Designing The OUD Cascade Of Care: What Works In Real-World Provider Setting

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Dr. Buttlaire 0:00

Good afternoon and welcome. I'm Dr Stuart Buttlaire, Vice President of Clinical Excellence in leadership at open minds. Thank you for joining us today, designing the oud cascade of care what works in real world provider settings. Today's session is part of Recademy's 12 part educational webinar series for 2026 focused on advancing evidence based opioid use disorder treatment and transitioning research into real world clinical, operational and system level practice. The Academy series is designed for providers, health systems, payers and policy leaders who are working to improve access, engagement and outcomes for people with opioid use disorder, particularly in the environment of increasing clinical complexity, workforce constraints and financial pressures. This session is intentionally structured as a fireside chat rather than a formal presentation, with a focus on practical lessons learned across emergency departments, residential programs, outpatient care and justice involved populations. So why does this topic matter? Well, despite major advances in medications for opioid use disorder, the national picture remains sobering. Across multiple studies and care settings, we continue to see steep drop offs at every stage of treatment. Only a minority of people diagnosed with oud ever initiate moud. Fewer than half remain engaged beyond the first 90 days, and only a small fraction achieve sustained retention at one year. These gaps aren't abstract. They show up every day in emergency departments, hospital discharges, detox and residential transitions and following release from incarceration, points where overdose risk is the highest and continuity of care is the most fragile, the oud cascade of care gives a framework to understand these patterns more clearly, rather than viewing engagement or relapses and individual failure, the cascade asks us to examine our system design. Where do people fall out of care? What happens at hand, offs and transitions, which workflows, staffing models and clinical strategies improve continuity, importantly, the cascade reframes oud treatment as a longitudinal system of care, not a single medication decision or episode of treatment for provider organizations, this is not only a clinical issue, it's an operational and strategic even modest improvements at one stage of the Cascade, earlier initiation, better stabilization, stronger transitions, can significantly reduce overdose risk, improve outcomes and support program sustainability. The challenge is even more acute in fentanyl era, where traditional induction and engagement models are under pressure and early instability drives dropouts. Today's discussion will focus on practical experience based insights into how organizations can strengthen the cascade across settings and populations. And I'm delighted to be joined by Dr Heidi Ginter. Dr Ginter is the medical director of Addiction Medicine at Cadia healthcare. She is a board certified in family medicine and addiction medicine. She brings nearly two decades of experience treating substance use disorders across a wide range of care settings. Dr Ginter earned her undergraduate degree from Yale University, her medical degree from the University of Maryland School of medicine, and completed her family medicine residency at the University of Massachusetts, Chan School of Medicine, early in her career, while practicing full spectrum family medicine at a community health center in Worcester, Massachusetts, she was introduced to addiction medicine through caring for incarcerated pregnant patients with opioid use disorder, an experience that profoundly shaped her career trajectory and commitment to improving care for highly vulnerable populations. She went on to launch her health center's first buprenorphine treatment program, and has since provided medical leadership across opioid treatment programs, inpatient

withdrawal management, residential treatment, outpatient office based programs and hospital addiction services. Throughout her career, Dr ginters work has focused on building bridges across levels of care, improving continuity, reducing stigma, and expanding access to respectful evidence based treatment. She is new. Nationally recognized speaker and advocate for improving public understanding and substance use disorders and their treatment. We're very pleased to have her with us today. Welcome. Dr Ginter, I have some questions for you.

Dr. Ginter 5:14

This is great. Thank you so much. Dr Valais, this is really exciting, and I'm glad we're going to be able to have this conversation.

Dr. Buttlaire 5:21

Well, thank you. And so I'm going to start this off with this framing, the cascade, which is when you think about the oud cascade of care. Where do you you know most commonly see patients fall out in real world settings, and why do those gaps persist despite all of our good intentions. And secondly, how does stigma play a role in retention?

Dr. Ginter 5:49

I think that we see most people falling out of care in it's almost like the rule of fours, the first four weeks when they initiate care, or the initial four weeks after leaving a very structured form of care. And I think that those two places are the highest risk places where people fall out of treatment. One reason is because they are still sick. So when somebody comes into treatment having fentanyl use disorder or any street opioid use disorder, they are often very worried about experiencing withdrawal, and if they sense that you get it and that you're going to offer them aggressive titration onto medication that is going to help manage their withdrawal, then they're all in. But if their experience is that their dose is staying too low, it's not changing fast enough, or they're not being treated as if they are really a person who has a chronic medical problem and needs chronic care is if it's more of a feeling of an episodic type treatment, then they may start to get this idea that, well, I'm just going to detox, I'm going to just go on medicine for a few weeks and then come off. And I think that giving people the right message about what works to really reduce overdose deaths. What is opioid use disorder? Like you said, it's not a personal failing. It is a chronic disease of the brain. It is a chronic behavioral health condition that has evidence based care associated with it. And then this other piece about stigma is just it's everywhere, and people have stigma toward themselves, about being individuals with a substance use disorder, but they also have stigma toward the medicine that we use to treat it, and that is so hard because a lot of people will initiate medication with this statement that I just want to be On this for a short time. I'm going to come off this real fast. And that's really sad, because there's so much missing from that discussion. And I think that giving people the opportunity to have a comparison with another chronic disease that is quite deadly, quite known, quite in the community where many people understand this is serious, this needs treatment can sometimes help people see, I will often compare opioid use disorder to diabetes, for example, and say, Hey, both of these are chronic diseases, and the treatment for diabetes may start out to be diet, exercise, weight loss, and in the same way, opioid use disorder, some people try to treat it with behavioral interventions. And when these conditions are continuing to progress and the behavioral interventions may not be making enough of a difference we add medications. But if I say, Hey, your diabetes is, you know, getting to a point where we need medicine, let's talk about Metformin, or let's talk about insulin, you feel really different than if I say your it seems like your opioid use disorder isn't really getting to a place where you're meeting your recovery goals. Let's talk about buprenorphine. Let's talk about methadone. People get tense. They get anxious because I don't want to be on that medicine. I don't want to be associated with those people, whereas we just don't have that same baggage associated with medicines for diabetes. So two chronic diseases that can cause death in people when they are not managed, but we just feel so differently about the treatment for diabetes than we do for methadone. So the stigma piece is huge, yeah, so

Dr. Buttlaire 9:53

it's not only managing it and thinking about it as an illness and. Medical condition, but it's also the really, the subjective sense that people have, as well as providers have, about this disorder,

Dr. Ginter 10:10

yes, and I think the, you know, we talked a fair amount about the initiation of treatment being really critical to making sure that somebody has a good experience, not only from the care that they're getting, so that they get on a medicine and they get to a stable dose quickly, but that they also get that psycho education about what helps support recovery, and how can we in this organization meet your needs, not just for medication, but also potentially for CO occurring disorders or other co occurring substance use disorders. And what else is going on from the perspective of social determinants of health? Sometimes individuals are they don't want to say that they're experiencing homelessness or that they have food insecurity or that they have transportation barriers. They I think sometimes want to sort of sink into the background and not make too much, too many waves. And I think that if we create a space where it's safe to define whatever is impacting your substance use as fair game for our treatment is really important, because then people can have an authentic and genuine relationship, where they come with their needs, and we help meet those needs without judgment. I think one piece that also happens talking about that at the end of treatment, oftentimes, people really want a quick fix. They want to be able to go into a residential program for 30 days and then say, hey, you know, I tapered off my medication, and I'm I'm sober and I'm good, like, you know, get me out of here. Get me back to my regular life. And I don't think a lot of people have the knowledge and experience of understanding that having no tolerance after you've been in a residential program and tapered off your medication really puts you at risk for overdose if you have a return to use in those first few weeks, leaving residential or leaving an incarceration. And so I think back to the education an individual who has this very serious disease of opioid use disorder should also have the knowledge that they need to manage it and to advocate for their needs, and we should be providing evidence based care so that people don't end up at risk when they leave these more restrictive type settings for care.

Dr. Buttlaire 12:33

And that leads me to our next question is, how does viewing oud treatment through a cascade lens change? How organizations think about accountability compared to a traditional program by program approach.

Dr. Ginter 12:47

This whole idea of cascade of care is so important because people will enter the cascade at a variety of different places. Some people will enter through the ER, some people will enter through a traditional I know we tend to call them detoxification locations, but it's really medically managed withdrawal, and it really probably should be, instead of a withdrawal management we really probably should be calling those locations places to initiate or induct onto MOU D. But whether you're going in through the mental health side or the ER side or the addiction side, or even primary care or even street outreach, wherever somebody is contacted with an opportunity to engage in care, they should have all the care options available. And it, I think, you know, there's, it's interesting, because there's this beauty of any open door being the right door. But the reality is that some open doors aren't the right door, and it would be much better if we could have all the open doors be true places where the initiation of Mo, you d, could happen seamlessly, or that somebody would get information about the options and then have a really tight, warm hand off to a place where that could be started, rather than a sort of rapid turnaround. Or, you know, like, not we're not the right place. Or, you know, thanks for showing up, but we are out at 4pm and so you came at 405, we can't help you come tomorrow. Or our facility doesn't have the licensure to provide that medication. Or my providers aren't trained. They don't feel comfortable initiating. And you think, Oh, my goodness, this person came in and was vulnerable and asked for help, and now we're going to send them out without the help like no each place where someone shows up needs to be a place that is a warm open door that welcomes

them into care and provides the care right there, or a very warm handoff to care that they can initiate. Now I think when somebody is ready for change, when they are ready, they are voting with their feet. They are voting with their voice to walk into the organization and say, hey, something needs to change. I need help. Help should be there, and the help should be the evidence based care that we know works, and it should be tailored to the individual's needs from an assessment perspective, thinking about the ASAM criteria, but also acknowledging that not everybody wants what the ASAM criteria says they are eligible for, and so meshing the eligibility with the patient's choice is part of that person centered consideration that the new ASAM guidelines have as that number six. So I think both of those pieces are important, and a lot of locations just don't have the knowledge or the skill or the tools to do that, yet, there's a hot a lot of opportunity there.

Dr. Buttlaire 15:59

So really, we need to meet the person, even though they open the door with expert care, and if it's not expert in that setting, for them to at least know where to send the patient so they can get immediate care and the best type type of care.

Dr. Ginter 16:16

Yes, and I think one of the challenges also becomes so what's the patient's healthcare coverage? If you know exactly in your community which places provide evidence based care, you also should know which places will accept the insurance products that the patients you're serving have, because you can do a beautiful job of making a warm handoff to a place where they're not going to be able to afford to get treatment, or the treatment that they want isn't covered by their insurance provider, or it's out of network, or there's some sort of barrier, and another barrier that often comes up is transportation. So the patient came to this, er, because that's in their neighborhood and that's close, but their er doesn't have a protocol in place to allow for using, for example, the 72 hour rule to initiate methadone, and they haven't established connections with opioid treatment programs to start a methadone dose using the 72 hour rule and then refer So what they say is, well, just go to the methadone clinic tomorrow. But how's the patient going to get there? And are you really going to let somebody leave the ER when they came in with a potentially life threatening disease with no treatment? You know, at least, let's talk about harm reduction. At least, let's acknowledge that if this individual continues to use they may overdose and die. So how can we engage them right now in something that will potentially change the trajectory of this illness until they can get into more definitive care? So making sure that nasal naloxone is available at every location of care that anyone who's ever used an opiate should have a couple doses on hand all the time, and so anywhere they go, they should not leave without nasal naloxone. Secondarily, the message about never using alone is really important, because an individual who overdoses alone dies alone, but an individual who overdoses when another person is present and has planned for that can survive the overdose. And so making sure that people understand the stigma associated with using drugs is real, and many people don't want to use with other people, not only because their stigma, but sometimes they don't want to share their drugs. It's pretty expensive to maintain a habit, and there are services like safe spot, for example, that allow for someone to be on a phone and have a remote person who is in recovery providing that support. So in the event that the individual who is using has an overdose, they can send EMS, and that person is not going to die from that decision to use alone. And so I think those two pieces, nasal Naloxone and never use alone, are two messages that anyone with opioid use or opioid use disorder should hear at any location where they go.

Dr. Buttlaire 19:17

You know, you started talking about the barriers, including transportation knowledge, you know, in terms of timely initiation of Mo, u, d, you know, what are some of the biggest barriers you see in terms of emergency departments, hospitals and residential settings, and which of those are most fixable? Oh, it's

Dr. Ginter 19:39

such a good question. So I am an optimist by design, and so I feel like they're all fixable. And I think it starts with education. It starts with making sure that each of these locations understands that the past way that they have been used to address. Saying individuals with substance use disorders is not the current way. So individuals who have substance use disorders are very much like individuals who have heart disease, that there is a body of evidence that is really solid to treat people, prevent death, prevent morbidity such as hepatitis C, severe infections, and reduce the overall harm associated with the disease. Just like we have evidence based treatment for an individual who has cardiac disease, we know what to do when somebody comes into the ER with chest pain, we should know what to do when somebody comes in the ER after an overdose or requesting treatment. And it really should be very similar no matter where they go. And I think that being able to initiate MOU D, which is currently the standard of care for best practice to engage somebody, reduce their withdrawal symptoms, reduce their risk of overdose and death. Should be available whatever door someone walks in, so whether you walk into a residential program or medically managed withdrawal or a dual diagnosis facility that is doing mental health care as well as substance use treatment or an ER or primary care office or an urgent care, every one of these locations should have the ability to initiate buprenorphine or initiate methadone after having a conversation with the individual about what their preference is, and if they're on the fence, then wait a few minutes, see another patient, and then go back and ask them again, because engagement is really important.

Dr. Buttlaire 21:40

So I hear the optimism and and what should be. But why do you think it's not happening? Since it's it's so much out there and we understand what would be basic good care. So why isn't it happening in all those settings?

Dr. Ginter 21:58

I think there are probably two major reasons, and one gets back to stigma, and the other gets back to lack of knowledge. Some of the lack of knowledge is that, for buprenorphine, for example, there are some providers who still aren't aware that the x waiver has been eliminated, that all medical providers, whether you are an MD, a do an NP or a PA, can prescribe buprenorphine so you do not need an X waiver. All you need is your regular DEA for the state where you work. I think that piece is huge. I think another piece is that people don't understand the regulations around methadone. They often think that from an ER, for example, that we're not licensed to provide methadone, and that statement is false. So you actually are. You're a hospital, and so there is not the same burden of regulatory licensure for an OTP, which is an Opioid Treatment Program outpatient, where we provide methadone for opioid use disorder that hospital needs. Just by virtue of being a hospital, you can provide methadone using the law, the 72 hour rule, to initiate that care for an individual who wants to be on MOU D and then refer them in the community, so understanding what the laws are and what the reality is compared to what the current practice is, I also think there's back to the stigma. Is a lot of people have still been introduced to the idea of substance use disorder in a really negative way, where, like the treatment of an abscess, for example, really interesting. You can do a procedure, you can put someone on antibiotics, you can watch it get better, and treating diabetes, complicated, fascinating. A lot of different medicines, a lot of different, you know, systems within the body that you can manipulate and and it's really interesting intellectually. And I think people are curious and sort of want to see people get better and like that piece of it. And I don't know that medical providers have had the same kind of introduction and experience of how rewarding and really amazing the treatment of opioid use disorder can be when you see somebody come in and just you think, Oh, my goodness, this poor individual like the suffering that they've experienced. But within two weeks, they've now got their job back. They got their car out of the impound. They are starting to engage in custody dialogs with the children who were removed from them when they were using like to watch somebody's life turn around on a dime with medications for opioid use disorder. It there's nothing in medicine that works faster or better and watching someone regain their life before your eyes like there's no diabetes that gets better that fast. There's no one's hemoglobin, a 1c That's going to go down below whatever range Their goal is. Similarly with blood pressure, like putting someone on an additional dose of lisinopril,

or increasing the calcium channel blocker, adding the diuretic, you can do all of that, and the person still looks the same. They still have the high blood pressure. They still have. You know, you got to see them again in three months, an individual who starts methadone and is able to get their use under control or stop using completely. It's magic, and to be next to somebody and walking that path as they change their life before your eyes, all you have to do is see that once, and you will never want to avoid the care again. But I think until you're introduced to the the real joy of assisting somebody in their recovery path, it feels like a burden, and so I wish more providers had the opportunity to see recovery happen, rather than seeing that sort of cycle of people coming in and not getting better, like when you see people get better, you know, oh gosh, I got to participate in this. This is amazing.

Dr. Buttlaire 26:08

Thank you. And you know, in the fentanyl era, you know, things are more complicated. You know, how have induction and early stabilization challenges changed engagement patterns in the first 30 to 90 days of treatment with fentanyl and other drugs like it. There's newer ones coming out all the time. I understand,

Dr. Ginter 26:29

yes, and you know, we've got to try to stay on top of what is happening within our communities. And as the synthetic opioids become more and more potent, it gets harder and harder to initiate medicines like buprenorphine and methadone tends to be the first line choice because there isn't that risk of precipitated withdrawal at the time of initiation. But interestingly, there are so I'll talk about these two medication pathways separately. On the buprenorphine side, we've learned so much in the fentanyl era about creative ways to initiate buprenorphine so that you don't put someone at risk for precipitated withdrawal. Some of those protocols are we used to call them micro dosing. It's now low dose initiation where you can have an individual who is continuing to use fentanyl, and we are initiating very small doses of buprenorphine daily to a point where they're on a stable buprenorphine dose that they're taking by mouth, and then they can extinguish their fentanyl use and be directly on buprenorphine without having to go into withdrawal. The other thing that's happened with the buprenorphine, not just the kind that you can stick under your tongue or in your cheek, is we have those long acting injectable buprenorphine options. And so there are a couple of different protocols where an individual can initiate a long acting buprenorphine in the emergency department at the time, where they're still using fentanyl, but not insignificant withdrawal, and not use buprenorphine under the tongue or in the gum, and then follow up within a week and initiate the films at that point if they want or continue the injectable so we have these and then there's all kinds of ways to transition from methadone over to buprenorphine or methadone to the injectables, but there's much more availability of creative induction onto buprenorphine products than we ever had before. And so if a person has had an experience with getting onto buprenorphine, that was bad, where they say, I'm not touching that that made me have precipitated withdrawal, not doing that again. I'll often say, Hold on a minute. Things are different. Now. Let's talk through some other options, I think on the other side with methadone. In the past, those of us who are initiating methadone were so careful not to put somebody at risk for methadone overdose because we were titrating too fast. And so there was a lot of discussion about, you know, start low, go slow. So you'd start at the maximum. Used to be 30 milligrams daily, unless you had the ability to observe and do a second dose of 10. So a total of 40 in the outpatient setting. And then every three days, go up by five milligrams, and that is not working for fentanyl. So fortunately, when the SAMHSA final rule came out with the changes to the starting dose, we now can initiate methadone at 50 milligrams a day or higher, if you document that the experience the patient has had with the 50 milligrams or with their prior methadone treatment didn't suppress their withdrawal, you can go higher, so we don't have that initial barrier. And then there are a lot of studies looking at how to rapidly induce somebody to a much higher dose, much more quickly. And. Getting them, maybe from 50 to, say, 80 or 100 milligrams within the first week, and then pausing to allow for that steady state stabilization before increasing again. And so those places that are willing to try some of these new, more aggressive and progressive ways of engaging patients to induce them onto these medications in a way that doesn't cause them to have prolonged withdrawal, or doesn't cause them to feel like they've got a white knuckle it through the precipitated withdrawal. And so there's just like, as

you get some success, and as talk on the street starts to happen, then more people will come in because they're saying, Oh, that place. They actually know what they're doing. I got, I got feeling better fast. Or, Hey, she tried me on that injection really fast. I didn't know that was possible. So I think the more of us do this, the more energy there's going to be in, the more talk. And then a little bit of peer pressure starts to happen. So other companies or other care locations start to say, hey, we're we're actually losing patients to that place because they're doing something we're not doing.

Dr. Buttlaire 31:09

Well, let's move on to retention and clinical complexity from your experience. What distinguishes organizations that achieve better 90 and 12 month retention from those that that really don't you had a lot of experience with organizations, so I think probably you have a good sense of that, even when serving similar populations.

Unknown Speaker 31:32

I think a lot of it

Dr. Ginter 31:33

is the approach. Are you as an organization very defined by meeting the patient's need, if you are caring for that patient, and having that be your your focus primarily. That's going to be the thing that drives the culture. It's going to be the thing that drives the reputation that you get when other individuals start talking about what their experience was with your company, and then it starts to become this word of mouth. There's almost like a tipping point where, as you create a culture that is accepting, that is very individualized, very patient centered, and getting results, where patients are going to talk and say about how wonderful their experience was that makes a huge difference. There also is something about getting on the right dose fast. When people are able to achieve a comfortable dose of buprenorphine or methadone, rapidly, they feel better physically, but they also feel better toward you as the provider, because now you've given them what they wanted, which is relief. And I think organizations that have that really focus on the patient satisfaction score, looking at the outcomes, are the patients staying, and if they're not staying, why? And then addressing that. So was it that the patient didn't understand they could ask for a dose change? Okay? So maybe that needs to be something that is more automatic, rather than a patient asking and similarly, looking at very individualized care places that have a more cookie cutter approach, is that's a hard sell in 2026 each person is going to define what their recovery is differently, and their needs are going to be different as well, having the idea that every single person needs to attend four groups in four weeks, and then three meetings per week, and Then one individual session like no what needs to happen is shared decision making and engaging patients with understanding what their goals are and then creating a treatment plan that needs those goals. I think those are the organizations that really have that there's like a stickiness to it. Their patients feel very brand loyal because they have been treated with dignity and respect. And so I find that the organizations that are really driving patient care, patient satisfaction and evidence based treatment are in that culture of of doing it right and doing it well, and people will come. If you build it, they will come. And so people do gravitate toward the place that has the reputation for being patient centered.

Dr. Buttlaire 34:26

So you point out two important things. One is person centered treatment, individualized care, and the other is organizations have multiple tools that they're just not cookie cutter, but actually they're trying to match the person's illness and condition and history with what they're providing treatment with

Dr. Ginter 34:45

absolutely I think sometimes the disconnect for some is in what we used to do in the past and what is currently

accepted practice and the standard of care that we're driving toward now. It. Used to be very much, very much driven by a protocol that if you checked these boxes and you had these risks, then you would meet for this level of care, and then once you had completed that level of care, you will now step down to this next level of care. And you know, progressing along the cascade in a very logical and and almost like stair step sort of manner. And the reality is that for some people, that's right, it's exactly what they need and what they want, and it fits their goals and they do it. And for a lot of people, it just isn't. And it tends to be that individuals who are marginalized in their identity, or who are parenting as sole parents, tend to not fit into those traditional sort of categories. And I think of it as if we're talking about like stairs, and you're walking down a set set of stairs, and it's really easy to put one foot down and one foot because the stairs are, you know, they're the height is correct, and the place where you put your foot is all right. It's so easy. But for many people, like our cascade that we are offering to them is almost like one of the stairs is broken. Another one, there's like a big jump. Another one, there's just a tiny little place for your foot, and then you have to turn left and you're about to step and you like a fall. It's like the steps that we put in front of them aren't really matching how they want to walk. And so if we say like, Hey, here's what the cascade has to offer. And let's talk about what your specific needs are to meet your recovery goals, where does this fit in? And and if it's not going to be the nice stair steps, then, like, what stairs do we need to put? Like, what? What additional support do we need? Do you need a shorter shoe? Do we need a bigger stair? Like, how are we going to adapt this system of care so that the parts that work for you are easily accessible, and the things that aren't really going to serve you are not being forced upon you that we are now taking them off of the the menu and adding something that actually does meet your needs. I do think that that you know that patient choice and that person centered consideration is so critical when when really trying to get people to feel engaged and to choose engagement, rather than saying, yeah, no, I'm all set. This was fun, but no, no, thank you. I'm not going to continue

Dr. Buttlaire 37:29

along with that. Is, you know, how do psychiatric comorbidities and poly substance use complicate retention, and what system level response seem to be most effective in your experience.

Dr. Ginter 37:43

This is crucial so many individuals who have substance use disorders also have co occurring psychiatric conditions. And if you thought it was hard to get your substance use disorder treated, wait till you try to get your mental health condition treated. Many individuals not only are on wait lists that are months and years long, but then by the time they get a call, it's for therapy and they have to meet with the behavioral health provider multiple times before they get to the psychiatric prescriber for psychopharmacology intervention, and by the time they get there, they're not well. And so falling off that curve is is very common because we don't have enough providers in the in the pool, and people are on wait lists that are too long and then access to medications that really change the dynamic of the mental health condition that is creating barriers to their recovery, not only from substance use disorder, but from the ongoing mental health condition itself. So I think that individuals with CO occurring disorders are really complicated, and in the ideal world, we would have a parallel treatment trajectory, where treatment for the substance use disorder happens in parallel with treatment for the mental health condition. It used to be that there was this thought that, well, can't really diagnose somebody's mental health condition until they're sober. The New Thought is somebody ain't gonna get sober until you are able to co treat their mental health symptoms and their substance use disorder. And you may not have a an adequate and complete and really rock solid diagnosis, but the symptoms that are interfering with that individual's life trajectory can be treated while you are assessing what their actual diagnosis is and making changes in their medication regimen. But in the ideal world, we would be able to do these things simultaneously, where you have access to excellent mental health care that includes. Includes prescribing and access to evidence based treatment for opioid use disorder and other substance use disorders too. One thing that is challenging is individuals who have severe, persistent mental illness sometimes aren't able to make the call about about staying in care because care doesn't feel safe. And if somebody is not going to engage in care because they're not safe there, we're going to have to treat the mental illness primarily so

that they'll be able to engage in substance use. But on the other hand, there are some people whose substance use is actually helping mitigate the risk of the symptoms that are really bothersome of their severe and persistent mental illness, and so like trying to figure out, from that patient's perspective, if they feel like it is too hard to engage in treatment on one side versus the other because they can't get co occuring treatment, then it's another discussion. What is going to serve you best? Should we focus on your bipolar one, or should we focus on the opioid use disorder? And if you have to choose, patients should be part of that discussion. In the ideal world, though, people shouldn't have to choose. They should get excellent care no matter where they go.

Dr. Buttlaire 41:16

So because it's so many people have comorbid conditions between their mental health disorder and their substance use disorder. Why aren't we seeing more clinics that actually provide both?

Dr. Ginter 41:31

Is such a great question, and I am hoping that some people who are listening to this are thinking, this seems like a good business plan for me, because I do think that being able to provide someone with both simultaneously is critically important. And then we get into the next question, which is, are you able to fund that so to have a good psychopharm provider present who can help with the psychiatric management and a team of people who feel competent to initiate methadone and buprenorphine and other treatments as necessary. But then, once you have somebody stable in a jail or prison or a residential or some sort of place that is more boundaried and restrictive a higher level of care, what happens when they leave, and so making sure that whatever we put together at those higher level of levels of care has connections to the community to continue that, because we can do whatever beautiful treatment regimen we want if the patient's insurance doesn't cover the medicines and There's no psychiatric provider who's comfortable managing them when they leave, then we haven't really solved the problem. We've put a band aid on a gaping wound. So I think trying to figure out, like, how are we going to grow the number of individuals who go into the field? So we definitely need more providers, and we need more people who are working in places where people need care, and then we've got to figure out how to pay for it, how to make sure that the care that individuals need, particularly those vulnerable people who are really struggling with both severe and persistent mental illness and severe substance use, can be on the medicine they need to stabilize their lives and get into recovery for both. So, yeah, there's, there's a business plan there for sure.

Dr. Buttlaire 43:25

So you're talking about transitions and transitions of care from different settings. And I'm wondering, you know, as you think about emergency departments to outpatient care to residential discharges or jail release, you know they people remain such high risk at those points. And what does a truly effective warm handoff look like in practice? What have you seen really in your experience that really helps in terms of the handoffs?

Dr. Ginter 43:53

This is one of my favorite topics to think about, because I think of and many people think of addiction as an illness of isolation and recovery as a system of support where you are no longer isolated. And I think that our systems of care need to do exactly the same thing. So right now we have a variety of silos where people can experience care, and then the silos need to start to actually have, you know, overlapping Venn diagrams, and the way those overlapping connections occur is by creating community and collaboration and coordination of care. That means that if you are a system that provides service and treatment for individuals with substance use disorders and mental health conditions that you definitely need to think of yourself, not as an island, but as a part of a Venn diagram. And so what else is touching you? And those are the places where you need to reach out. You need to have, whether it's a uh. On a Qualified Service Organization Agreement, or a business associate agreement, or some sort of connection that allows you to share care, to communicate about patients and to make sure that a

true warm handoff happens. Now there are patients who may not want this, and so they may decline to sign the releases that are necessary to collaborate and coordinate. But if we already have the system built where we know, hey, I'm a jail, and I know that while people are in within my walls, I can treat them, but then as soon as they get released, I can't treat them. Well, what are you going to do? So you're going to make connections with the OTPs, with the local treatment providers, psychiatric services, and make sure that your social work team is connecting to these places, so that at the moment, your individual who had been incarcerated gets released. They've already got phone numbers, they've already got appointments, and those connections are easy. You've shared the documents or maybe even handed them to the patient on the way out the door. So really creating from the silos a community of care that doesn't allow people to fall off and and some people do fall off. On the other side, somebody falls off because the earth is flat, and there are, you know, not enough places for people to, you know, land solidly when they show up at your door again, take them. Don't put up any other barriers. Don't make them go back to square one and start over like so glad you're here. We're going to start from now. So do you mind signing a release so I can get their paperwork and just, we just start from where we are. So I think a willingness to do a little more work to help somebody who's walked in and do a little more work on the on the front end, to make sure that those community connections exist.

Dr. Buttlaire 46:55

You touched on regulations, and a lot of providers complain that 42 CFR Part Two is really a barrier to treatment and sharing records and being able to actually follow people through the transitions. Is that what you see as well?

Dr. Ginter 47:14

So it did change a little bit, and it's a little less restrictive with with the changes, with the final rule. At the same time, it is one of the features of the care of our patients to protect their privacy, and so it really should be like part of the initial intake, as you are bringing somebody into treatment, this is one of the first things you talk about, is, hey, like, we're going to do the treatment that you've come here for, and this treatment works best when we have connections in the community. We're going to protect your privacy, and there's this special law that does that really well. But in order for me to collaborate and to get you the community resources you need, I'd like you to sign this. And so I think if that becomes something that is part of our initial communication with patients to to get it done now and then it's already done, then we move forward. But it's it's a necessary part of the work that we're doing to allow our patients to be served in a safe way that their information doesn't get used against them. So many people know about HIPAA, and they feel really attached to HIPAA, and so I'll often say like HIPAA and 42 CFR are like your bodyguards, and so they're keeping you and your information safe, and they're also making it a little tricky for me to communicate if you want to leave here. So if you're okay with me signing, you know, you signing these sort of permission slips for your bodyguards to let go a bit so that I can talk that'll help me to keep you engaged and help you meet your recovery goals. But it's a really good point. And I think sometimes it's like, is that the excuse is that, really, we're gonna say that 42 CFR is the reason we can't communicate like do better, do better when we know better, we do better. And I think that's an important thing too.

Dr. Buttlaire 49:07

I have an example for you. Know. I ran a part of my portfolio at Kaiser was a substance use disorder and and of course, we had Medicaid contracts as well. And one of the things I found was that, and talking to some of the community based providers, when I would ask them, you know, we really want to coordinate the person's medical care, their psychiatric care, why aren't we hearing about them? And what some of them will say to me is, you know, Stuart, I really would like to communicate with you, but they don't want their health plan and providers to know that they're getting treatment. So that really is that back to that concept of stigma. You know, it seems to me, and I always wondered, how well are they these programs trying to push for that person to really want that and understand? And explain to them the benefits, actually, of having a coordinated care. So that's been partly my more negative experience with with coordination.

Dr. Ginter 50:10

I love that example because it is a perfect example of the real life impact of stigma. And the reality is that we actually have the power to break that down. And so in that situation, what I would do is say to the patient or the provider is, hey, I I hear you, and I know this is hard, but it's also something that we've got to figure out. And so one thing that I've offered to patients is to say, Hey, how about you? And I both get on the phone. We're going to do speakerphone. If you allow me permission to call your doctor, I would like you to be on the speaker and me on the speaker, talking to your doctor, and have us have a conversation. I'm your wing man. I've got you. I'm going to talk about substance use disorder, I'm going to talk about how I'm treating you, and I'm going to ensure that your doctor understands that I fully support you continuing to be on the medication that you're on, and that I really feel very confident in your ability to use that medication correctly, and that stopping your care, whether it's you know, a lot of times it's with the prescribing of Clonazepam, for example, or another antipsychotic medicine that Someone's now afraid of being on methadone with them. I'm going to put myself on your team. And so it's me and you, not just you. And so I have found that doing a little bit of that extra support to provide education to a provider, then again, like there gets to be a tipping point where I've had enough of these conversations, where the community starts to understand, oh no, Dr Ginter is going to call me if I threaten to take the patient off the medicine. And then you do get to a place where we are functioning as a community and we're no longer using our lack of knowledge, our lack of education, our stigmatized beliefs, as barriers for our patients. But yeah, it's a great example,

Dr. Buttlaire 52:04

yeah, and that's a great way of overcoming that as well. And I'm curious in terms of transitions, what do you see in terms of the role of peers, navigators, care coordinators, in strengthening these transitions, and where do you see organizations most commonly under invest

Dr. Ginter 52:23

the inclusion of people with lived and living experience in the continuum of care is and the cascade of care is so important, it has, I think, created so much reduction in stigma And so much opportunity like so I think that absolutely having whether it is navigators or peer recovery coaches or some sort of person with lived or living experience participating in the care team is huge for many patients, they just feel like there's too much of a barrier between them and the health care provider and to have somebody who feels more like them because that person is sharing their substance use history, that patient then is like, Oh, I've got someone on my side. Oh, this person actually gets it. And having that person shepherd them through the different types of care and offer and explain it in a way that means something more significant or more helpful than the way that I may explain it, or a clinician may explain it, or the nurse may explain it. That's enormous. I also think that people with lived experience who are in these peer support roles will be able to use their lived experience as an engagement tool to say, hey, you know what I had that happen too, and you know what I found? You know this other meeting? I know you said you went to that one, but try this one. There's another meeting down this way. I promise. Let's go. Let's we'll go together, and I'll show you like to just be able to really like in a very real way, connect with that person and break down the barriers in real time that it just feels so real. I very much think that whatever an organization can fund, and many of the peer recovery coaches and navigators are becoming things that are billable by insurance, fantastic, but having some sort of peer support is really, really important, and having those voices of peers on the multidisciplinary team, I think, to keep us honest, to make sure that we are attending to what people with lived and living experience care about. And by having a member on our team that keeps us grounded in what we're doing and making sure that we are continuing to be very patient centered. Sometimes patients can't tell us, but the peer can, because the peers, you know, just a step removed to be able to say, yeah, that doesn't work, or that's a great idea. No. Not this time. So I think that piece is huge.

Dr. Buttlaire 55:02

We're kind of going back to the future in that way, because, you know, 12 step programs have sponsors and lived experiences. We've known this for decades. How helpful that is. So in some ways, we're kind of learning, relearning, something that we should probably have known a while ago. And it is true that a lot of organizations I know, the state of California, where I am, is actually providing state funding for navigators in the emergency department, which is such an important part of things.

Dr. Ginter 55:34

Yes, and I think that at those crucial points where they're, you know, from a perspective of the stages of change where somebody comes in with an acute issue, like they ended up in the emergency room, whether it was after they got Narcan or after, you know, some sort of major thing, life event, they that is a reachable moment. You have gone from pre contemplation right to action and to be able to connect with somebody who you instantly trust because they are speaking your language and they are going to connect you with the next thing, I think that just makes the those connections much more sticky and much more likely to to prevent that fall off. So, yeah, you're hugely important.

Dr. Buttlaire 56:16

And in terms of transitions, you know, how have you seen long acting injectable buprenorphine meaningfully strengthen the cascade. And where is it sometimes misunderstood or misapplied?

Dr. Ginter 56:31

Really, I think one of the most incredible opportunities we have now with the long acting buprenorphine is at the time somebody is leaving a treatment where they have been abstinent so they no longer have opioid tolerance, and we are going to set them up for not overdosing when they leave and give them that protection. I think that there's a huge opportunity at the time of whether it's leaving a setting of incarceration or leaving a setting where there's a residential program that didn't permit moud and or that only permits for a certain period of time, giving somebody the benefit of A 30 day MO You d to give them tolerance so that if they use they have a they have less chance of overdosing and dying in that really vulnerable initial couple weeks. Is critical. The other thing it can do is allow somebody a little more flexibility in terms of when they need to follow up again. Some programs have gotten in the habit of initiating buprenorphine and then sending a bridge script for seven days. Well, I mean, you just were in treatment for 30 days. How are you going to get to the doctor for the next prescription? Now, all of a sudden, you've run out of it, or you're stretching it, and now it's not lasting. If you give somebody an injection and they've now got 30 days worth of protection that gives a little more flexibility to actually get to that follow up appointment. And so I think there's a huge opportunity to really create a huge reduction in overdose risk at the time of people leaving those more restrictive levels of care, from the perspective of it being misunderstood, these are medications that are relatively new, and people need to know what we know and what we don't know, and the medicines are expensive, and so understanding what it's going to cost to get that initial injection and then ongoing injections. If that's something that somebody wants and it's not covered by their insurance, what are their other options? It may be that the injection is going to have to switch back over to the films or the pill, because that's what their insurance covers. And so somebody should have the reality explained to them. The second piece that I think people need to know is that even if you've had one injection of one of these medications, the toxicology testing is going to remain positive for a very prolonged period of time in most patients. And so if somebody is worried about having a positive toxicology test demonstrating that they have buprenorphine in their urine like they, should know that once you get that first injection, it may be positive for months and months and months. It's not like the traditional Hey, it's going to be out in 72 hours, so understanding what the ramifications of the treatment are, thinking about what the patient's priorities are are, I think informed consent, but yeah, a lot of opportunity there to

use the injectables differently.

Dr. Buttlaire 59:38

So now, in terms of closing reflections, I'm going to give you a magic wand, and I'm going to ask you if a provider organization could improve just one stage of its oud cascade over the next year. Where would you advise them to focus the for the **greatest impact, and why?**

Dr. Ginter 59:58

I would say at the time. Time of discharge from whether it's the hospital, the ER, the medically managed withdrawal or residential, everyone's got to be on mo Ud. Have to be and if they do not want to be on moed because that's not consistent with their recovery goals, then they should really understand what the risks of that are, and should have a very good counseling session to acknowledge the risks. And then all individuals should be sent out with nasal Naloxone and advice around never using alone and getting resources such as safe spot so that they can call and have somebody spot them if they do have to use a loan. The the way in which we take care of people with stroke, for example, has become so regimented and so protocolized that there's no room for error. We all know fast. We all know, you know brain to to injection and how you know the timing is critical. I would love for us to understand and believe and really treat our patients with opioid use disorder in a same way, like when that person is leaving a residential level of care or prison or any kind of inpatient level of care, they are about to have a potentially fatal event. And if you initiate evidence based treatment, you can reduce the likelihood of that potentially fatal event 100% of the time you can reduce the likelihood. And so if you're not offering moud At the time of discharge or pre you're not doing the standard of care, and you're putting the patients at risk. So if there's one thing my wands going to do, it's going to be m, o u d for everyone on the way out the door, for sure.

Dr. Buttlaire 1:01:52

Thank you so much, Dr Ginter for sharing your experience and insights. You've been terrific, and it's been great talking with you and and thank you to everyone who joined us today. We hope this conversation has provided practical perspectives on how strengthening even one stage of o, u, d, cascade, initiation, stabilization, retention and our transition of care can really meaningfully improve outcomes and reduce the risk for individuals and communities and really save lives the web. This webinar is part of the academy 12 part series for 2026 and we invite you to join us for the next session on March the 10th. That topic for the upcoming webinar is what's working in oud treatment and system transformation, the ROI of long acting injectable MOU D for health systems, payers and communities, that session will focus on emerging evidence and real world experience demonstrating how long acting injectable MOU D can impact engagement, retention, utilization and the total cost of care across systems. We hope you'll continue with this series with us, and thank you again for being part of today's discussion, and with that, thank you very much. You.