What's Working in OUD Treatment & System Transformation

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Dr. Buttlaire 0:00
Welcome. I'm Dr. Stuart Buttlaire, Vice President of Clinical Excellence and Leadership at *OPEN MINDS*. Thank you for joining us for today's webinar, What's Working in OUD Treatment & System Transformation: The ROI of MOUD for Health Systems, Payers & Communities. 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 translating research into real world, clinical, operational and system level practice. The RECADEMY series is designed for provider organizations, health systems, payers and policy leaders who are working to improve access, engagement and outcomes for people with opioid use disorder, particularly in an environment of increasing clinical complexity, workforce constraints and financial pressure. This session is intentionally structured as a fireside chat rather than a formal presentation, with a focus on practical lessons learned across emergency departments, inpatient residential programs, outpatient care and justice involved populations. If you have any questions, please submit them via the Q&A feature of the webinar. Why does this topic matter? Long-acting injectable medications for opioid use disorder have now been available long enough that the question is no longer whether they work clinically. The efficacy data is well established. The more pressing questions facing providers, health systems and payer leaders today are about value, impact and sustainability. Where does long-acting injectable MOUDs meaningfully strengthen the OUD cascade of care? Which populations benefit most and under what conditions, how do these medications affect engagement, retention, utilization and total cost of care, and how should organizations evaluate the return on investment and environment of workforce, shortages, financial pressure and increasing payer scrutiny, emerging real world evidence suggests that LAI MOUD can play meaningful role in system transformation. When deployed strategically, they provide improved treatment retention, particularly beyond 90 days, compared to daily formulations, especially among patients with prior non adherence, unstable housing or co-occurring psychiatric and substance use disorder, reduced acute care utilization, including fewer opioid related emergency department visits and hospitalizations with the greatest impact, often seen in the first 30 to 90 days after initiation, when overdose risk and system costs are clearly

the highest, stronger performance during high risk transitions of care, including ED discharge, inpatient residential transitions and release from incarceration, patients in the OUD cascade where continually frequently breaks down lower total cost of care despite higher pharmacy spend as reductions in inpatient emergency and readmission costs offset medication costs and Medicaid and integrated delivery systems operational gains related to adherence and workforce burden with less daily medication management, fewer missed doses and reduced diversion risk benefits that matter in resource constrained environments and closer alignment with Value Based Payment and payer expectations as LAI mud is increasingly viewed as population level risk mitigation strategy tied to engagement, retention, reduced utilization and continuity metrics at the same time, LAI MOUD is sometimes misunderstood, either positioned as a universal solution, or dismissed as an added pharmacy cost or without clear return. Today's discussion will focus on how organizations are using LAI MOUD thoughtfully, where it delivers the greatest clinical and financial value, and how leaders can align medication strategy with broader system performance goals, rather than viewing it as a standalone clinical decision. I'm delighted to be joined today by Dr. Charles Whitehill. Dr. Whitehill is the Chief of Addiction Medicine and Recovery Services for Kaiser Permanente and the Permanente Medical Group in the Napa Solano Service Area in California. He is Board Certified. Applied in both Family Medicine and Addiction Medicine, and before focusing his career on Addiction Medicine, in 2014 he practiced Family Medicine in diverse clinical settings, beginning in 2002 his prior clinical experience includes practicing and underserved community clinics private practice in both outpatient and inpatient medicine, before coming to work for Kaiser's HMO program, his work emphasizes compassionate, accessible, evidence based addiction treatment, and he brings extensive experience implementing OUD care at scale within an integrated health system. Dr. Whitehill earned his undergraduate degree in anthropology from the University of California Berkeley. He completed the UC Berkeley, UCSF joint MediCal program, obtaining a Master of Health Services from UC Berkeley and a Doctor of Medicine from the University of California, San Francisco. He then completed his post-graduate training at the University of Hawaii Family Practice visiting program in Oahu, Hawaii. Welcome, Dr. Whitehill.

Dr. Whitehill 6:10
Thank you, Stuart. Thank you for having me.

Dr. Buttlaire 6:13
I have some questions for you, and the first set really is about framing the value and return on investment. So, when health system or payer leaders ask about ROI of long-acting injectable MOUD, what are they often getting wrong at the outset; what metrics usually matter most?

Dr. Whitehill 6:35
Okay, when you look at the long-acting injectables coming maybe from the administrative side. The first thing you noticed is, you know, the class, they're pretty expensive to use. They're

typically $1,500 to $2,000 for a monthly dose, which really gets your attention. But when appropriately used buprenorphine and all its forms, whether injectable or even sublingual doses, can actually increase treatment adherence, immediately reduce risk for overdose, and in some studies, we've seen evidence that it's reduced emergency department visits for all causes, including mental health, overdose, other complications. So, you have to think of it in terms of, if this is a high-risk individual, what are our savings? Should this person overdose appear in our ER, be admitted to the ICU. And when you think of it in terms of that, this medicine opens up a pretty exciting opportunity.

Dr. Buttlaire 7:48
So over and above, the cost of the medication care that's provided actually overcomes some of the cost that the total cost of care that a patient would unnecessarily need if they were on the MOUD, is that right?

Dr. Whitehill 8:05
Once somebody has been dosed, particularly with a long-acting injectable, the dose is done. You've got you bought a window of 30 days of opioid overdose protection, reduction in cravings, reduction in withdrawal, you've achieved stability, and so that's a reduced number of visits and contacts. Yeah.

Dr. Buttlaire 8:30
So how should organizations think differently about value when they move from daily or sublingual formulations to long-acting injectables?

Dr. Whitehill 8:39
So when it comes to the value applying it to a situation that's where you have a high risk individual, maybe somebody who you've had experienced difficulty initiating buprenorphine or taking it correctly using a long-acting injectable, what we would call the LAI, I could be very useful and immediately buy you some of that stability that you're looking for. So there comes a choice, do we go with the sublingual dosing, or do we need to use a long-acting injectable to achieve our stability?

Dr. Buttlaire 9:20
Really good points. And so, I'm going to ask you now about where LAI MOUD strengthens the cascade of care across OUD cascade initiation, stabilization, retention, transitions. Where have you seen LAI MOUD make the most meaningful difference?

Dr. Whitehill 9:41
Classically, when we go to use buprenorphine, you achieve some stability almost immediately

within the first couple of minutes of dosing. Actually, you can actually see physical changes in people, you know. It's really kind of a privilege to see, but there are. A great number of individuals that we are not able to tolerate any withdrawal from the opioids that are out there, fentanyl and the like, and we have difficulty getting them through that initial period. So, when you use an injectable medication, you can achieve almost immediate stability from the initiation phase to that first month of stability. And so, we've seen people, usually people can come from all walks of life, but typically I think of like a young, impulsive person using a fair amount of fentanyl. And each day, each moment, there's a changing priority. And when you use the long-acting injectable, you can achieve this stability for the first time, and we've had some pretty amazing results.

Dr. Buttlaire 10:47
Yeah, that makes a lot of sense. And you know, going with your comment, are there specific patient profiles of care, care settings where the return on investment is especially strong?

Dr. Whitehill 11:00
Yeah, so you have to think in terms of outpatient settings and something closer to an inpatient setting, like an emergency department in an outpatient setting, somebody who you may have either tried multiple times to start and you've been unsuccessful, or a very transient window of opportunity, it may be useful. That's the person that we would like to use that on. In the emergency department, there's typically a very small window in which you see people, and you become familiar with the people that are extremely high risk. Maybe they've had multiple ED visits for overdose or substance use related, and this would be somebody where a long-acting injectable would be particularly useful.

Dr. Buttlaire 11:48
Those are good points. And you know, along with that, the focus on engagement, adherence and retention from, you know, a practical standpoint, how does LAI MOUD change engagement, retention patterns in the first 90 days and over the first year of treatment, which people are most susceptible to falling?

Dr. Whitehill 12:10
Yeah, it's not uncommon to start buprenorphine several times on somebody you know through through a year. Oh, you again. You were going to try. Okay, we're up for it. We're going to try. So, treatment dropout is a very common issue. When the long-acting injectables are used, we see a higher rate of retention, and there's been some research done on this. When you get an appropriate buprenorphine dose, it can double or triple the retention at 3060 days, much higher than in the high-risk population that we're using it.

Dr. Buttlaire 12:51
In terms of other issues, such as missed appointments, medication gaps, treatment continuity compared to how does it compare to daily dosing models using LAI MOUD?

Dr. Whitehill 13:04
The daily dosing, I think, is an important relationship for people who have an opioid use disorder, getting into the pattern, getting out of the pattern of using the substance and into the pattern of taking care of yourself. However, there are some people that have great difficulty achieving that stability. So it eliminates the need for going to the pharmacy, getting a medication, maybe getting your medication, your refill declined once that that injection is done, most people are generally good depending on the type of injection that's used either a seven day formula, you know, or a 30 day formula. There are no prescriptions to pick up, so you have, you know, built in adherence.

Dr. Buttlaire 13:49
Can you think of a recent patient, for example, that the change in going from daily to long-acting made a difference in terms of their adherence and coming to see you?

Dr. Whitehill 14:01
Absolutely. Two patients come to mind, young males, impulsive, using lots of fentanyl. And every day in our communication network, you know, our chat is like, Oh, so much so. And so is calling to start you like, oh, you again, okay, we're going to do this. Or someone's calling; they're out of their meds. Again, like somebody, we've had multiple tried every intervention. We cut you down, you know, from four weeks to a two-week supply, to a one-week supply, to a three day to a okay, nothing's working. Using the long-acting injectable in one to actually initiate treatment adherence and starting a long-acting injectable and the other and seeing that retention at 30 days, 60 days, 90 days, having this young man come in dressed for work. Yeah, he came in from his job. He's on his way to his job. And this. Like, wow, this is a really big change for this person.

Dr. Buttlaire 15:04
Those are terrific examples. And, you know, I want to move to actually talking about high-risk populations and transitions. You know, transitions of care remain, you know, one of the most fragile points in OUD treatment. You know, how does LAI MOUD function differently during ED discharges, hospital transitions are released from incarceration. I know in California, there's been a huge effort to try to help out the emergency departments for those who have a serious substance use disorder.

Dr. Whitehill 15:39
Yeah, that transition is a difficult point of seeing someone in the emergency department and getting them to engage in care with an addiction medicine specialist. So the long-acting

injectable gives you 30 days, 7 depending on the formula used, of course, 30 days to 60 days of stability, giving us an increased chance for reaching out, particularly if you get 30 days of stability, I think you're going to be more likely to engage in treatment to continue that.

Dr. Buttlaire 16:15
Yeah, that's really true and an excellent point. And you know, what role does it play in reducing overdose risk during those vulnerable windows? Since overdose risk is such a high issue, such a strong issue, during that first 30 days.

Dr. Whitehill 16:34
I think that one in five ED visits for opioid related use can result in an overdose event within 30 days. So about 20% of the people can be involved can't in an overdose event, and one in 22 within two days of an emergency department visit. This is if somebody coming in being treated for withdrawal, not started on buprenorphine. If there's started on a buprenorphine, an adequate dose, be that sublingual or better yet, long-acting injectable, you have almost immediate protection from an overdose that will exceed 30 days.

Dr. Buttlaire 17:22
I'm thinking, as you know, I was responsible for inpatient care for so long. I'm wondering, you know when people leave inpatient psychiatric care, since so many people in psychiatric inpatient care have comorbid substance use disorders, what role do you actually see in reducing overdose risk during those vulnerable windows as well? And you know, how do we educate some of the providers?

Dr. Whitehill 17:50
Yeah, that would be an option. It's another tool to use somebody's approaching discharge and to evaluate them. Okay, what is their intention to continue buprenorphine? Are they capable and are they interested in continuing buprenorphine? What are their resources upon discharge? So looking at that carefully, because that would be a very, you know, kind of a fragile population, you wouldn't necessarily use it for everyone across the board, but when you see particularly high risk, like difficulty transitioning to a care you know, to an experienced provider, that would be a useful tool.

Dr. Buttlaire 18:38
It's your experience that a lot of these inpatient providers understand the use of buprenorphine and suboxone, or do they need more education?

Dr. Whitehill 18:47
Always more education. You know, always more education. And here in our organization, here at

Kaiser, we encourage calls. We love it when hospitalists call, when, when anybody calls and wants more information, because not everybody understands all the risks. It's becoming more commonplace, but I would say, don't be afraid to reach out and ask for help. Ask, is this appropriate? Is it appropriate to discharge on sublingual? Is it appropriate to just ask for an injection?

Dr. Buttlaire 19:21
Those are great points. And now I want to move on to the concept of operational and financial considerations. What operational barriers, workflows, staffing, side of care issues or prior authorization, most commonly slow adoption, even when leadership is supportive of the change.

Dr. Whitehill 19:48
That's a great question. All the long-acting injection injectables, there's two of them presently, Sublocade and Brixadi are under a, it's called an REMS protocol, which is a risk mitigation strategy. So, these medicines, if, when they're injected, turn into a gel and slowly release buprenorphine. However, if you are to inject that into a blood vessel, you could see and imagine that that could cause an immediate problem. So, you have to be careful who's injecting it that they have the appropriate knowledge, the appropriate technique. This is not something that you want out there, you know, on the street or in the hands of an inexperienced provider. So, providers typically apply for the REMS protocol, get approved and provide these medications in settings that are considered safe and within the protocol, but it's a little bit restrictive. It's a little bit intimidating to do this, so it takes a little bit of time to get approved to provide these medications.

Dr. Buttlaire 21:00
People trained in and able to do this. I'm imagining that might be some of the barriers that, particularly for organizations that may not have champions.

Dr. Whitehill 21:11
Yeah, the manufacturers provide pretty good training for almost any healthcare provider to inject this medicine. You wouldn't want an inexperienced provider to inject the medication, not understanding that this medication turns into a gel, you know, upon injecting. So, this is part of the REMS protocol to make sure the people that deliver the medication have an understanding and at least some technique.

Dr. Buttlaire 21:41
You know what comes to mind? You know, in thinking about our general system of care, you know, our primary care providers getting REMS training, are they knowledgeable by and large, or is that still an area where, you know, we need more?

Dr. Whitehill 22:00
We do need more. Yeah, it's not really in the realm of primary care. You're probably going to be an addiction specialist. I carry the REMS protocol for, you know, my area, so all the injections are basically done, you know, under my name, through addiction medicine specialists, some areas have their injection clinic trains in how to inject it. But by and large, primary care probably avoids some of these specialty medicines, and it's probably just as well.

Dr. Buttlaire 22:32
Thank you. So how have organizations successfully aligned clinical issues? Pharmacy, the teams, and finance around shared value framework.

Dr. Whitehill 22:48
That takes a little bit of persistence, charisma, good rapport, and a lot of communication with the team. You have an organization who has a mission of providing better care and has faith and understanding in their addiction medicine providers that they will provide this medication appropriately. And that's one other thing we'll talk about to the appropriate individuals. Yeah, a steward of the resource.

Dr. Buttlaire 23:24
Thank you. So, let's now move on to payers, policy, and system alignment. You know, how are payer expectations evolving around LAI MOUD, particularly in Medicaid and value-based arrangements. And I know that's a challenging area.

Dr. Whitehill 23:41
Yeah, right now it is covered under Medicaid, although I can imagine that that would be, could be subject to change in politics. You know, whether it's covered or not, especially if a, you know, a budget was significantly shortened. But this is such a valuable medication. I hope it to be a protected resource for Medicaid. Not all other insurance carriers will cover it. Sometimes there's an out-of-pocket cost that can range from $20 on up to the full price of the medication.

Dr. Buttlaire 24:17
So, how are the payer expectations evolving? What are their thoughts about that?

Dr. Whitehill 24:23
I think it is slowly being adopted due to realization of the value of the medicine, when properly used, this can save money, this saves lives, clearly that it can be a value to an organization.

Dr. Buttlaire 24:41
Do you think the federal government has that awareness? You know, I'm thinking of centers for

Medicaid and Medicare, since we're talking about the Medicaid population, do they see the value?

Dr. Whitehill 24:51
I would hope that they wouldn't just be looking at the bottom line. I think you would have enough advocates in higher places that could be able to explain the value. So, I would hope that they would be open to that.

Dr. Buttlaire 25:09
We seem to have that alignment in California.

Dr. Whitehill 25:12
Yeah, we do. I think we're very lucky in California. You know, politically, it's favorable climate to provide a lifesaving medication and to share that cost.

Dr. Buttlaire 25:25
So, what should provide organizations be doing now to position themselves as strong partners focused on outcomes, rather than utilization alone? What do they need to do in terms of positioning themselves?

Dr. Whitehill 25:39
This is where I think it's important to partner with your addiction medicine providers and develop a protocol of who is appropriate to start on this long-acting injectables, and maybe consider other situations that are considered gray areas, and in fact, other situations where this medication may not be appropriate to use, as I mentioned before, you have to be a steward of this resource. It's very valuable, and if you use it, you know, without proper indication, you will significantly increase the cost of care for everyone. Do they worry about risk? I have not seen any adverse outcomes for using this medication. So, no adverse outcomes. You would consider risk in what is the cost of somebody who's unmedicated or under medicated that's already maybe demonstrated or perceived as a high-risk individual?

Dr. Buttlaire 26:52
You know, I would really think about people who are coming out of being incarcerated, my goodness, if they're not being able to be provided with the medication, the re-incarceration, and all the problems that are, you know, tantamount to not being able to be provided with services and LAI MOUD would really, really be very, both tragic as well as challenging.

Dr. Whitehill 27:21
Yeah, I agree. You're, you're coming out of a situation where you suddenly have access to a lot of

people, a lot of substances, you're going to be extremely high risk and not protected. So, this would be a very reasonable protection to allow you to establish care in the community.

Dr. Buttlaire 27:44
And that may be an important policy that governments and states really need to adopt, and counties, you know, really consider medication while people are come, you know, incarcerated, so that they can continue with it afterwards, rather than having high risk behavior and all the vulnerabilities that are in the community.

Dr. Whitehill 28:06
Yeah, I agree, if you address some of the high-risk things, you're going to reduce risk, reduce risk for overdose, reduce risk for incurring costs associated with an overdose, and, you know, other mental health issues as well.

Dr. Buttlaire 28:23
You know, along those lines, I'm wondering about avoiding misuse and over generalization. So where do you see LAI MOUD being misunderstood or misapplied?

Dr. Whitehill 28:35
Great question. Three situations come to mind. The biggest one is that there is a very strong social media presence about using this to taper. There is a belief that if you get this medication, you can stop using opioids. You will never have cravings. And in practice, I have not seen that. I have heard case studies of people who have received one to several injections and claim no opioid use, no cravings ever again. However, none of these have ever been followed with what I think is, you know, good evidence of no return to any other substance, any other opioid or even return to buprenorphine use. So, that's probably the highest one most people I see, the most common misperception is I want to get this injection because I want to taper off like it doesn't work that way. So that's one part of that, also these medications are designed to significantly increase the dose. So, if you're looking to get off the medication, you're this medication is the wrong one, because it significantly increases the dose. So, there's no objective information that actually works. The other area that I see it misunderstood is just a casual option. Oh, I'd like to do this because I don't want the hassle of taking a pill every day. I think the medication is too expensive to use for convenience. I think we have to pick and choose who's going to go on it based on based on risk.

Dr. Buttlaire 30:19
Gotcha. And so how can organizations avoid treating it as either a silver bullet or a last resort option, and instead integrate it appropriately into a broader treatment strategy?

Dr. Whitehill 30:30
What we did here in my organization is we had an agreement with the providers, and we came up with a written set of criteria. Of these are the indications that we would use it for high-risk situations, failure to take buprenorphine appropriately. You know, by the sublingual dose, multiple overdoses. There's a few others you know that come up with people with intractable nausea, vomiting from sublingual dosing or severe dental decay, as buprenorphine can accelerate dental decay. So those would be appropriate indications and sticking to these indications for using it.

Dr. Buttlaire 31:19
Thank you for that. So, now I'm going to give you a magic wand, and I'm going to ask you to have some reflections. You know, if a provider organization could take just one concrete step in the next year to maximize the clinical and financial value of LAI MOUD where would you advise them to focus and why?

Dr. Whitehill 31:44
I think I would advise them to focus on developing a set of indications for using LAI that would make sure that it was used appropriately, that it was not used inappropriately, and we would see value every time it's been used.

Dr. Buttlaire 32:04
Thank you for that and any other further thoughts.

Dr. Whitehill 32:08
Just honor and a privilege to be there, working with this population and using these medications. It's so rare in medicine to actually see something that changes somebody's life so fast for the better. I appreciate being able to share that and share your enthusiasm and your excellent questions today.

Dr. Buttlaire 32:32
Thank you, Dr. Whitehill and for sharing your experience and your insights and thank you to everyone who joined us today. We hope this conversation provided practical perspectives on how long-acting injectable MOUD can strengthen engagement, retention, transitions of care and overall system performance when aligned with organizational strategy and payer expectations. This webinar is part of RECADEMY's 12-part series for 2026 and we invite you to join us for our next session: Treating Fentanyl & High-Potency Synthetic Opioid Use Disorder: Evidence-Based MOUD Strategies for Real-World Care Settings. That session will focus on how organizations are adapting to MOUD protocols, induction strategies and care models in a fentanyl era where early instability, polysubstance use and overdose risk challenge traditional approaches. Thank you.