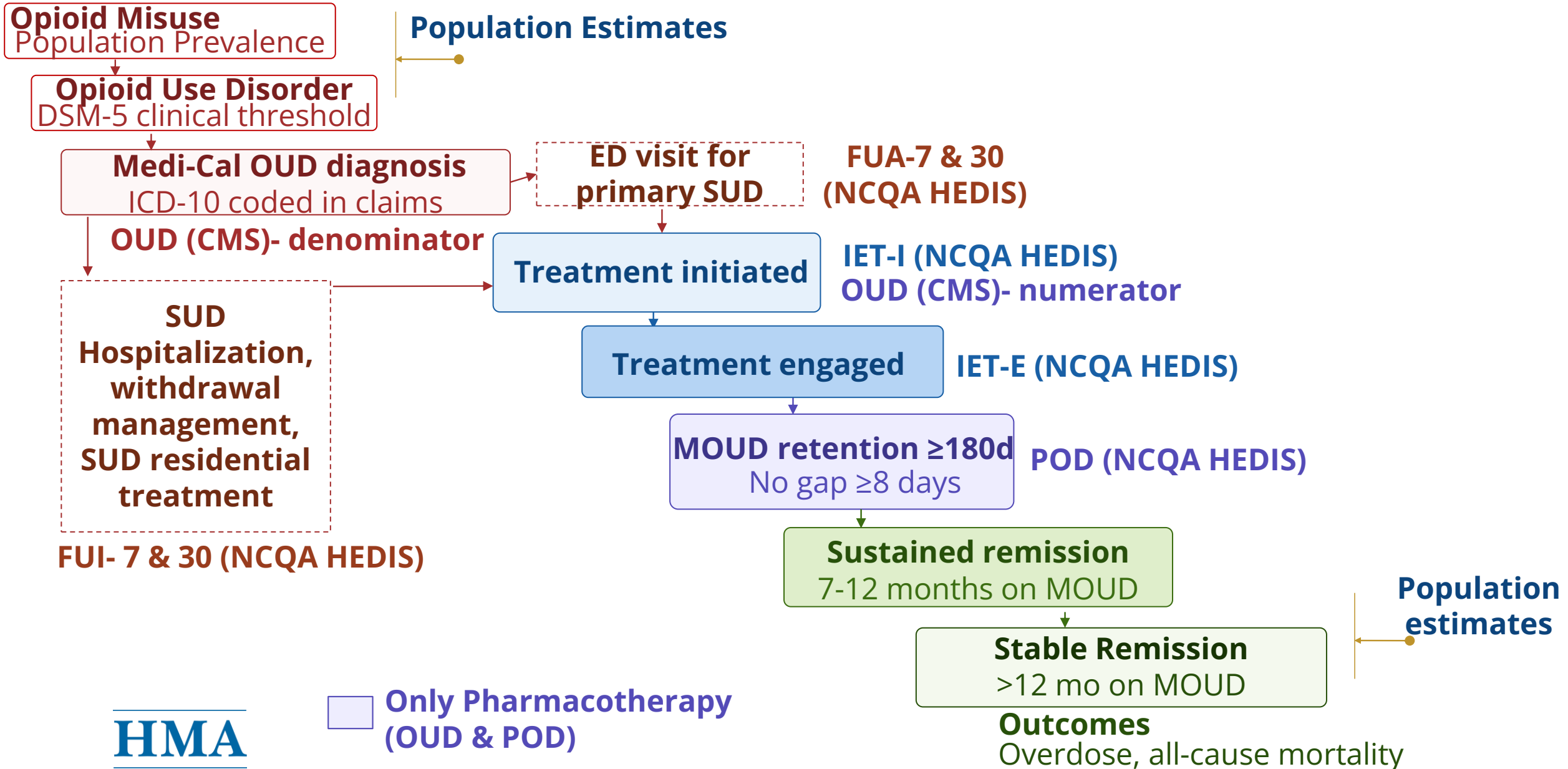
BEHAVIORAL HEALTH SERVICES ACT COUNTY POLICY MANUAL



Medications for Opioid Use Disorder Cascade of Care



Medications for Opioid Use Disorder Cascade of Care



- » **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.

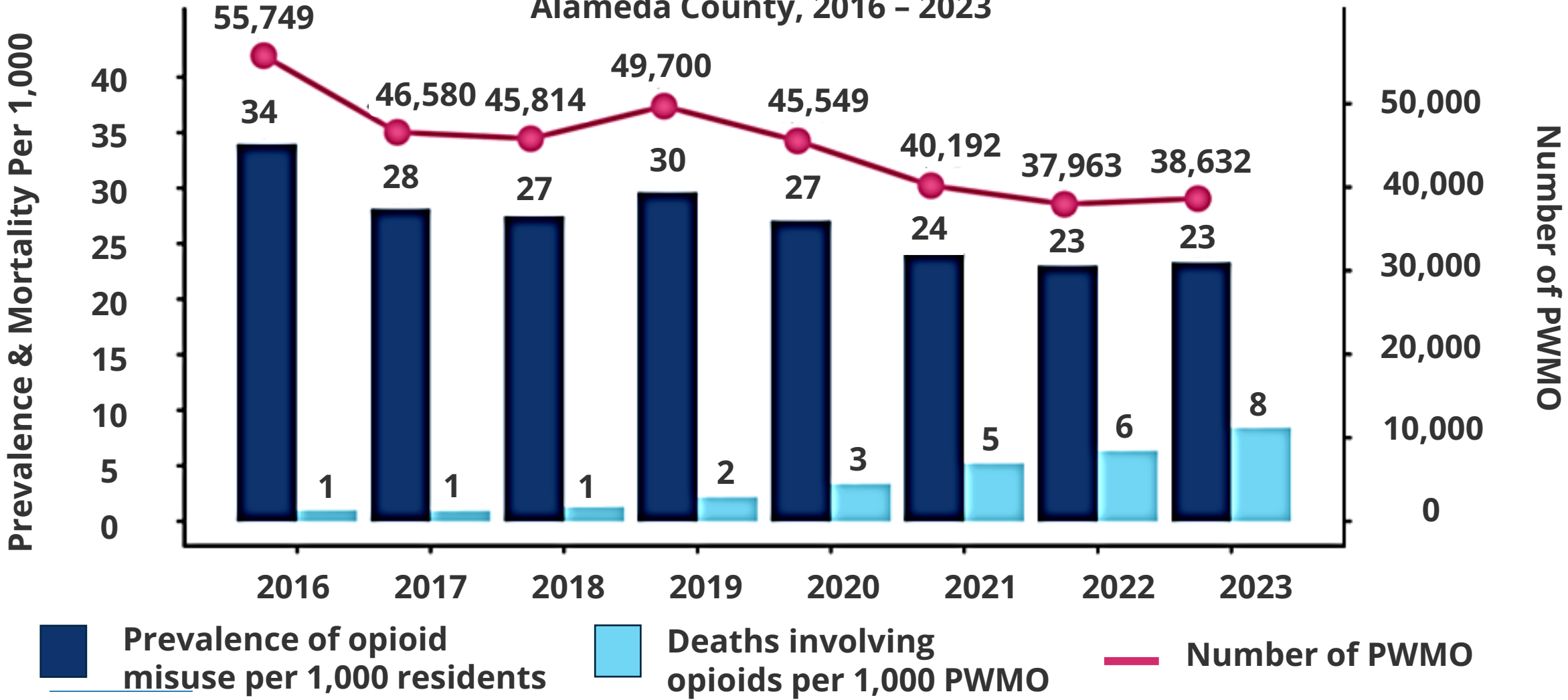
By the Numbers

- » 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.

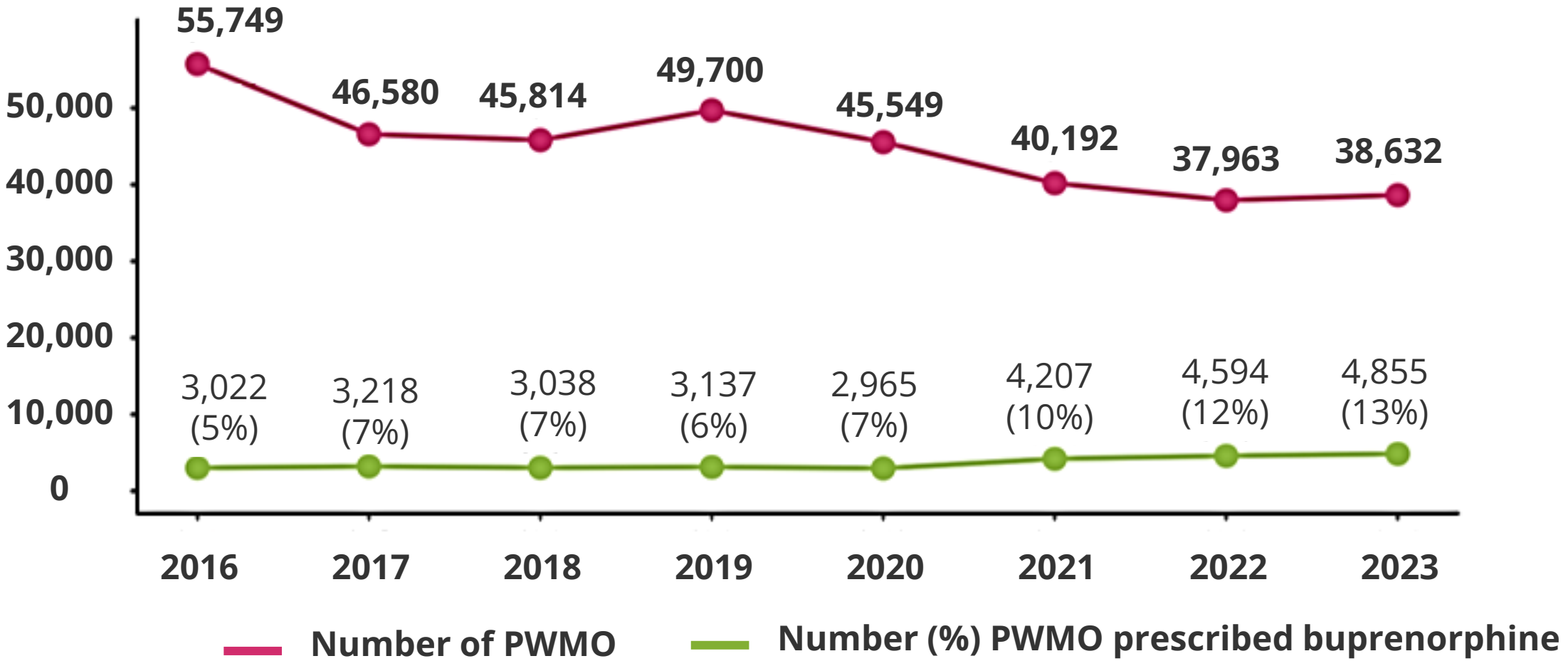
CA Bridge Opioid Epidemic Status Report

Estimated Trends in Opioid Misuse and Mortality
Alameda County, 2016 - 2023



CA Bridge Opioid Epidemic Status Report

Estimated Trends in Buprenorphine Prescribing
Alameda County, 2016 – 2023



» 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



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

» 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: Consider Mike



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

» 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.



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

Starting Buprenorphine

Myth #1: Buprenorphine Management is Complicated

Buprenorphine Initiation

BUPRENORPHINE (bupe, subs)

WHAT CAN BUPE DO FOR ME?

Reduces
cravings &
withdrawal



Protects
against
opioid
overdose



Treats pain &
stabilizes
energy



You can pick buprenorphine
up at a pharmacy like
any other medication.

Buprenorphine can be
tablets, films, or injections.



SO YOU WANT TO TRY BUPE?

Would you consider an INJECTION?

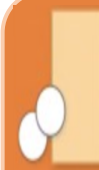
Yes



Direct to Inject
Once you're in mild
withdrawal, you can start a
weekly injection.

After that first week, you can
stay with injections or switch to
films or tablets if you prefer.

No



**How much
withdrawal
can you
handle?**

**I CAN TOUGH
IT OUT**

HIGH dose tabs
or films
Stop opioids,
then when
withdrawal gets
severe, start bupe
and increase dose
over 1-2 days.

VERY LITTLE

LOW dose tabs or films
Start bupe 1 week before
stopping other opioids, either:
- **7 day:** take bupe 2 times a day
- **4 day:** take bupe 4 times a day

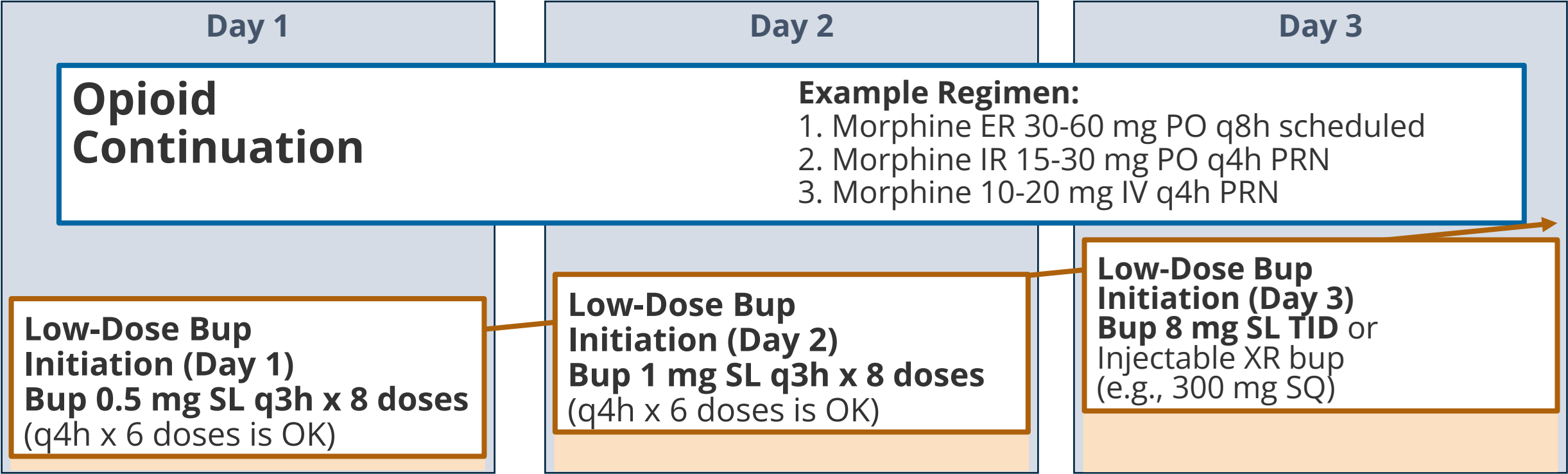
**Withdrawal (e.g., runny nose, body aches, nausea,
et.c) is treatable. Make a plan with your provider.**

Buprenorphine Initiation Strategies: Low-dose Initiation with Opioid Continuation

Low-Dose Buprenorphine Initiation with Opioid Continuation

Treatment Bundle Over Three Days

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



SOURCE(S):
CA Bridge, 2025.

ER/XR = extended release
IR = immediate release
IV = intravenous
mg = milligram

PO = by mouth
PRN = as needed
SL = sublingual (under the tongue)

SQ = subcutaneous
TID = three times a day

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

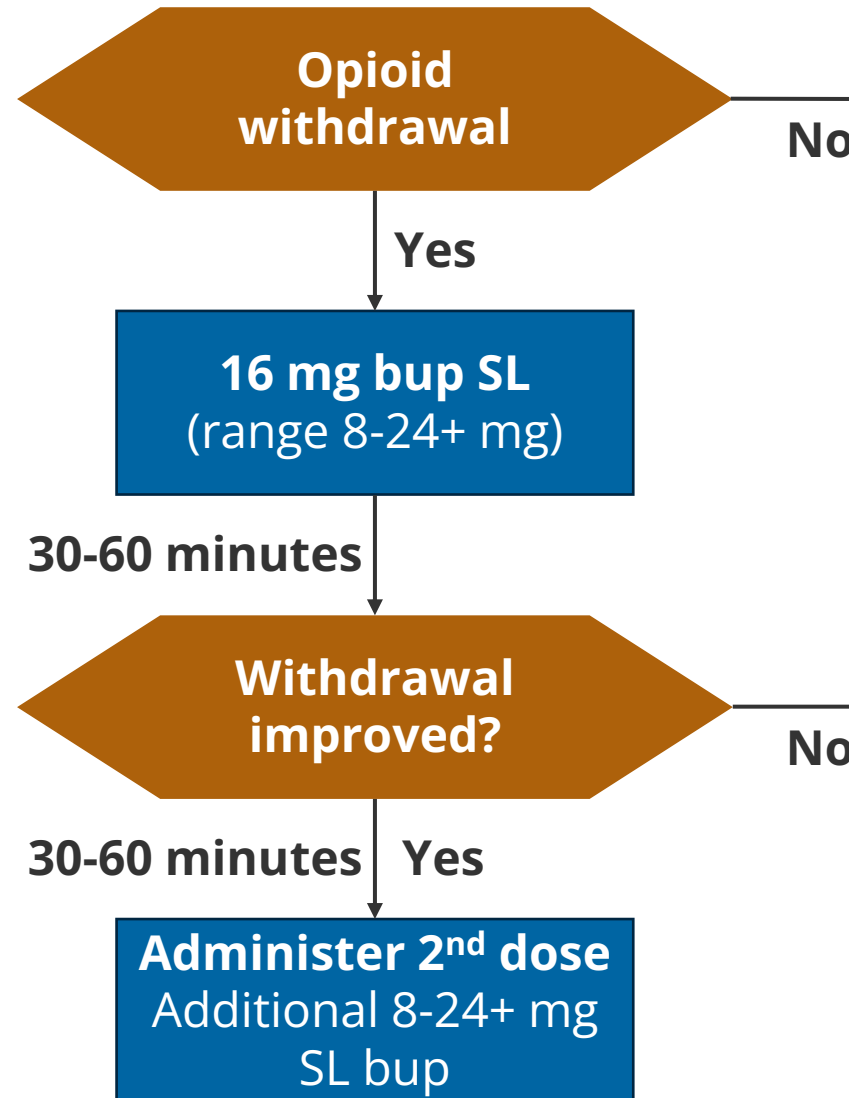
SOURCE(S): Cohen et. al., 2022; Suen et. al., 2022.

Buprenorphine Initiation Strategies: High-Dose Initiation

Higher-Dose, Rapid Buprenorphine Initiation

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

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



RX self-directed start:

- Wait for severe withdrawal then start with 8-24+ mg SL.
- Rx per “Discharge” box below.

If no improvement or worse, consider:

- **Worsening withdrawal (common):** Occurs with lower starting doses and heaving tolerance; improves with more bup (additional 8-16 mg SL).
 - **Other substance intoxication or withdrawal:** Continue bup and manage additional syndromes.
 - **Bup side-effects:** e.g., nausea or headache. Continue bup and treat side-effects with supportive medications.
 - **Medical illness:** Continue bup and manage underlying condition.
- If sudden and significant worsening, consider precipitated withdrawal (rare).**

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.

Buprenorphine Initiation Strategies: Direct-to-Inject Initiation

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

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/>

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.

Direct-to-Inject Studies

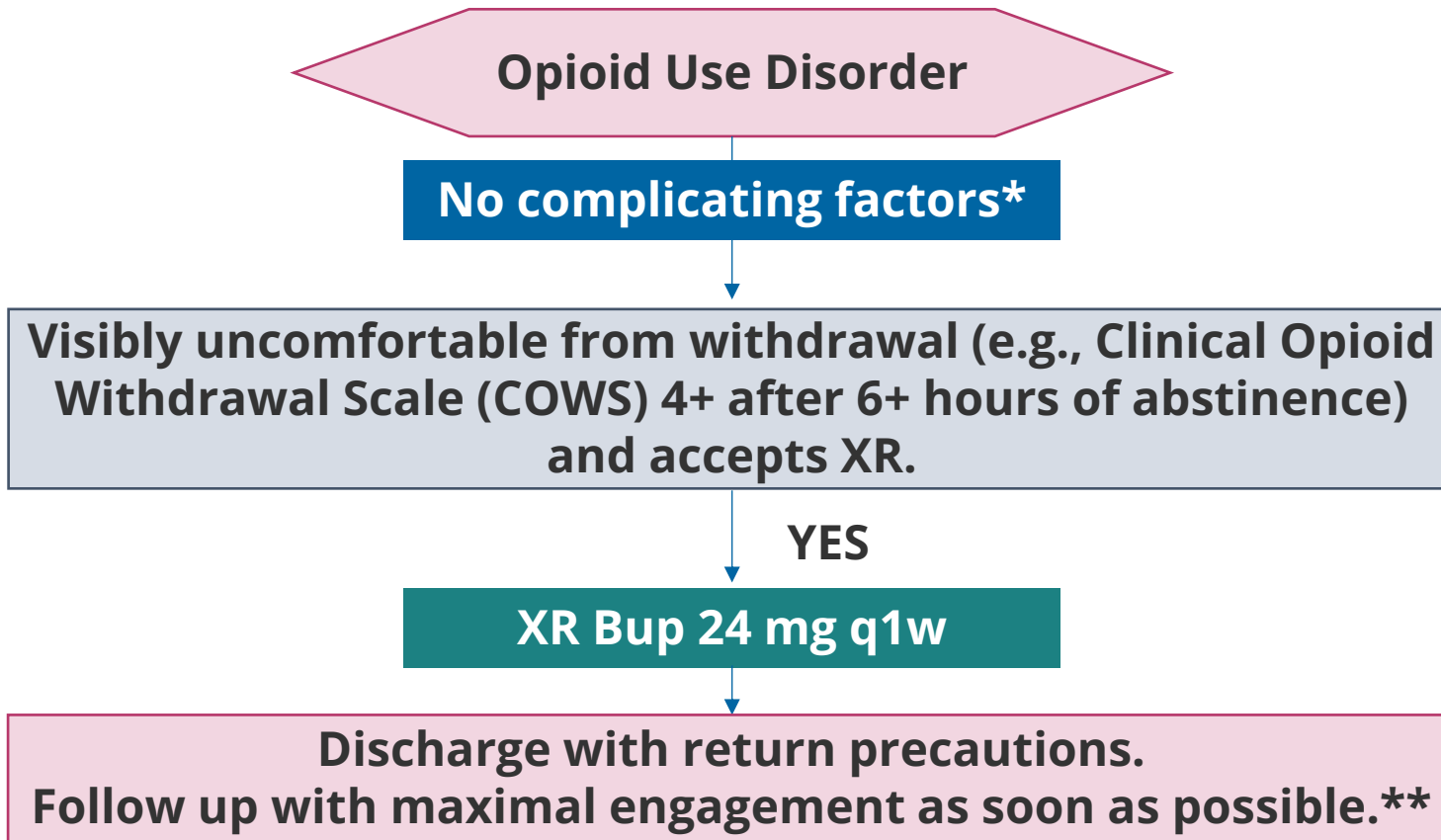
- » “Direct to Inject” is the initiations of LAI buprenorphine in patients not currently taking SL buprenorphine
- » Protocols vary:
 - Sample: Day 1: 8mg weekly Brixadi®
 - Day 2: 16mg weekly Brixadi®
 - Day 3: 128mg monthly Brixadi® or 300mg Sublocade®
- » Precipitated withdrawal: 3 – 7%



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

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:

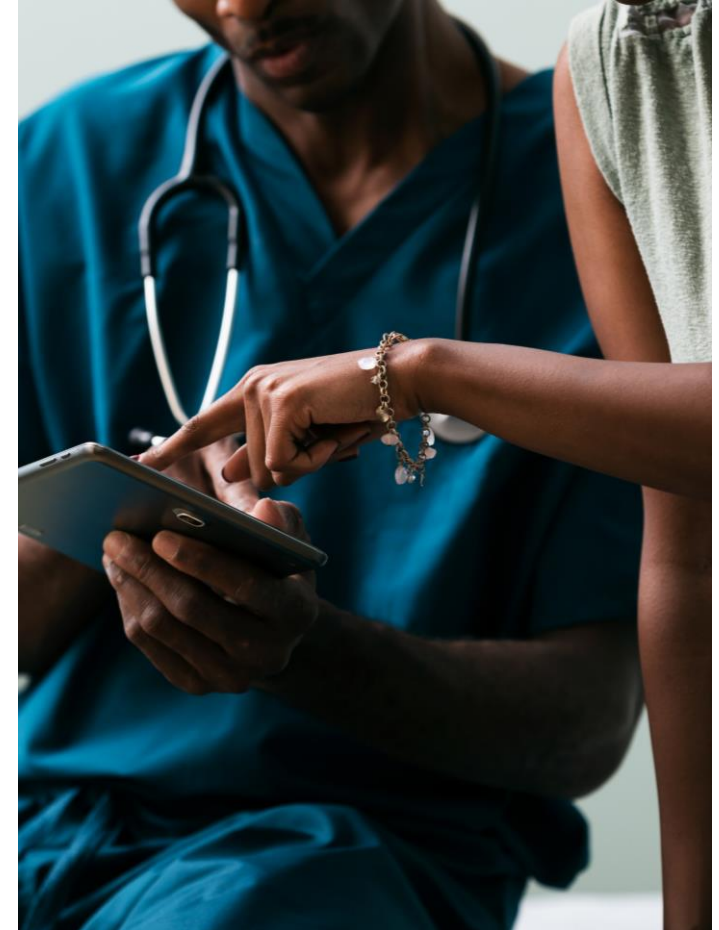
- Altered mental status, delirium, intoxication, recent methadone use (within 1 week).
- Pregnant: Risk/benefit discussion. Risk of untreated OUD generally higher than risk of XR bupe, but only limited studies.
- The only absolute contraindication is known true buprenorphine allergy (exceedingly rare).

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

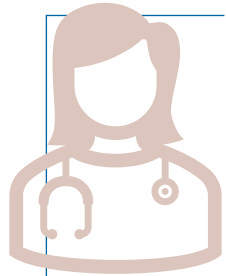
Criteria for Tailoring the Approach to the Individual and the Setting

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.



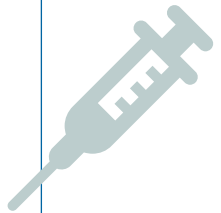
System-Level Factors for Consideration in Selecting an Approach



Prescriber
availability



Prescriber expertise
and comfort



Medication
availability



Insurance/funding
for medications

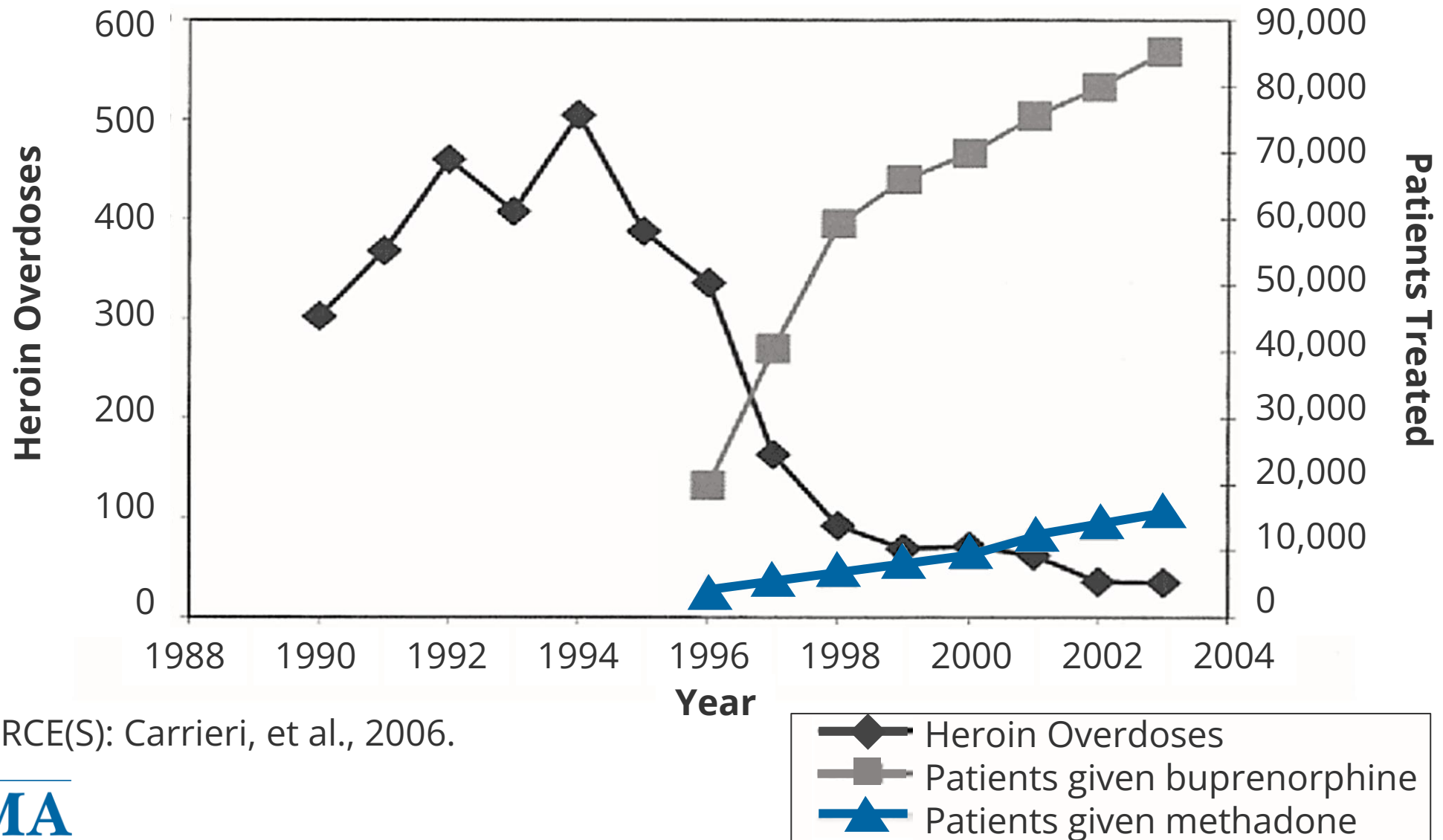
Ideas in Action

- » **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.**



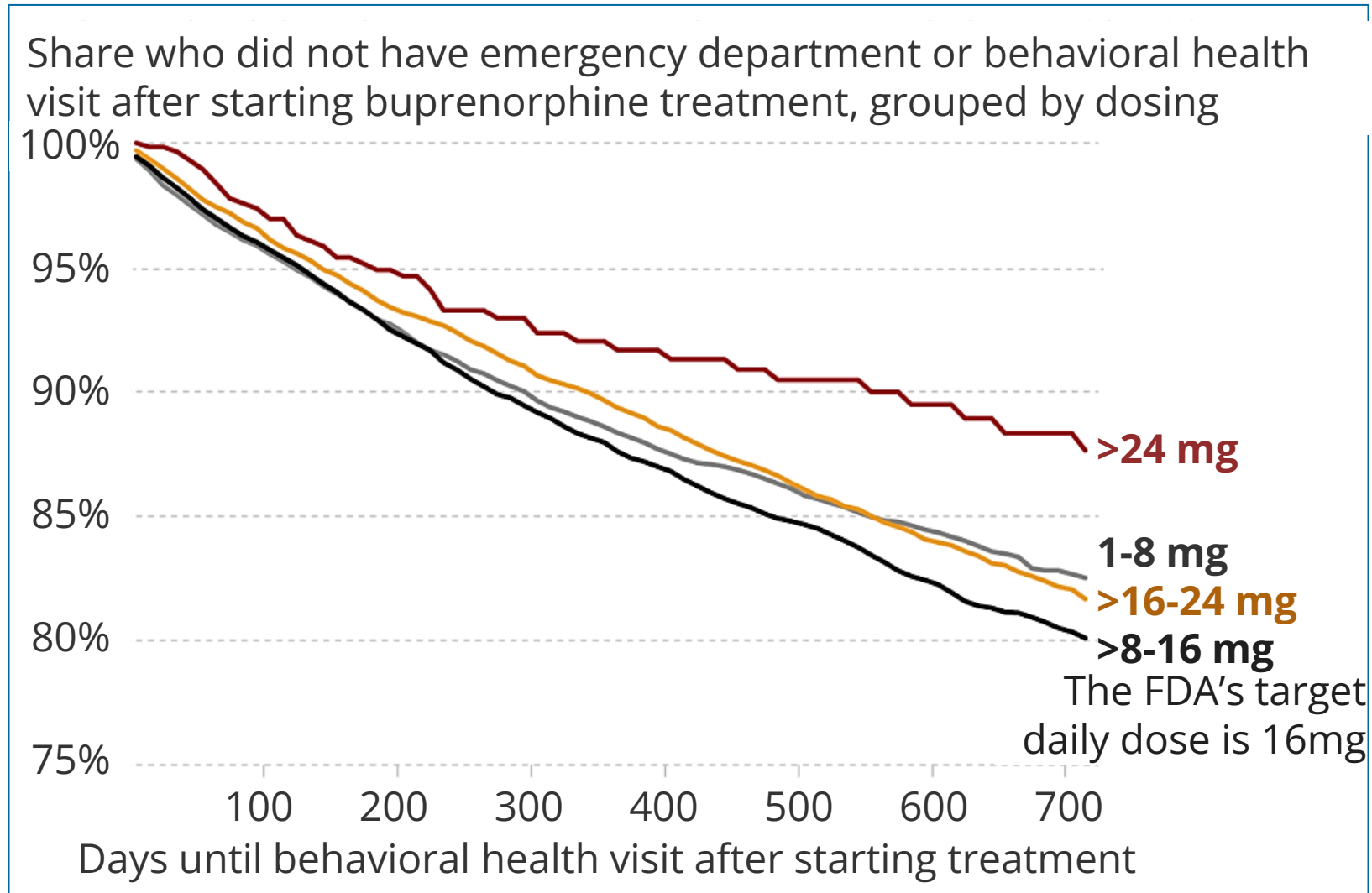
Myth #2: Diverted Buprenorphine is a Public Health Risk

Buprenorphine Access Lowers Population Level Opioid Mortality

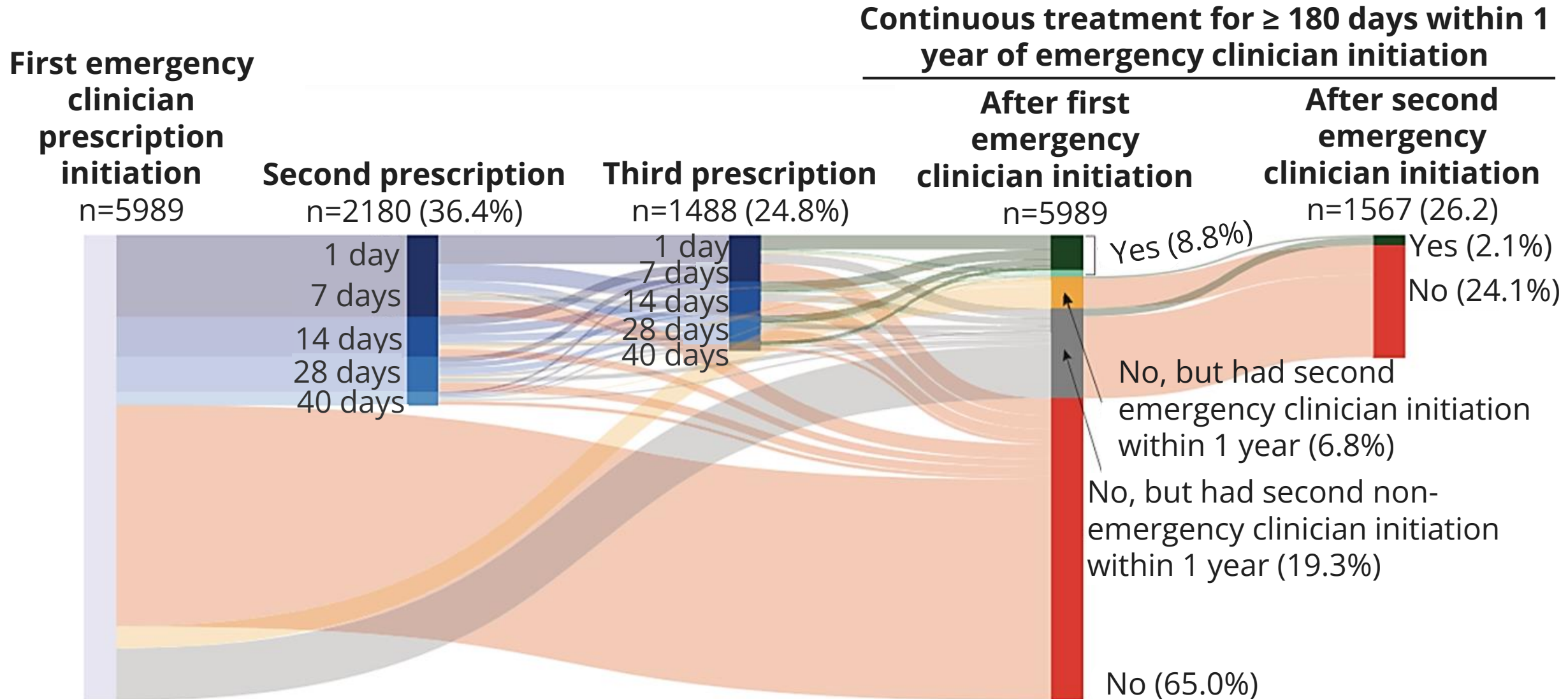


Myth #3: Buprenorphine Treatment is not Recovery

Higher Buprenorphine Doses Associated with Less Use of Behavioral Health Care



The Journey to Recovery is Complex



Provider Partners



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

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.





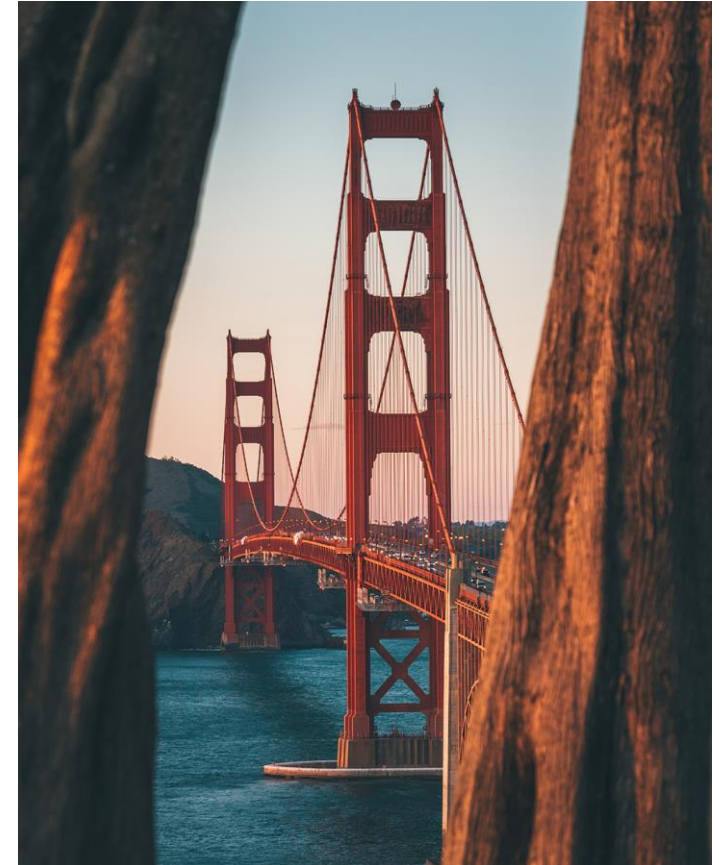
This Photo by Unknown author is licensed under [CC BY-NC-ND](#).

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)

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.

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.





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

Ideas in Action

» Which of these organizations you are 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



The Footprint of Partnership Models



**Behavioral Health
Services**

**Jail, Shelter, Other
Touchpoints**

**Medical
Services**



Empowering NAVIGATORS Reach people in need and link them to available clinicians

Images from 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

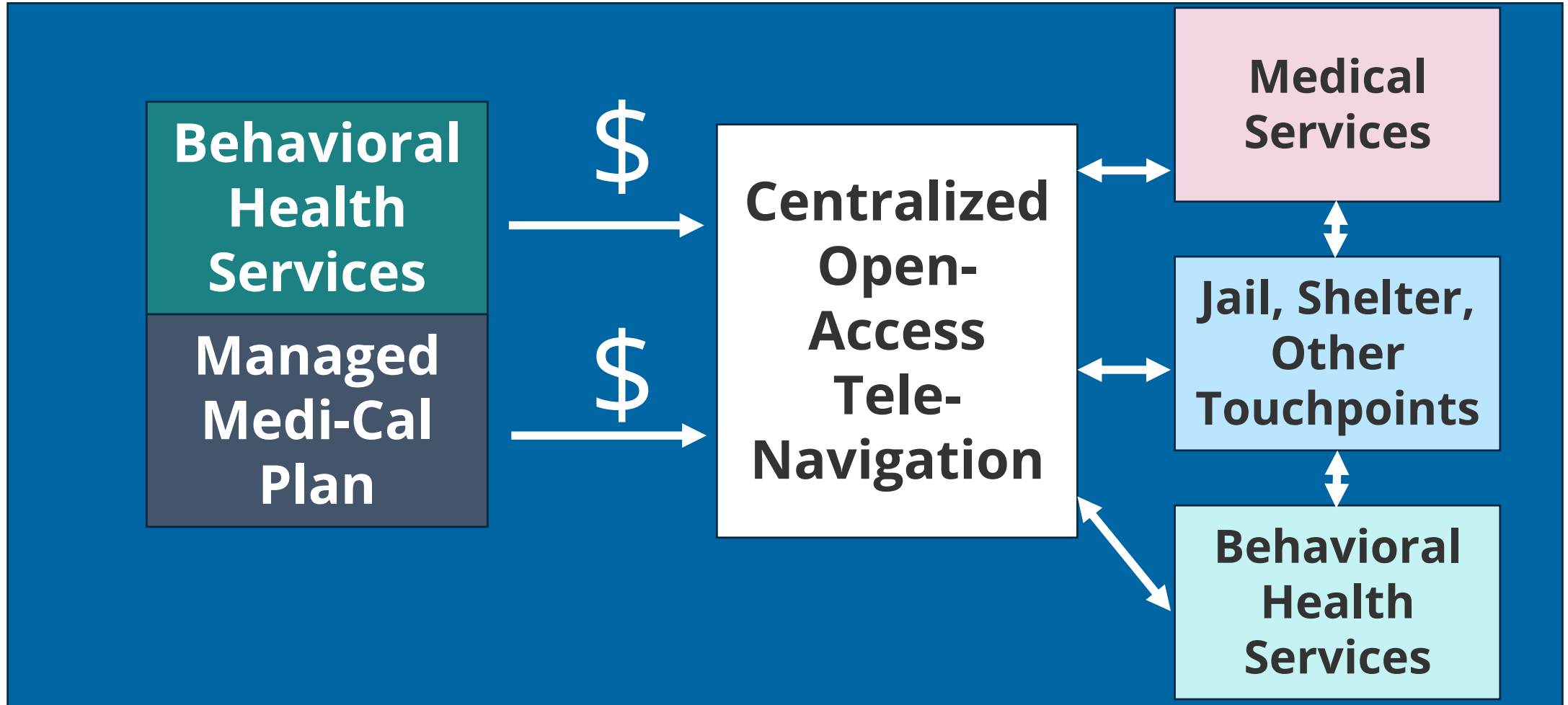
Text: 1-833-308-0461

Mon – Fri | 9am to 5pm PT
Currently available in
El Dorado County.



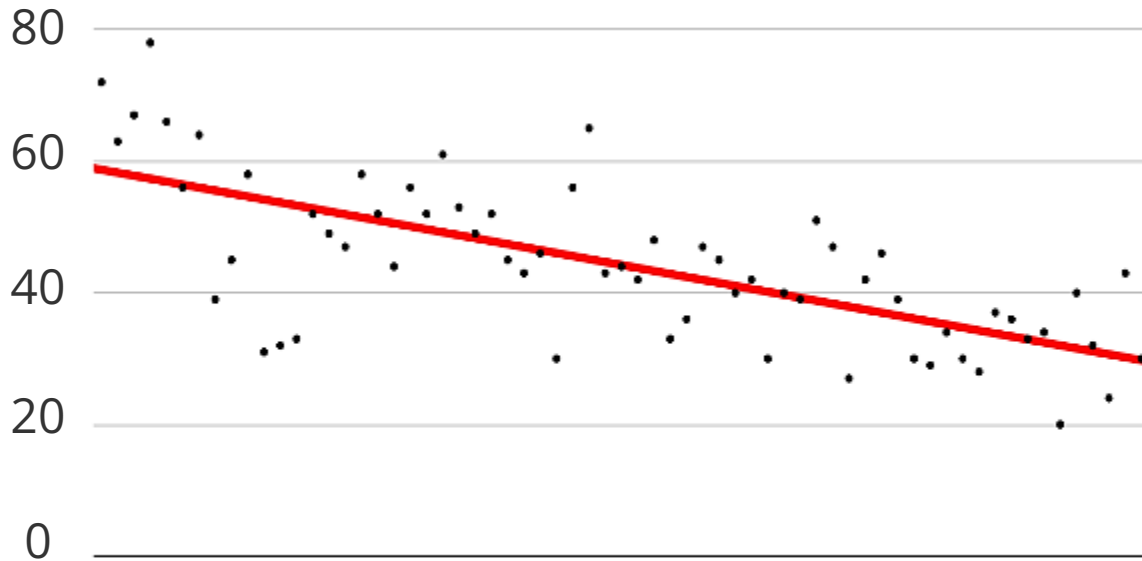
Disclaimer: This is a hypothetical case example. Any resemblance to an actual person is purely coincidental, including race, nationality, and gender.

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



Alameda Pilot Results: Improving Care and Reducing Costs

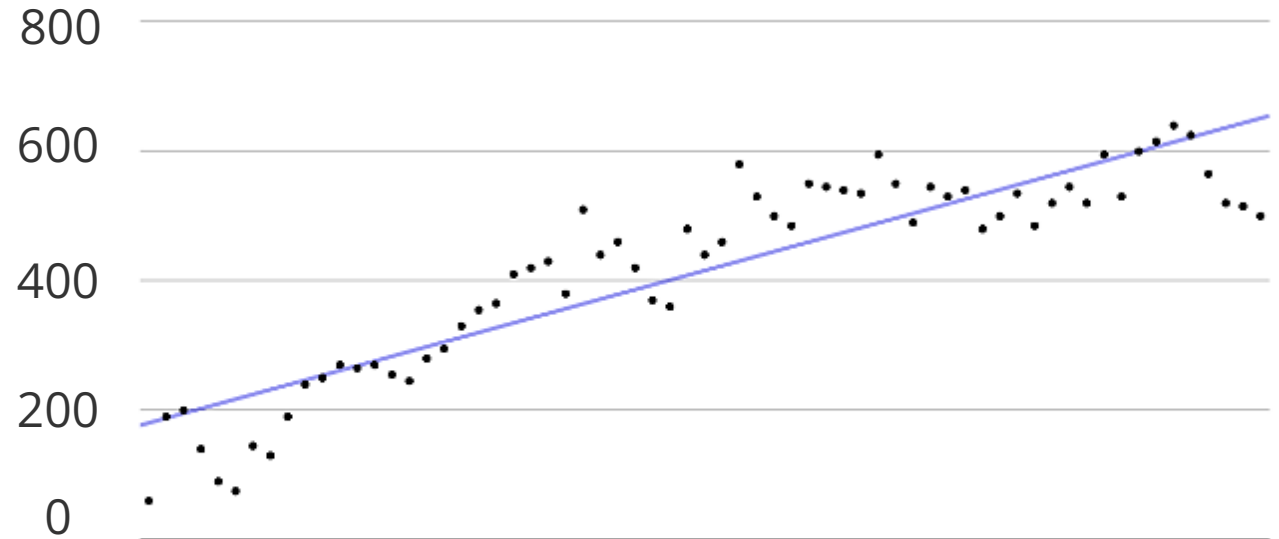
Decreased ED Visits



December 2019 – April 2025

**59.4% Decrease in ED Visits for
Buprenorphine Treatment**

Increased FQHC Eligible Clinic Visits



December 2019 – April 2025

**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.

Telehealth BUP is Not Complicated



SSP

Residential Treatment Program

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.

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.

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

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?

Ideas in Action

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



Questions?

info@afbsstraining.org

References (1 of 11)

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