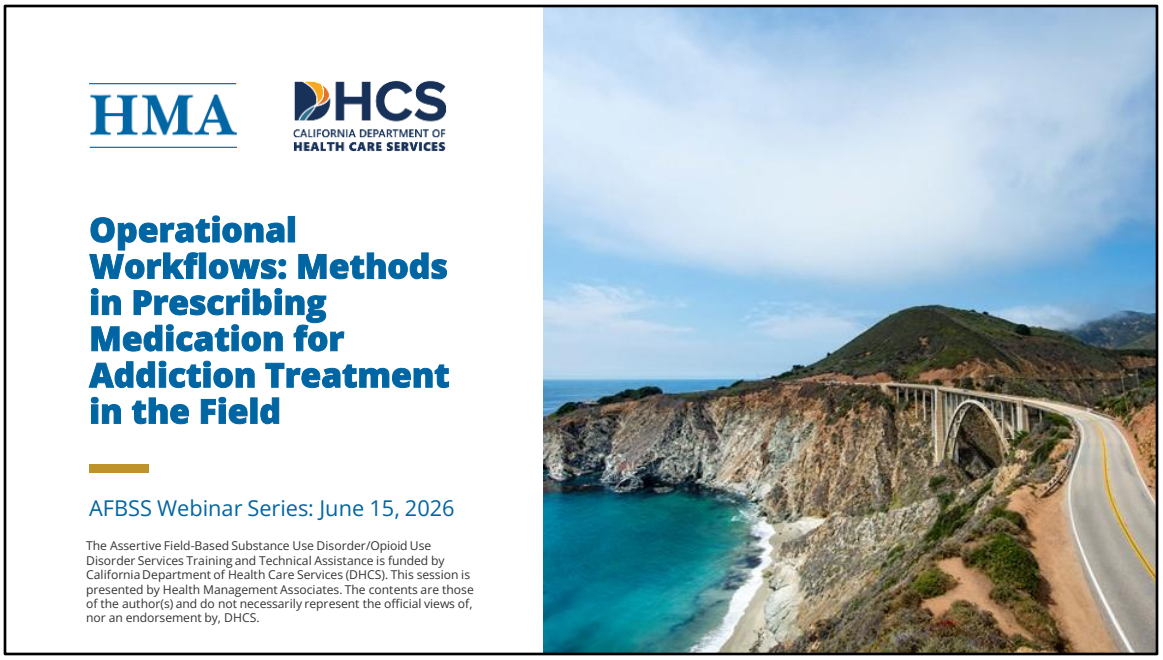

[Slide Image Description: This cover slide introduces the title of this webinar. It contains the logos for Health Management Associates.]

Disclaimer: 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, California Department of Health Care Services.

Disclosures

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.
Corinne T. Feldman, MMS, PA-C	Ms. Feldman discloses that she is an employee of USC Street Medicine and Keck School of Medicine of University of Southern California.
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.

HMA discloses all relevant financial relationships with companies whose primary business is producing, marketing, selling, re-selling, or distributing health care products used by or on patients.

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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.
- Corinne T. Feldman, MMS, PA-C: Ms. Feldman discloses that she is an employee of USC Street Medicine and Keck School of Medicine of University of Southern California.
- Jeanene Smith, MD, MPH: 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.

Presenters

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

Corinne T. Feldman, MMS, PA-C
Director
USC Street Medicine
Clinical Associate Professor
Keck School of Medicine of USC

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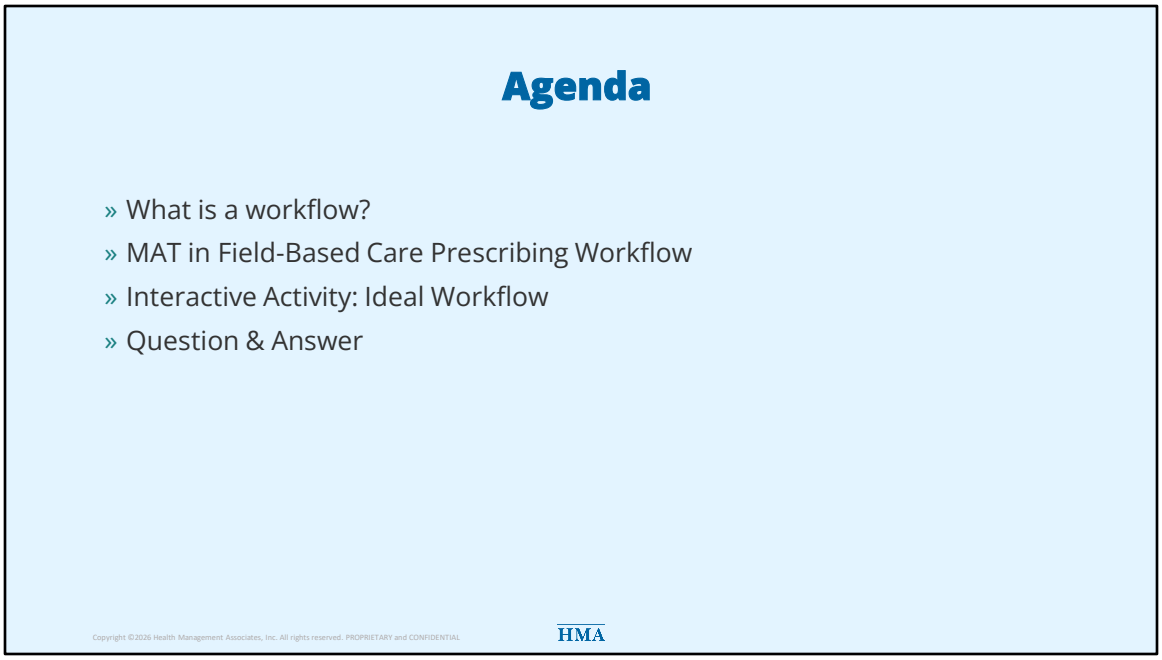
[Slide Image Description: This slide includes images of the presenters of this webinar on a light blue background.]

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.

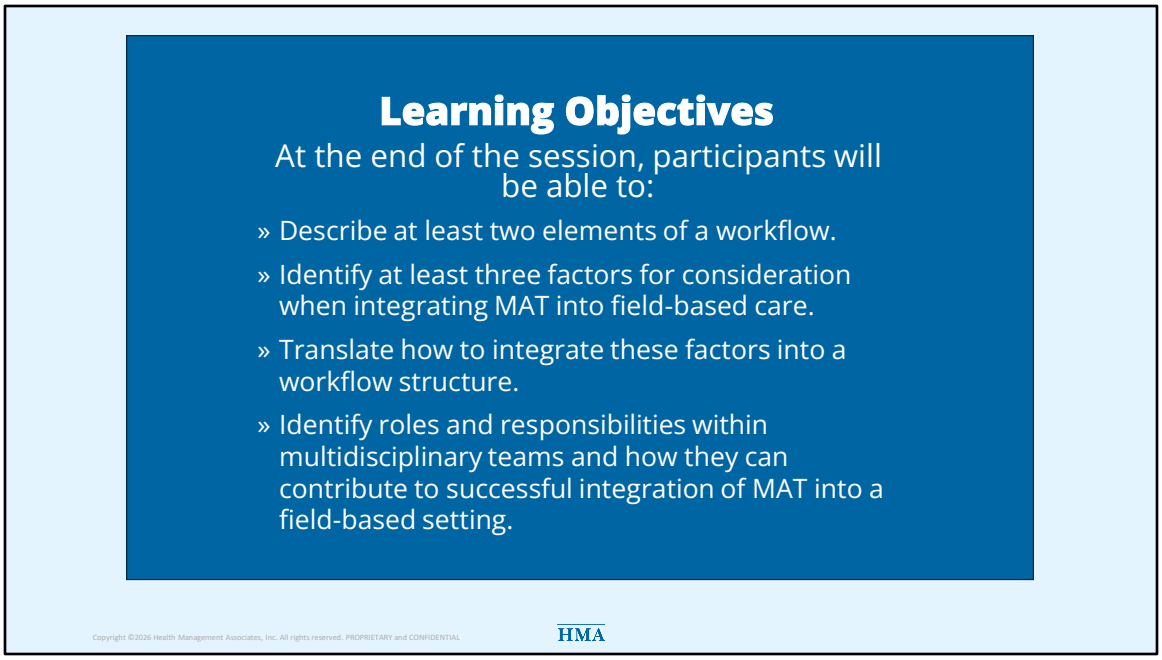
Corinne T. Feldman, MMS, PA-C is a Clinical Assistant Professor of Family Medicine in the USC Primary Care Physician Assistant Program. A graduate of Midwestern University (Downers Grove, '05), she has practiced medicine in the areas of trauma, HIV and geriatrics. Her passion is providing quality primary care for people experiencing unsheltered homelessness, which has been the cornerstone of her career since 2007. She has contributed to

the development of shelter and street-based care in the Lehigh Valley (PA) and Los Angeles and currently sees patients experiencing unsheltered homelessness with KSOM of USC Street Medicine. In the PA program, she has worked to develop curriculum and is the PI for a $1.5M HRSA grant called the USE PeaCE (Underserved Equity-Based Primary Care) Project. USE PeaCE Project seeks to expand the teaching of working with vulnerable populations in the classroom and develop street-based learning opportunities for students including Street Medicine rotations. She is the Director of the Street Medicine rotation for the Keck Family Medicine Residency. She also leads the development and implementation of academic street medicine curriculum for learners and street medicine teams through her Workforce Development efforts with KSOM of USC Street Medicine. Nationally and internationally, she serves as an advisor to the International Street Medicine Institute Student Coalition and is contributing to the development of an International Street Medicine Institute Educator Coalition. Her publication history includes the development of adapted clinical practice guidelines for the care of unsheltered homeless, an intake tool for taking a history on a person experiencing unsheltered homelessness as well as how street medicine integrates into higher medical education.



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

Agenda:
- What is a Workflow
- MAT in Field-Based Care Prescribing Workflow
- Partnership and Provider Engagement Workflow
- Interactive Activity: Ideal Workflow
- Question & Answer



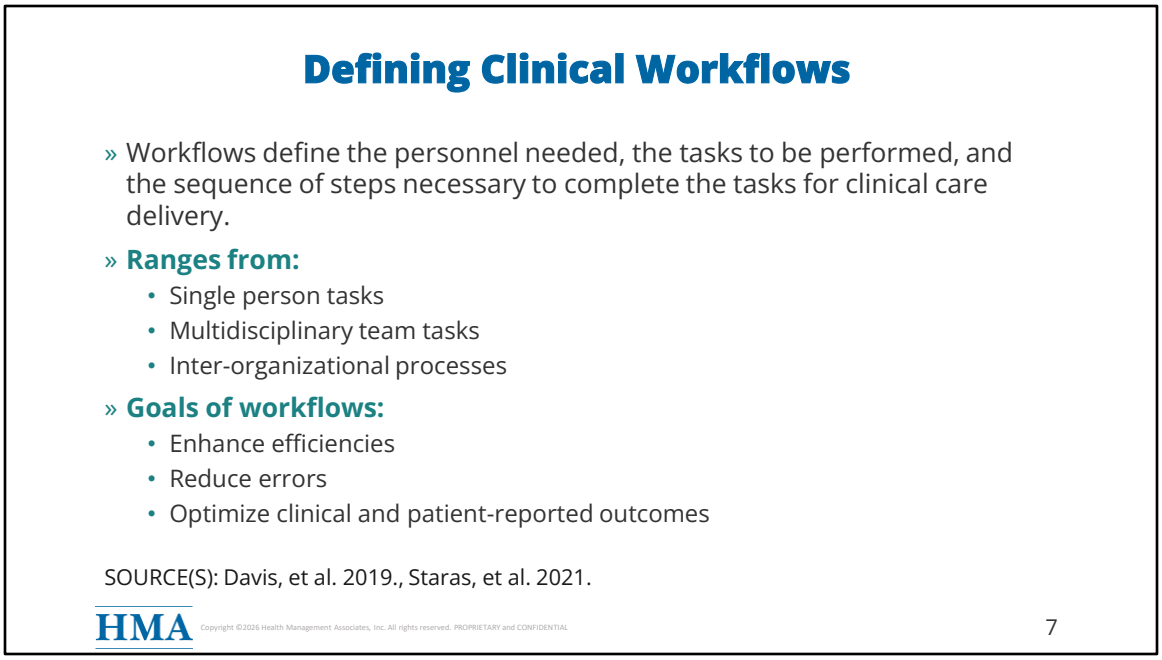
[Slide Image Description: This slide shows the learning objectives for this webinar with a light blue background.]

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

- Describe at least two elements of a workflow.
- Identify at least three factors for consideration when integrating MAT into field-based care.
- Discuss how to integrate these factors into a workflow structure.
- Identify roles and responsibilities within multidisciplinary teams and how they can contribute to successful integration of MAT into a field-based setting.

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

This first section describes workflows.



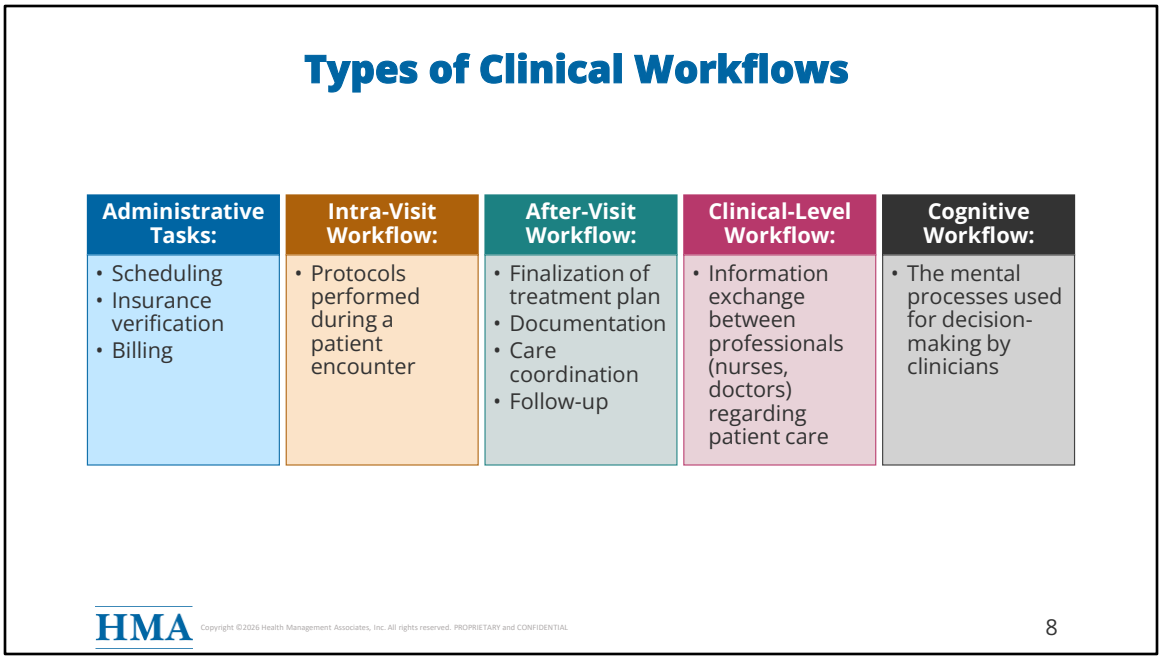
[Slide Image Description: This slide shows defining clinical workflows, the definitions of workflows, ranges of tasks, and goals of workflows.]

A workflow is a repeatable, step-by step process for completing sequential tasks that are designed to accomplish a specific goal

Workflows define the personnel needed, the tasks to be performed, and the sequence of steps necessary to complete the tasks for clinical care delivery.
Ranges from:
- Single person tasks
- Multidisciplinary team tasks
- Inter-organizational processes

Goals of workflows
- Enhance efficiencies
- Reduce errors
- Optimize clinical and patient-reported outcomes

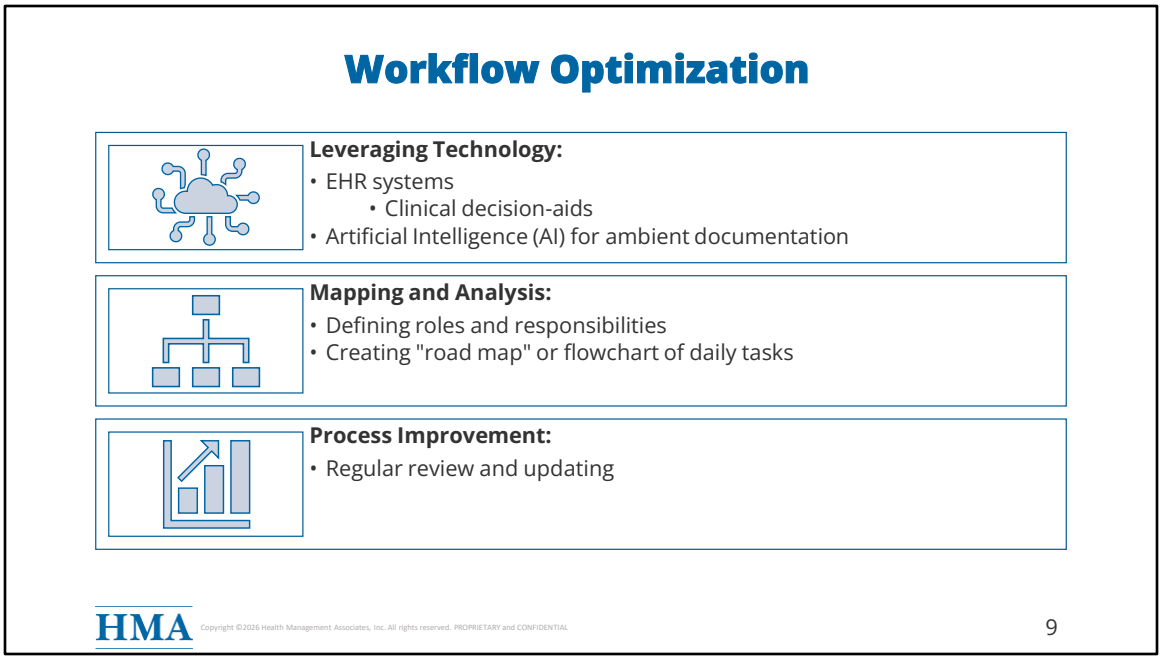
SOURCE(S): Davis, et al. 2019., Staras, et al. 2021.



[Slide Image Description: This slide shows a list of different types of clinical workflows.]

Consider the following types of clinical workflows:

- Administrative Tasks: Scheduling, insurance verification, and billing., Calling or texting the patient to remind them of their appointment
- Intra-Visit Workflow: Protocols performed during a patient encounter.
- After-Visit Workflow: Finalization of treatment plan, documentation, care coordination, and follow-up.
- Clinical-Level Workflow: Information exchange between professionals (nurses, doctors) regarding patient care.
- Cognitive Workflow: The mental processes used for decision-making by clinicians.

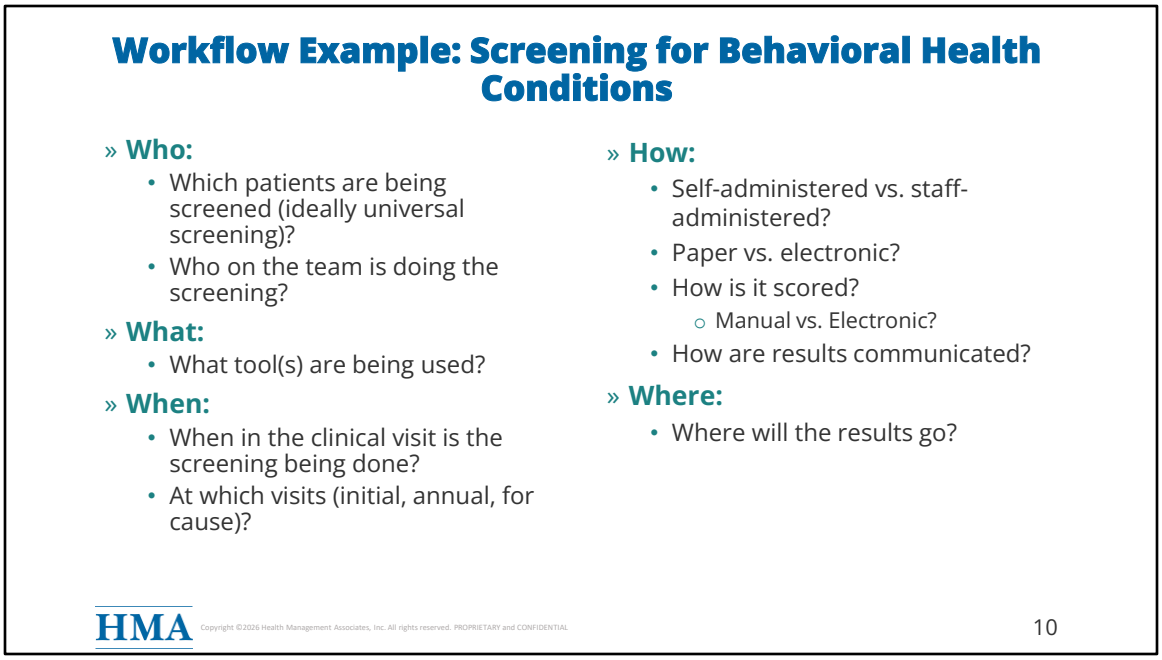


[Slide Image Description: This slide shows workflow optimization with a list of leveraging technology, mapping and analysis, and process improvement.]

Recall that we said that the primary goals for use of workflows are:
- to maximize efficiency,
- reduce medical and administrative errors, and
- ultimately improve outcomes.

In many instances, there are things we can do to optimize our workflows in to achieve these overarching goals.

Workflow optimization includes the following:
- Leveraging Technology:
    - EHR systems
        - Clinical decision-aids
    - Artificial Intelligence (AI) for ambient documentation
- Mapping and Analysis:
    - Defining roles and responsibilities
    - Creating "road map" or flowchart of daily tasks
- Process Improvement:
    - Regular review and updating



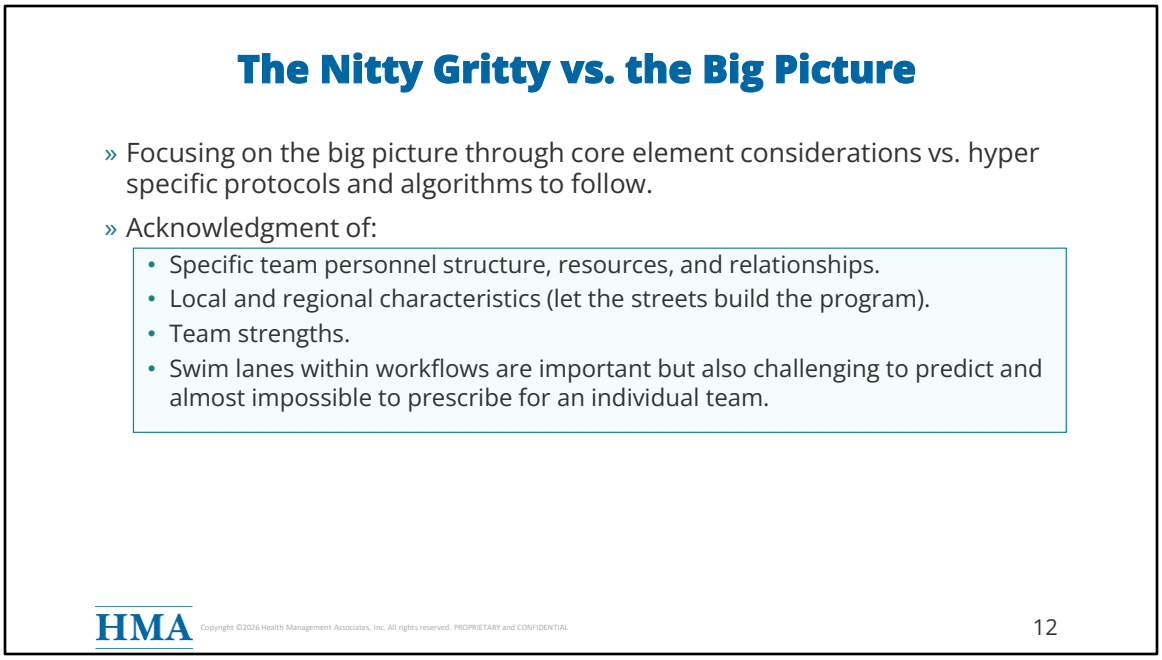
[Slide Image Description: This slide shows a workflow example.]

Let's consider a workflow example: Screening for Behavioral Conditions:

- Who:
  - Which patients are being screened (ideally universal screening)?
  - Who on the team is doing the screening?
- What:
  - What tool(s) are being used?
- When:
  - When in the clinical visit is the screening being done?
  - At which visits (initial, annual, for cause)?
- How:
  - Self-administered vs. staff- administered?
  - Paper vs. electronic?
  - How is it scored?
    - Manual vs. Electronic?
  - How are results communicated?
- Where:
  - Where will the results go?

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

This second section details MAT in field-based care prescribing workflow.

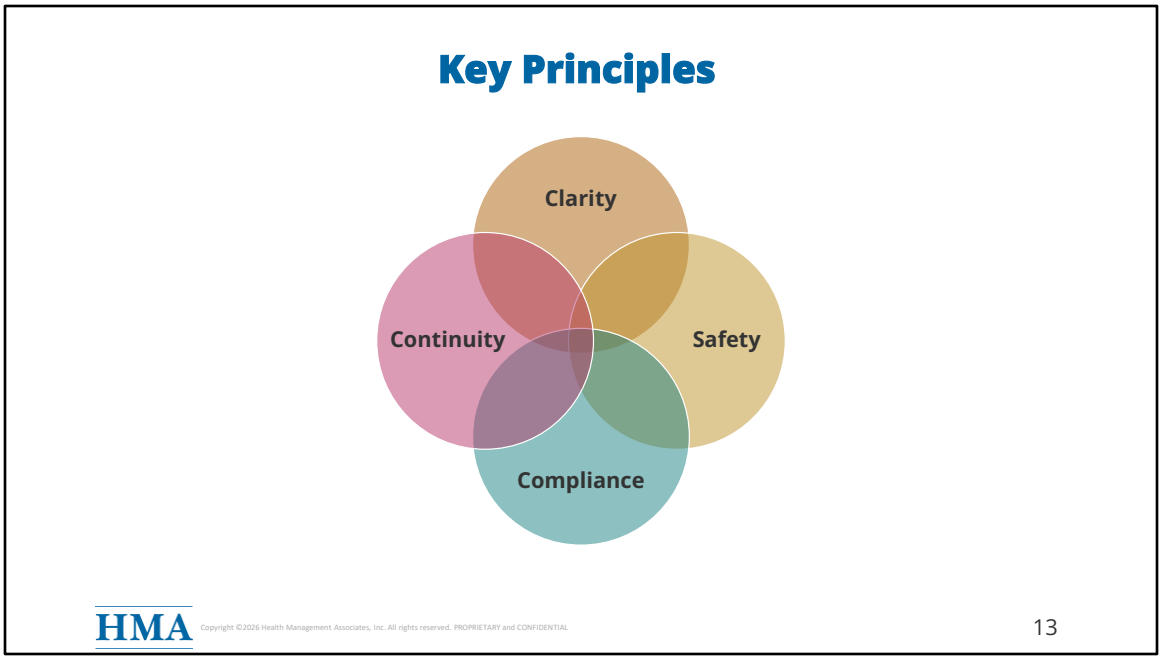


[Slide Image Description: This slide outlines the nitty gritty vs the big picture.]

Focusing on the big picture through core element considerations vs. hyper specific protocols and algorithms to follow.

Acknowledgment of:

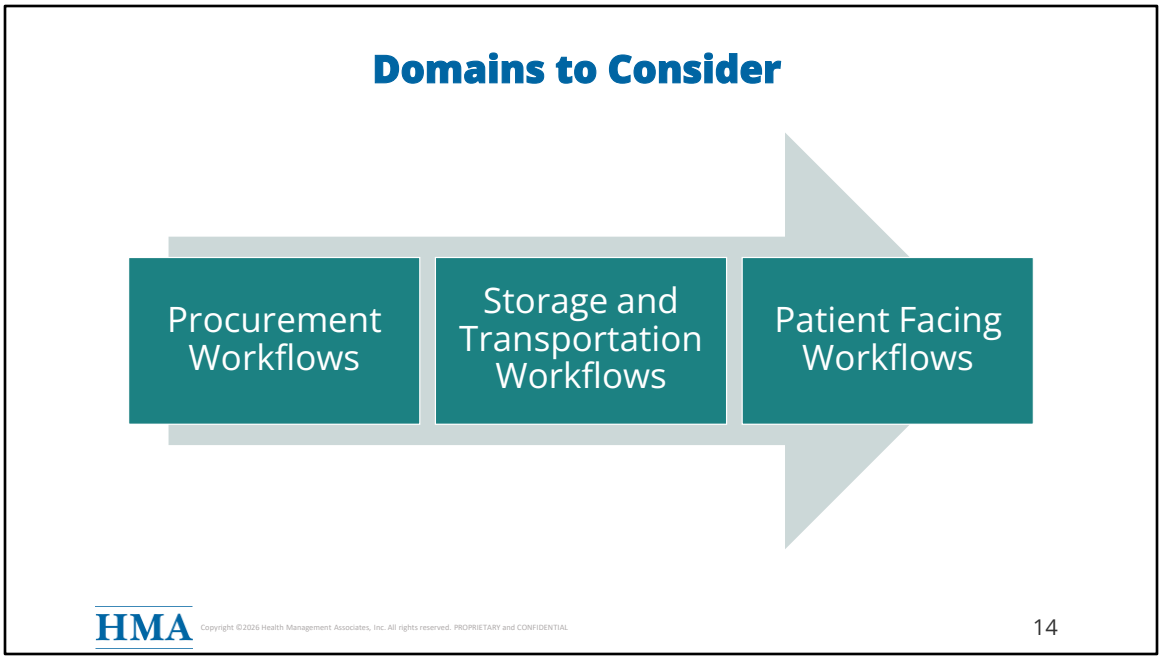
- Specific team personnel structure, resources, and relationships.
- Local and regional characteristics (let the streets build the program).
- Team strengths.
- Swim lanes within workflows are important but also challenging to predict and almost impossible to prescribe for an individual team.



[Slide Image Description: This slide shows a colorful Venn diagram of the key principles of clarity, continuity, safety, and compliance.]

Workflow key principles include:

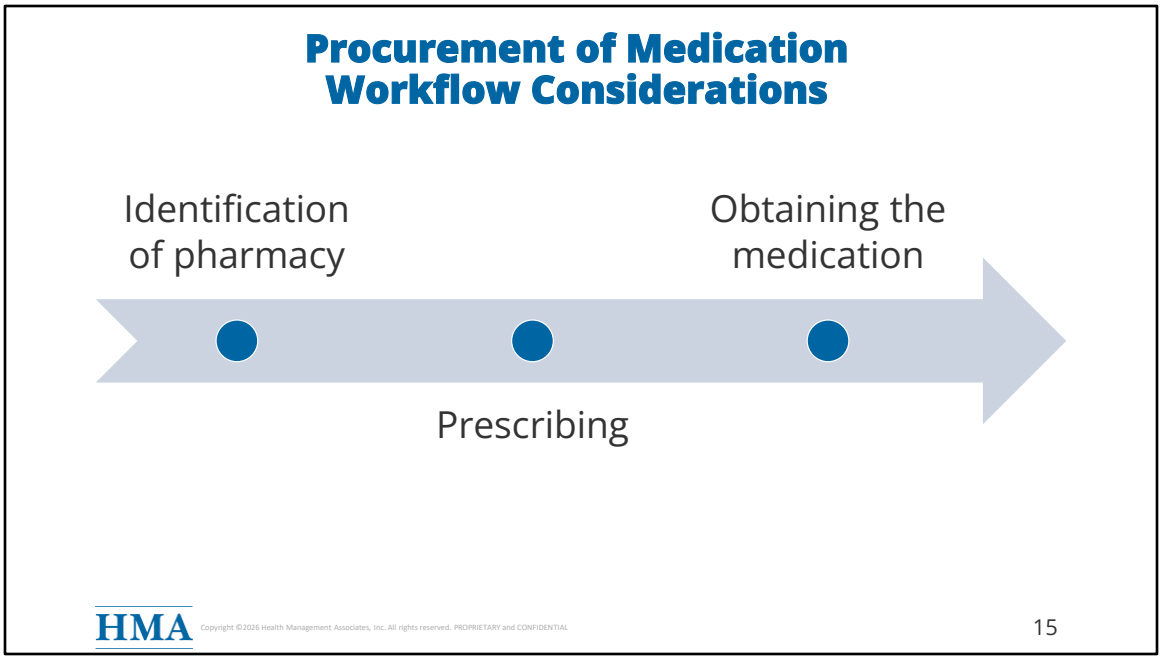
- Clarity
- Safety
- Compliance
- Continuity



[Slide Image Description: This slide shows the domains to consider in three colorful boxes with an arrow.]

Domains for consideration:

- Procurement Workflows
- Storage and Transportation Workflows
- Patient Facing Workflows



[Slide Image Description: This slide shows procurement of medication workflow considerations with three blue dots and a colorful arrow.]

Procurement of medication workflow considerations:

- Identification of pharmacy
- Prescribing
- Obtaining the medication

Identification of a Pharmacy

- Do **not** skip this step.
- Why it matters:
  - Stigma around treatment support using medications can influence procurement and speed of procurement of medication.
  - Do not want to have gaps in ability to get medication; the patient suffers, rapport is trampled.
- Mom and Pop vs. Big Box Pharmacy vs. 340B considerations:
  - Likely need more than one depending on geography of encampment locations.

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[Slide Image Description: This slide shows the identification of a pharmacy. Image illustrates a dot labeled “identification of pharmacy” outlined in a blue box.]

The first consideration for the procurement of medication workflow is identifying a pharmacy.

Do not skip this step.

- Why it matters:
  - Stigma around treatment support using medications can influence procurement and speed of procurement of medication.
  - Do not want to have gaps in ability to get medication; the patient suffers, rapport is trampled.
- Mom and Pop vs. Big Box Pharmacy vs. 340B considerations:
  - Likely need more than one depending on geography of encampment locations.

Identification of a Pharmacy (Continued)

- In-reach is almost always needed.
  - Relationships are worth your time investment.
  - Example: Direct to Inject Protocols with Brixadi:
    - Day 1: Give an injection meant to last 1 week.
    - Day 2 (the next day): Give an injection meant to last 1 week.
    - Day 3: Give an injection meant to last 1 month.
    - Plus, sublingual buprenorphine.

Note: There is a lot of potential for denials of early refills; often need pharmacy and insurance education.

[Slide Image Description: This slide shows Identification of a Pharmacy (Continued). Image illustrates a dot labeled “identification of pharmacy” outlined in a blue box.]

In-reach is almost always needed when identifying a pharmacy:

- Relationships are worth your time investment.
- Example: Direct to Inject Protocols with Brixadi:
    - Day 1: Give an injection meant to last 1 week.
    - Day 2 (the next day): Give an injection meant to last 1 week.
    - Day 3: Give an injection meant to last 1 month.
    - Plus, sublingual buprenorphine.
- Note: There is a lot of potential for denials of early refills; often need pharmacy and insurance education.

Prescribing

- Who on the team is legally permitted to prescribe:
  - Active DEA Number required for any controlled substances.
  - Cover costs of DEA Licensing ($800+).
- E-scribing (electronic prescribing) and call-in considerations.

Common Medications	Drug Class Schedule	Prescribing Options
Buprenorphine (Subutex)	III	Call, e-scribe, fax
Naltrexone	Not a controlled substance	Call, e-scribe, fax
Naloxone (Narcan)	Not a controlled substance	Call, e-scribe, fax
Bupropion (Wellbutrin)	Not a controlled substance	Call, e-scribe, fax
Mirtazapine (Remeron)	Not a controlled substance	Call, e-scribe, fax

SOURCE(S): Drug Enforcement Administration, 2023.

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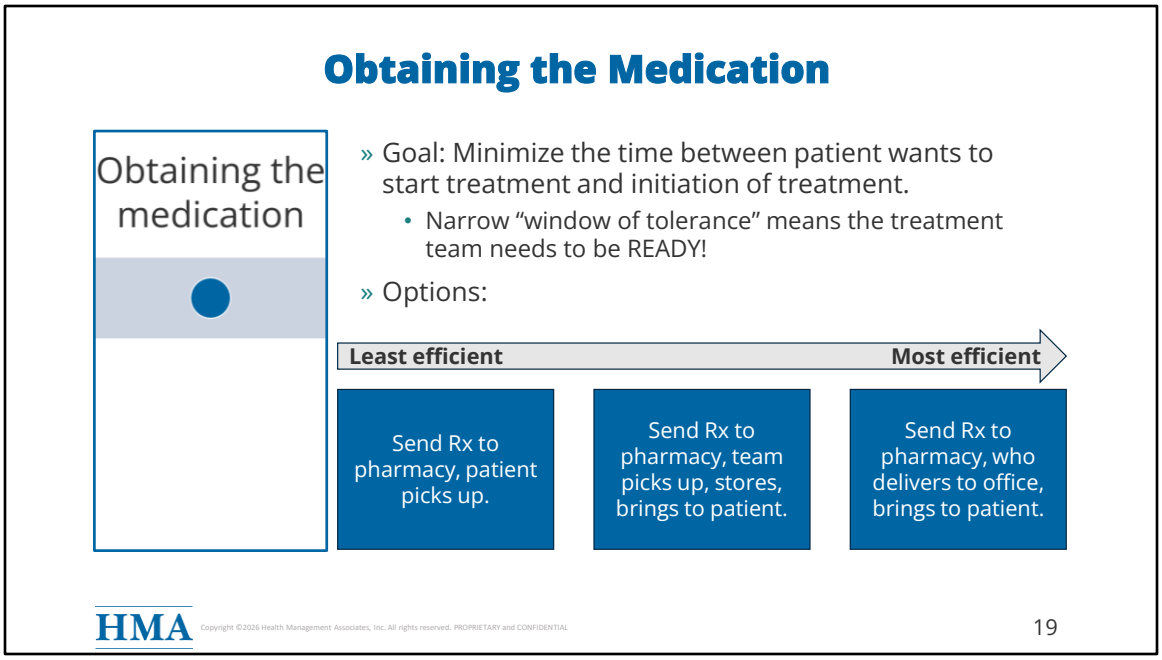
[Slide Image Description: This slide shows Prescribing in a chart labeled common medications, drug class schedule, and prescribing options. Image illustrates a dot labeled “prescribing” outlined in a blue box.]

The second consideration for the procurement of medication workflow is prescribing:

- Who on the team is legally permitted to prescribe:
  - Active DEA Number required for any controlled substances.
  - Cover costs of DEA Licensing ($700+).
- E-scribing (electronic prescribing) and call-in considerations.

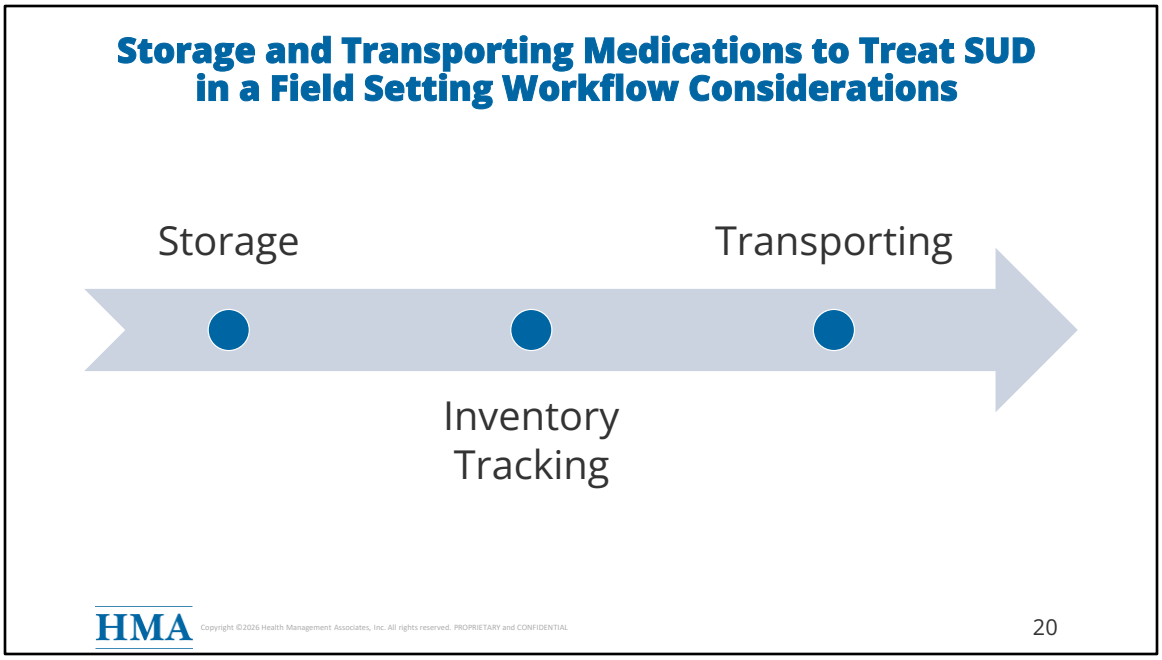
SOURCE(S): Drug Enforcement Administration, 2023.



[Slide Image Description: This slide shows the procurement of medication workflow considerations. Image illustrates an arrow labeled "least efficient" to "most efficient" in light gray with three blue boxes underneath.]

The third consideration for the procurement of medication workflow is obtaining the medication:

- Goal: Minimize the time between patient wants to start treatment and initiation of treatment.
    - Narrow "window of tolerance" means the treatment team needs to be READY!
- Options from least efficient to most efficient:
    - Send Rx to pharmacy, patient picks up.
    - Send Rx to pharmacy, team picks up, stores, brings to patient.
    - Send Rx to pharmacy, who delivers to office, brings to patient.

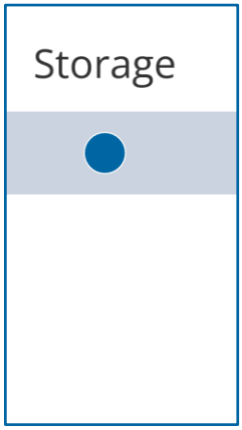


[Slide Image Description: This slide shows Storage and Transporting Medications to Treat SUD in a Field Setting- Workflow Considerations with three blue dots and a colorful arrow.]

Workflow considerations for storage and transporting medications to Treat SUD in a field setting:

- Storage
- Inventory Tracking
- Transporting

Medication Storage



» **Controlled Substances Considerations:**

- Secure location behind two locked doors (cabinet, safe, locked room).
- Access restricted to authorized licensed personnel ONLY.
- If refrigeration needed for medication, it must also lock.

» **General Medications Considerations:**

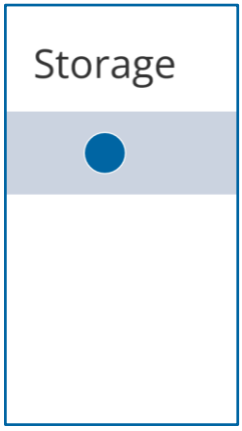
- Secure location behind two locked doors.
- Accessible only to designated personnel.
  - Many practices have same restricted list regardless of controlled substances.
- Many practices require non-licensed people to be with a licensed person in the medication room or area.

[Slide Image Description: This slide outlines the Medication Storage. Image illustrates a dot labeled “storage” outlined in a blue box.]

The first consideration for the storage and transporting medications to treat SUD in a field setting workflow is medication storage.

- Controlled Substances Considerations:
  - Secure location behind two locked doors (cabinet, safe, locked room).
  - Access restricted to authorized licensed personnel ONLY.
  - If refrigeration needed for medication, it must also lock.
- General Medications Considerations:
  - Secure location behind two locked doors.
  - Accessible only to designated personnel.
    - Many practices have same restricted list regardless of controlled substances.
  - Many practices require non-licensed people to be with a licensed person in the medication room or area.

Medication Storage (Continued)



» Buprenorphine (Sublocade) and naltrexone (Vivitrol) long-acting injectable must be refrigerated unless administered within 7 days. Stable at room temperature (59° - 86° F) for up to 7 days.

- Refrigerator at 35.6° - 46.4°:
  - No food or other items can be stored in same fridge as patient medications.
  - Fridge must lock.
  - Temperature log policy must be developed.
- Once removed from the refrigerator, Sublocade can remain at room temperature for up to 12 weeks.

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[Slide Image Description: This slide outlines the Medication Storage. Image illustrates a dot labeled “storage” outlined in a blue box.]

Buprenorphine (Sublocade) and naltrexone (Vivitrol) long-acting injectable must be refrigerated unless administered within 7 days. Stable at room temperature (59° - 86° F) for up to 7 days.

- Refrigerator at 35.6° - 46.4°:
  - No food or other items can be stored in same fridge as patient medications.
  - Fridge must lock.
  - Temperature log policy must be developed.
- Once removed from the refrigerator, Sublocade can be stored at room temperature for up to 12 weeks before being discarded. Thus, if a patient is not able to get their medication at the initially scheduled appointment, there is a 4-month window to reengage and initiate the medication.

Inventory Tracking

» Recommend for Controlled Substances:
- Sign in: date, time, medication (and for who), personnel name, signature.
- Sign out: same information.
- Determine a process owner that does inventory and log review at planned intervals.

SOURCE(S): National Archives and Records Administration, 2026.

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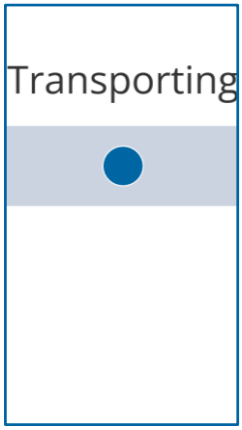
[Slide Image Description: This slide outlines the Inventory Tracking. Image illustrates a dot labeled “inventory tracking” outlined in a blue box.]

The second consideration for the storage and transporting medications to treat SUD in a field setting workflow is inventory tracking.

- Recommend for Controlled Substances:
  - Sign in: date, time, medication (and for who), personnel name, signature.
  - Sign out: same information.
  - Determine a process owner that does inventory and log review at planned intervals.

SOURCE(S): National Archives and Records Administration, 2026.

Transporting



- No restrictions on who can transport medicine (even controlled substance).
- Recommend freezer bag with ice packs if transporting Sublocade, Brixadi, and/or Vivitrol due to potential extended temperature increases in a vehicle beyond 86° F.

SOURCE(S): Braeburn Inc., 2025; U.S. Food and Drug Administration., 2023; U.S. Food and Drug Administration., 2026.

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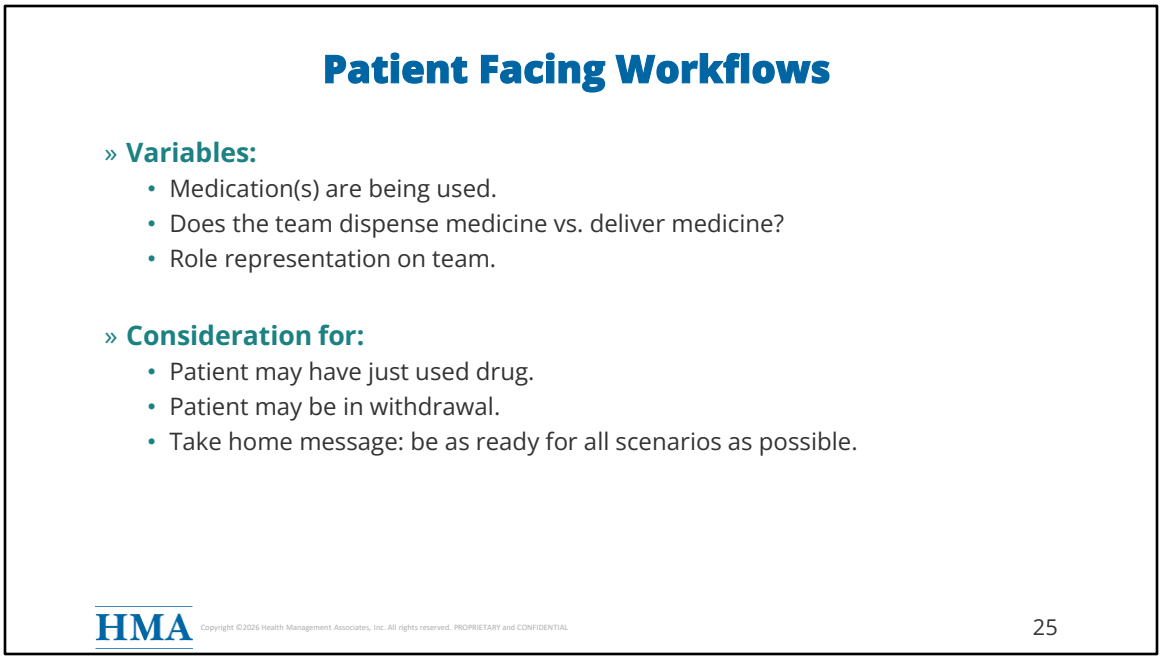
[Slide Image Description: This slide outlines the transporting. Image illustrates a dot labeled “transporting” outlined in a blue box.]

The third consideration for the storage and transporting medications to treat SUD in a field setting workflow is transporting.

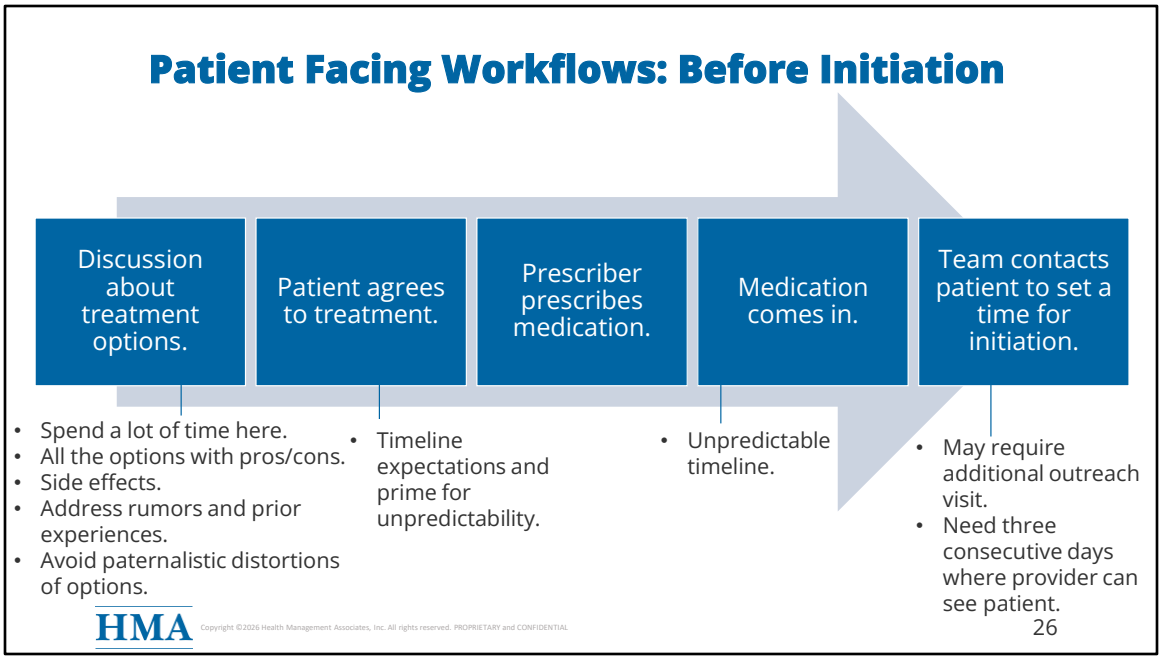
- No restrictions on who can transport medicine (even controlled substance).
- Recommend freezer bag with ice packs if transporting Sublocade, Brixadi, and/or Vivitrol due to potential extended temperature increases in a vehicle beyond 86° F.



[Slide Image Description: This slide outlines the patient facing workflows.]

Variables:
- Medication(s) are being used.
- Does the team dispense medicine vs. deliver medicine?
- Role representation on team.

Consideration for:
- Patient may have just used drug.
- Patient may be in withdrawal.
- Take home message: be as ready for all scenarios as possible.



[Slide Image Description: This slide shows the Patient Facing Workflows: Before Initiation in three colorful boxes with an arrow.]

Considerations for patient facing workflows before initiation:

- Discussion about treatment options.
    - Spend a lot of time here.
    - All the options with pros/cons.
    - Side effects.
    - Address rumors and prior experiences.
    - Avoid paternalistic distortions of options.
- Patient agrees to treatment.
    - Timeline expectations and prime for unpredictability.
- Prescriber prescribes medication.
- Medication comes in.
    - Unpredictable timeline.
- Team contacts patient to set a time for initiation.
    - May require additional outreach visit.
    - Need three consecutive days where provider can see patient.

Drug Toxicology: Pearls and Pitfalls

» Considered point of care testing → **Clinical Laboratory Improvement Amendments (CLIA) Waiver required, test must be added.**

» **Which test:**

- Each urine drug screen has its own procedure.
- Prioritize short reading times (e.g., McKesson UDS- 2 minutes).
- Prioritize simplicity of reading (e.g., McKesson peel back labels on UDS to read result).
- Beware of variation of accuracy.

» **Who or When to Test:**

- Many street medicine teams do not require UDS every time compared to many clinics often test routinely for a range of reasons.

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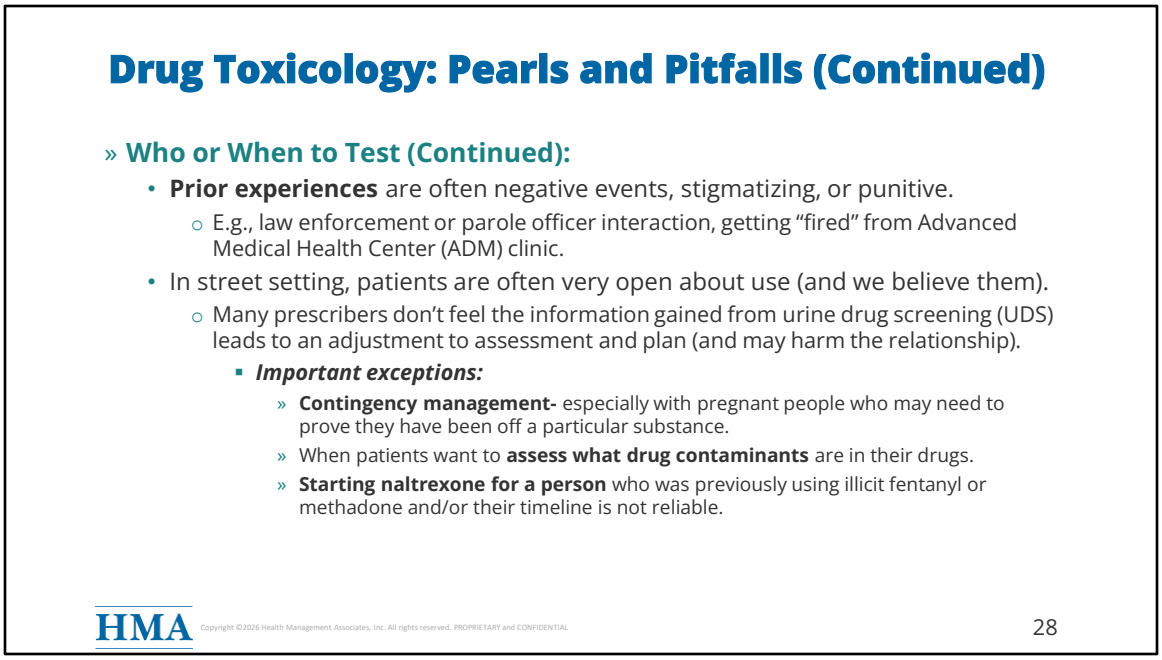
[Slide Image Description: This slide lists drug toxicology pearls and pitfalls.]

See the following for drug toxicology:

- Considered point of care testing → Clinical Laboratory Improvement Amendments (CLIA) Waiver required, test must be added.
- Which test:
    - Each urine drug screen has its own procedure.
    - Prioritize short reading times 9e.g. McKesson UDS- 2 minutes).
    - Prioritize simplicity of reading (e.g. McKesson peel back labels on UDS to read result).
    - Beware of variation of accuracy.
- Who or When to Test:
    - Many street medicine teams do not require UDS every time compared to many clinics often test routinely for a range of reasons.



[Slide Image Description: This slide lists drug toxicology pearls and pitfalls.]

Who or When to Test (Continued):

- Prior experiences are often negative events, stigmatizing, or punitive.
    - E.g. law enforcement or parole officer interaction, getting "fired" from Advanced Medical Health Center (ADM) clinic.
- In street setting, patients are often very open about use (and we believe them).
    - Many prescribers don't feel the information gained from urine drug screening (UDS) leads to an adjustment to assessment and plan (and may harm the relationship).
        - Important exceptions:
            - Contingency management- especially with pregnant people who may need to prove they have been off a particular substance.
            - When patients want to assess what drug contaminants are in their drugs.
            - Starting naltrexone for a person who was previously using illicit fentanyl or methadone and/or their timeline is not reliable.

Patient Facing Workflows: Initiation

- Recommend prescriber is there for every initiation.
  - Review all the treatment options, including the one they chose.
  - Review the plans for after Day 1 initiation.
- If injection, follow regulations on who can give specific types of injections by regulatory bodies and internal policies.
- Always in pairs (at minimum).
  - Person administering the medication.
  - Person performing situational awareness and supporting partner.

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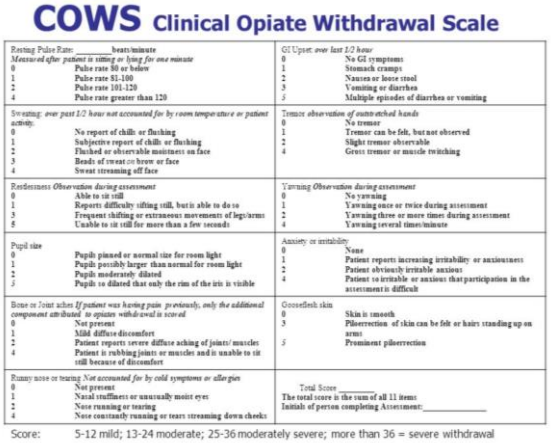
[Slide Image Description: This slide outlines the Patient Facing Workflows: Initiation.]

Considerations for patient facing workflows during initiation:

- Recommend prescriber is there for every initiation.
  - Review all the treatment options, including the one they chose.
  - Review the plans for after Day 1 initiation.
- If injection, follow regulations on who can give specific types of injections by regulatory bodies and internal policies.
- Always in pairs (at minimum).
  - Person administering the medication.
  - Person performing situational awareness and supporting partner.

Patient Facing Workflows: Initiation (Continued)

- Recommend prescriber (in person or via telemedicine) is there for every initiation.
- Review all the treatment options, including the one they chose.
  - Confirm their choice and obtain verbal consent to proceed (document).
- Perform vitals.
- Perform COWS assessment.
- Assess last use.
- If using injection, prepare medication and be sure to have a sharps container.



COWS Clinical Opiate Withdrawal Scale

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 Pulse rate 80 or below 1 Pulse rate 81-100 2 Pulse rate 101-120 4 Pulse rate greater than 120	GI Upset: *over last 1/2 hour* 0 No GI symptoms 1 Stomach cramps 2 Nausea or loose stool 3 Vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 No report of chills or flushing 1 Subjective report of chills or flushing 2 Flushed or observable moistness on face 3 Beads of sweat on brow or face 4 Sweat streaming off face	Tremor *observation of outstretched hands* 0 No tremor 1 Tremor can be felt, but not observed 2 Slight tremor observable 4 Gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 Able to sit still 1 Reports difficulty sitting still, but is able to do so 3 Frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds	Yawning *Observation during assessment* 0 No yawning 1 Yawning once or twice during assessment 2 Yawning three or more times during assessment 4 Yawning several times/minute
Pupil size 0 Pupils pinned or normal size for room light 1 Pupils possibly larger than normal for room light 2 Pupils moderately dilated 5 Pupils so dilated that only the rim of the iris is visible	Anxiety or irritability 0 None 1 Patient reports increasing irritability or anxiousness 2 Patient obviously irritable anxious 4 Patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 Not present 1 Mild diffuse discomfort 2 Patient reports severe diffuse aching of joints/ muscles 4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort	Gooseflesh skin 0 Skin is smooth 3 Piloerrection of skin can be felt or hairs standing up on arms 5 Prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 Not present 1 Nasal stuffiness or unusually moist eyes 2 Nose running or tearing 4 Nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing Assessment:_____
Score: 5-12 mild; 13-24 moderate; 25-36 moderately severe; more than 36 = severe withdrawal	

SOURCE(S): Wesson, et al., 2003.; Medication Use Improvement Committee, 2025.

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[Slide Image Description: This slide outlines the Patient Facing Workflows: Initiation. Image illustrates the COWS Clinical Opiate Withdrawal Scale. The COWS assessment includes resting pulse rate, sweating, restlessness, pupil size, bone or joint aches, runny nose or tearing, GI upset, tremor, yawning, anxiety or irritability, gooseflesh skin, and space to calculate score. Scores: 5-12 mild; 13-24 moderate; 25-36 moderately severe, more than 36 = severe withdrawal.]

Considerations for patient facing workflows during initiation:

- Recommend prescriber (in person or via telemedicine) is there for every induction.
- Review all the treatment options, including the one they chose.
  - Confirm their choice and obtain verbal consent to proceed (document).
- Perform vitals.
- Perform COWS assessment.
- Assess last use.
- If using injection, prepare medication and be sure to have a sharps container.

(>4 if direct to inject protocol, >11 for others)

Patient Facing Workflows: Initiation (Continued)

- Review the plans for after Day 1 initiation.
- Go over all the adjunctive medications.

Pro tip:
Either apply matching stickers to bottle or draw shape with sharpie.

Symbol	Symptom (medication)	Instructions (take only if needed)
	Insomnia/Can't sleep (Trazodone 50mg)	1-2 tabs at night as needed for sleep (do not take if sleepy)
	Diarrhea (Loperamide 2mg)	2 tabs after 1st loose stool, then 1 tab every 4 hours thereafter as needed
	Agitated/Restless/Irritable (Clonidine 0.1mg)	1 tab every 12 hours (do not take if dizzy or sleepy)
	Nausea/Vomiting (Zofran 4mg)	1 tab under the tongue every 6 hours as needed
	Anxiety Hydroxyzine 25mg)	1-2 tabs every 6 hours as needed (do not take if sleepy)
	Muscle Spasm (Baclofen 5mg OR Methocarbamol 750mg)	1 tab every 8 hours as needed (do not take if sleepy)

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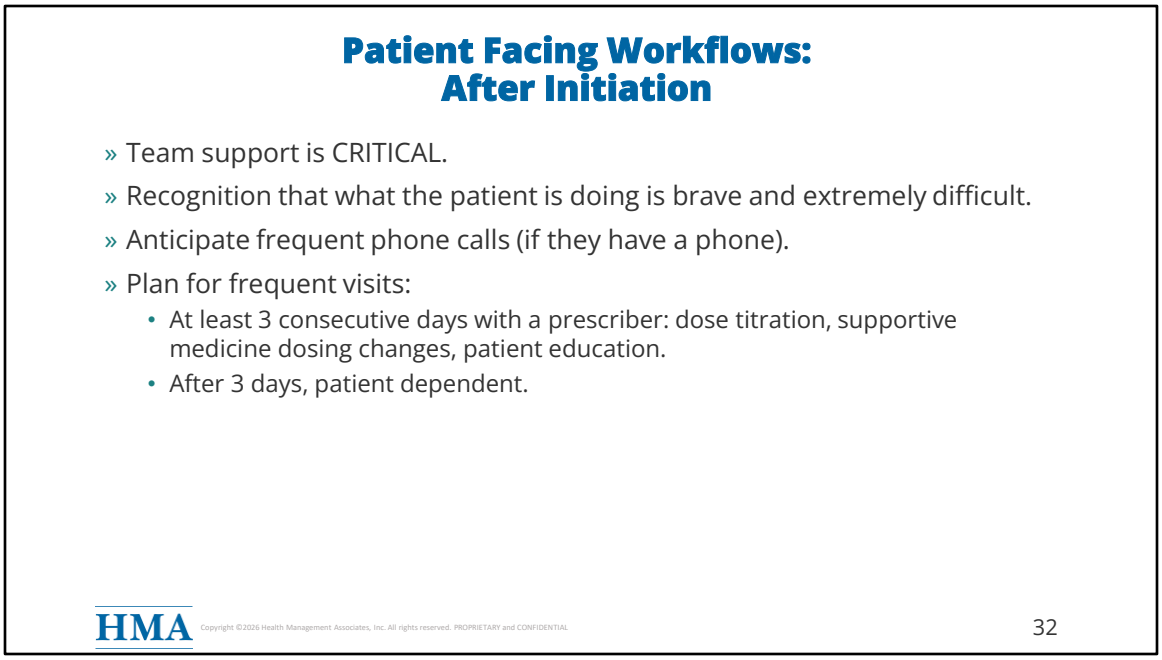
[Slide Image Description: This slide outlines the Patient Facing Workflows: Initiation. Image illustrates the Support Medications outlined in black.]

Considerations for patient facing workflows during initiation:

- Review the plans for after Day 1 initiation.
- Go over all the adjunctive medications.
- Pro tip: Either apply matching stickers to bottle or draw shape with sharpie.



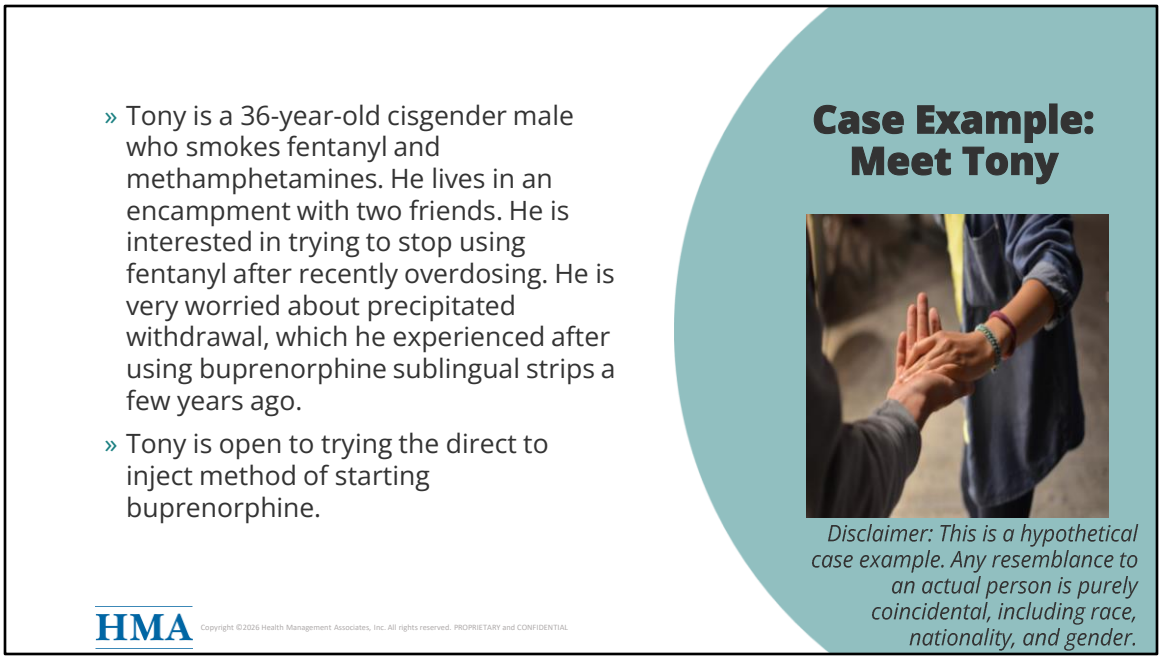
[Slide Image Description: This slide outlines the Patient Facing Workflows: After Initiation.]

Considerations for patient facing workflows after initiation:

- Team support is CRITICAL.
- Recognition that what the patient is doing is brave and extremely difficult.
- Anticipate frequent phone calls (if they have a phone).
- Plan for frequent visits:
    - At least 3 consecutive days with a prescriber: dose titration, supportive medicine dosing changes, patient education.
    - After 3 days, patient dependent.

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

This third section will provide an interactive activity for an ideal workflow.



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

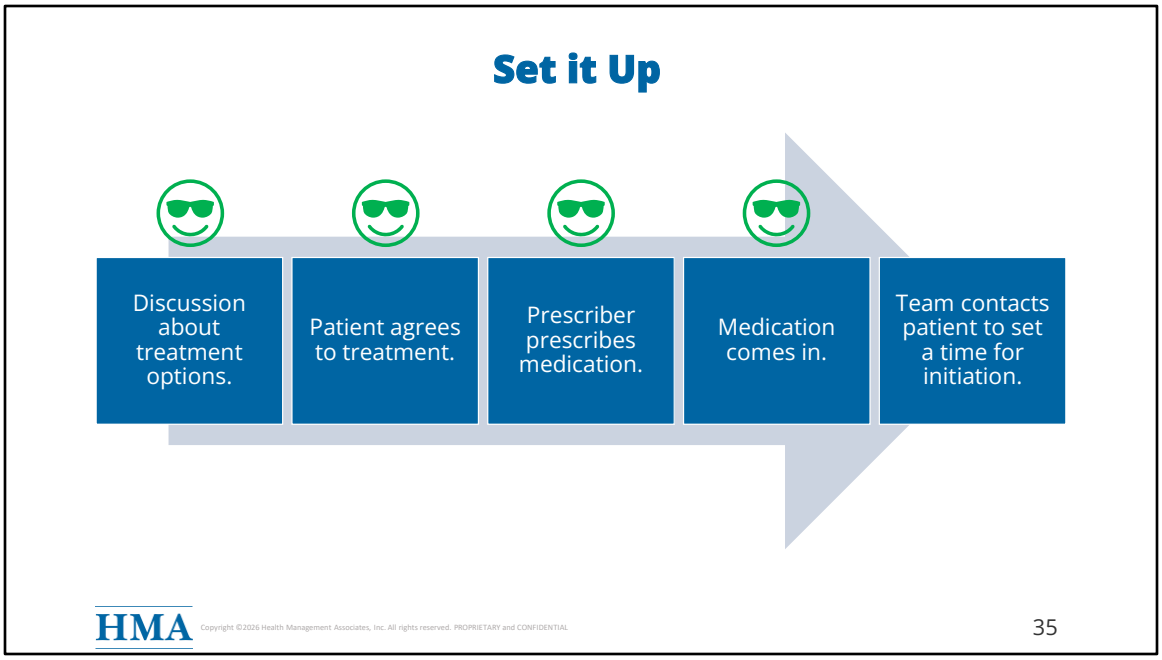
Consider the Case Example, Tony:

- Tony is a 36-year-old cisgender male who smokes fentanyl and methamphetamines. He lives in an encampment with two friends. He is interested in trying to stop using fentanyl after recently overdosing. He is very worried about precipitated withdrawal, which he experienced after using buprenorphine sublingual strips a few years ago.
- Tony is open to trying the direct to inject method of starting buprenorphine.

Starting with medication already inquired:

- Start with case of patient.
- Who is doing education, prescribing, administering, follow-up?

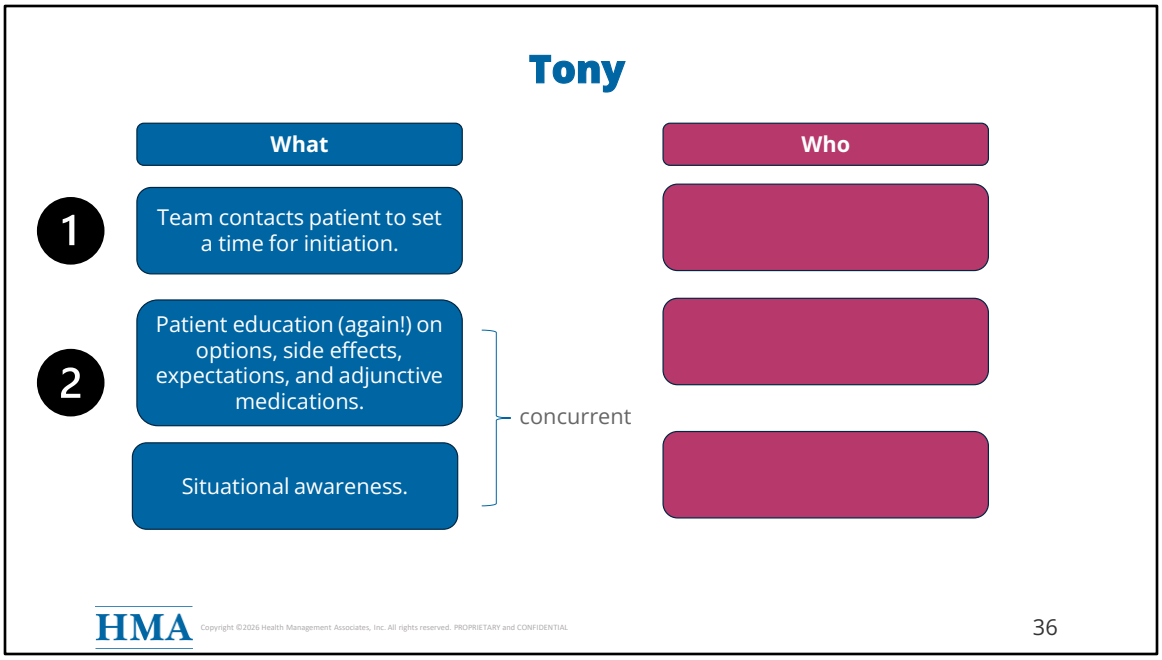
Disclaimer: This is a hypothetical case example. Any resemblance to an actual person is purely coincidental, including race, nationality, and gender.



[Slide Image Description: This slide shows five colorful boxes with an arrow and four green smiley faces.]

Set up the actionable part of the case; green smiling faces indicate these are steps that have already been completed.

- Discussion about treatment options. (Complete)
- Patient agrees to treatment. (Complete)
- Prescriber prescribes medication. (Complete)
- Medication comes in. (Complete)
- Team contacts patient to set a time for initiation.

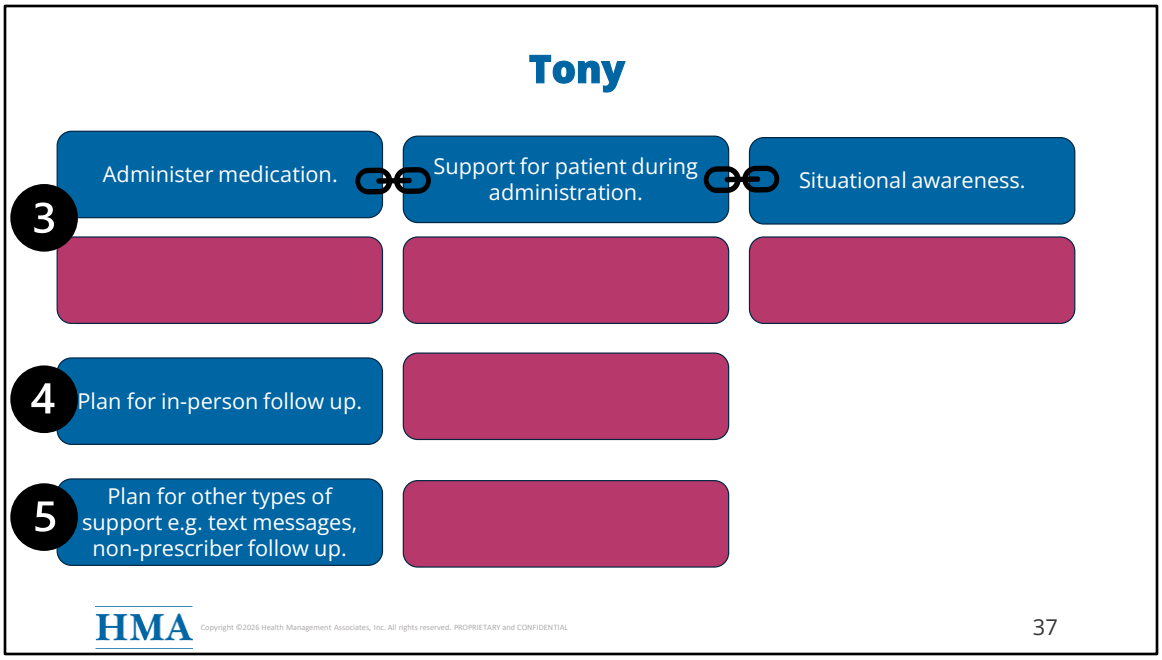


Slide Image Description: This slide shows a workflow for Tony. The image illustrates “what” in four blue colorful boxes and “who” in four pink colorful boxes.]

Team contacts patient to set a time for initiation→ Options: CHW, nursing support, medical assistant, case manager. Recommend it is not the prescriber unless special circumstance.

Patient education again→ Ideally it is the prescriber either via telemedicine or in person because decisions will be made by the patient based on this information. If trained up (meaning, this is a competency that is checked off in a field setting and not a quiet room with sensory control), other team members (depending on training) could be nursing support, others.

Situational awareness → CHW, case manager, housing navigator, drug and alcohol counselor (i.e., whoever is not doing the patient education).



[Slide Image Description: This slide shows a workflow for Tony. The image illustrates the linkages of administer medication, support for patient during administration, and situational awareness in three blue colorful boxes. The image also illustrates five blank pink boxes with two more blue boxes.]

Administer medication – based on licensing and available supervision. Medical assistant can deliver injection (IM, SQ, ID) but cannot administer lidocaine (so no field blocking for Sublocade administration) AND a prescriber must be physically on site during the injection; cannot supervise via telemedicine. Nursing support, prescriber.

Support during administration, if personnel available→ The other person who is not administering the medication or providing situational awareness.

[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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