

Treating Fentanyl & High-Potency Synthetic Opioid (HPSO) Use Disorder: Evidence-Based MOUD Protocols, Induction Strategies, & Harm Reduction Approaches in Real-World Care Settings

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Dr. Buttlare 1:48

Welcome. I'm Doctor Stuart Butler, Vice President of Clinical Excellence and Leadership at Open Minds. Thank you for joining us for today's RECADEMY webinar, Treating Fentanyl and High Potency Synthetic Opioid Use Disorder.

Evidence-based MOUD protocols, induction strategies, and harm reduction in real-world care. Today's webinar is part of Academy's 12-part educational webinar series for 2026, focused on advancing evidence-based opioid use disorder treatment and translation.

Translating research into real world clinical, operational and system level practice. Today's conversation is structured as a fireside chat. Our goal is to surface practical lessons from health systems, emergency departments.

Residential and outpatient programs and justice involved settings that are navigating fentanyl dominant opioid use in real time. If you have any questions during the discussion, please submit them via the Q&A option.

In the team's platform. So why does this topic matter? Well, high potency synthetic opioids, primarily illicitly manufactured fentanyl and its analogs now dominate the opioid epidemic. Recent CDC national data shows that while total drug.

Overdose deaths have declined from their peak. Synthetic opioids remain the dominant driver of opioid related mortality. In the most recent finalized CDC national data, synthetic opioids were involved in roughly 70%.

Of all opioid deaths and most opioid related.

Does not see potent opioid fentanyl has altered the clinical and operational landscape in several important ways.

Higher opioid tolerance levels, less predictable or delayed withdrawal onset. Increased concern about precipitated withdrawal during buprenorphine induction. A dramatically shorter window between relapse and fatal overdose. The methadone and buprenorphine is well.

All established CDC, national data and NIDA continue to really affirm that medications for opioid use disorder are associated with significant reductions in both overdose and all-cause mortality, and that retention and treatment is strongly associated with survival.

In fact, the federal guidance often summarizes the impact in this way. Treatment with methadone or buprenorphine can reduce the risk of death by at least 1/2. The question is no longer whether MOUD works. The more pressing question is whether our clinical protocols.

Operational workflows, workforce competencies and reimbursement models have kept pace with the fentanyl era. For leaders, the practical questions are immediate. How should induction strategies evolve in high fentanyl exposure settings?

When should methadone be prioritized for patients with high tolerance? How should low dose or flexible induction strategies be implemented safely and consistently? How do we embed harm induction into the core system infrastructure rather than treating it as an adjunct?

How do we manage fentanyl combined with stimulants and other substances? And how do we scale these approaches across large public systems under workforce shortages and financial pressures? Fentanyl is not only a clinical challenge, it's a system design challenge as well.

That is what we will be exploring today. Our featured expert today is Doctor Bryan Hurley, an addiction physician and medical director of the Bureau of Substance Abuse Prevention and Control for Los Angeles County Department of Public Office.

He currently serves as the immediate past president of the American Society of Addiction Medicine and has served on numerous ASAM committees and councils, including originating ASAM's motivational interviewing course and co-authoring the ASAM and American Academy of Addiction Psychiatry National Practice.

Guideline on the Treatment of Stimulant Use Disorder Hurley has led and facilitated projects funded through competitive grant awards from the US Substance Abuse and Mental Health Services Administration, the US Center for Disease Control and Prevention and the California Department of Healthcare.

Services Opioid Response programming. These initiatives support harm reduction services and expand access for addiction medications across the public sector programs in Los Angeles County. He's a member of the Motivational Interviewing Network of Trainers and completed the Robert Wood Johnson.

Foundation Clinical Scholars Program at UCLA. He trained in psychiatry at Massachusetts General Hospital and McLean Hospital and completed an addiction psychiatry fellowship at New York University. Thank you, Doctor Hurley, for joining us today.

And I have some questions for you my.

Dr. Hurley 7:16

Sure. Thanks for having me. Let's get to your questions.

Dr. Buttlare 7:19

Let's get on with it. Yes, Doctor Hurley, from your vantage point in Los Angeles County, how has fentanyl exposure, fentanyl exposure changed the way opioid use disorder presents clinically compared to five to seven years ago? And what are the frontline clinicians encountering?

That feels fundamentally different.

Dr. Hurley 7:38

Sure. You know, roughly 10 years ago we would see where I live in Los Angeles, 500 or so overdoses a year on a regular basis. And that would include heroin, that would include prescription opioids, that would include.

Dr. Buttlare 7:50

But.

Dr. Hurley 7:55

The dominant stimulant we have here is methamphetamine. And then in 2023 we were up to 3000 overdoses a year, right? It totally changed the landscape and and what happened in LA is not just specific to here across the country.

We saw fentanyl driving overdose rates that had been previously unseen here in the United States. So from my vantage point, what fentanyl has done is transition to condition that.

Could kill you, but people would develop and you know, continue in in opioid use disorder to a condition that killed so many people that that it sort of came from like could kill you to like well maybe would kill you if there wasn't intervention. So it really.

Pushed health systems and clinics like I just like myself to think creatively. How do we get treatment of people? And just as you mentioned, addiction medications for opioid use disorder or medications for opioid use disorder are the standard of care.

And so it pushed us to think creatively around how to how to make sure that care became universally accessible and not gatekept behind a whole set of admission requirements that, you know, may may not be relevant to people who, you know, could be just one use of fentanyl away from dying.

Dr. Buttlare 9:27

So you know, the frontline clinicians encountering, you know, does feel fundamentally different. Have you provided some additional education for your system?

Dr. Hurley 9:41

There used to be something called an X waiver, and the X waiver was this extra DEA registration you had to get to prescribe buprenorphine for opioid use disorder. And in early 2021, the Biden administration actually eliminated the X waiver as a as a requirement to prescribe.

Buprenorphine and I trained previously 1000 clinicians in various settings across Los Angeles on the X waiver curriculum. And so one of the first things we did in 2021 was make sure that people know that anyone with the DEA registration could prescribe.

And then the other thing we did is we took the starting instructions, right? So there's a kind of a standard set of starting instructions for buprenorphine, how buprenorphine get started and titrated up to an effective dose. And I don't want to say we threw it out the window, but we kind of threw it out the window. We said, OK, look.

In a fentanyl era, because fentanyl is so potent, the doses that people need may not resemble the doses that we used to use for heroin and prescription opioids. And the way we start buprenorphine. And forgive me, I use the word start buprenorphine as opposed to induction just because.

I like to keep it simple. That's one of the strategies is try to keep it really, really direct and really non-technical and then make sure that everyone knew that emergency rooms knew that. And we've got this program called the California Bridge Program around, you know, low threshold initiation of buprenorphine in the emergency room and our street medicine programs know about it.

Dr. Buttlare 10:56

Yeah.

Dr. Hurley 11:13

And our primary care clinics know that our community health systems know that, and our correctional health services know that, and our substance use treatment providers know that. So yes, we provided a lot of training, but it was less on the pharmacology of buprenorphine, although we did teach people about that and more around the universal, the importance of universal access to buprenorphine and.

Dr. Buttlare 11:21

Hey.

Dr. Hurley 11:33

Other medications for opioid use disorder and how important that is to save lives.

Dr. Buttlare 11:38

A real focus on intervention as a primary educational tool as well, it sounds like. Excellent. I love your response. You know, there is a concern about precipitated withdrawal among patients with heavy fentanyl exposure. You know, what are you seeing in practice and you know is.

Dr. Hurley 11:43

That's right.

Dr. Buttlare 11:57

Risk truly higher or is fear of it sometimes delaying initiation unnecessarily?

Dr. Hurley 12:04

So I've always felt like the risk of precipitated withdrawal has been this elephant in the room. Oh, I can't initiate buprenorphine because it could precipitate withdrawal. And what's interesting about the data is there's actually pretty good evidence.

Arguing two sides of an adaptation. So my colleagues in the emergency room use what I'll call a macro dosing strategy. If somebody's coming in on fentanyl, they're probably using high potency opioids at a much higher to to borrow an inaccurate term.

Morphine equivalents than somebody who is not using fentanyl. So let's get the dose up and let's get the dose up quickly over the course of few hours. So dosing like 8 to 16 milligrams an hour up to like north of 32 milligrams, which are much, much higher doses that kind of was standard.

Became standard practice in many hospitals across California and they published research. OK, what are the outcomes of high dose buprenorphine initiation in people using fentanyl? And it turns out people do pretty well. You know what I mean? There were very rarely instances of medically complicated precipitating withdrawals.

But I'll also say in an emergency room you have access to round the clock nursing. You have access to ketamine, you have access to, you know, sedatives. You have access to other things that you can give somebody right away, even injectable things that you can give somebody right away in order to manage precipitated withdrawal that people don't.

Dr. Buttlair 13:25

Right.

Dr. Hurley 13:38

Necessarily have access to, and certainly not in a medical context, at their homes, at a encampment, at a outpatient clinic, right? Like in in in outpatient settings.

In outpatient settings, the evidence on low dose initiation of buprenorphine has been really mixed, right? Because oftentimes people don't get the dose quite high enough. There's really now promising evidence of using injectable buprenorphine to try to get people started on low dose, and that's one low dose strategy in people with pain. The transdermal buprenorphine is also.

Been sort of a promising approach or you know, for lack of a better term, poor man's version of that. We just sort of start slicing up buprenorphine strips, right? The idea is you try to get people, you know, as low a dose as they can tolerate and get started.

Dr. Buttlair 14:22

Yeah.

Dr. Hurley 14:26

But one of the things that I teach clinicians is precipitated withdrawal is, generally speaking, something you can get people through. It's it's, you know, generally speaking. But so I I don't. What I'm not saying is that everyone is completely comfortable whenever they start buprenorphine in all situations, but I'm also saying that it's worth

continuing.

The benefit of getting a patient stabilized on buprenorphine is substantial and worth the effort, cuz it is oftentimes effort. It's not impossible effort, it's just time and attention in order to get people initiated. And the right way to start buprenorphine is oftentimes the one that's accessible to you at the time.

Time, right? So it's it's you use what you have where you have it in order to be able to get people the care they need.

Dr. Buttlare 15:11

Along with that, have you taught outpatient providers a strategy or techniques to actually implement low dose or watch patients for longer periods of time so that they know whether or not they're going through withdrawal or not?

Has there been any strategic thinking about outpatient in particular?

Dr. Hurley 15:36

There, there has been. So I would say there's sort of like 3 core strategies. One is frequent contact. That doesn't necessarily mean somebody has to sit in the office for days at a time, but that usually means sort of telephones. Um, oftentimes, you know, you can send stuff out to where somebody is if necessary.

The off label direct to inject protocol right now that's working its way through ASAM and other organizations are sort of publishing more information around this right is like a visit once a day for three days is like a strategy and whether the person.

Comes into the clinic or whether you go out to them are both options. And I think like if all else fails, you have an office visit, you have a prescription that gets sent, you have comfort medications that you can oftentimes offer and you have a telephone, right? So most outpatient programs have.

You know, within what they have a feasible set of tools to be able to help support patients through initiation. So that oftentimes means having a substance use navigator or even if the prescribing clinician can do it, time to spend coaching a patient through what they're experiencing and options right. Often options often.

Excluding medications that can reduce precipitate withdrawal if it happens. It's not rocket science, it's comfort meds, but oftentimes making sure people have access to the tools that they that they know they can access to feel better.

Dr. Buttlare 17:03

You know, I really like what you're saying about your strategies because most of them are related to engagement, right? Keeping them connected with treatment in some way and making sure to follow up so that the patient's not overwhelmed and fearful. You're really doing an amazing job.

Dr. Hurley 17:11

That's right.

Dr. Buttlair 17:23

Of keeping contact with them if you can keep them engaged. So I really appreciate that.

Dr. Hurley 17:27

Well, thanks. And that they don't feel alone, because I think that's what's the most frightening thing. If a patient starts a medication and something happens unexpected or something happens and scares them, it's the feeling that there's no one there to help. That's the scariest thing, I think. So making sure people know they're not alone.

Dr. Buttlair 17:29

Yeah.

Yeah.

So many organizations are experimenting with micro induction or low dose approaches and you've kind of hit on a little bit about that. Where do you see things fitting into standard care and you know what guidance would you offer systems trying to implement?

You know them consistently.

Dr. Hurley 18:04

I think that for any system that's thinking about initiating a low dose buprenorphine strategy is to offer people a menu of options. So what what might that look like? I mentioned direct to inject that is people don't start with a cell level dose, but they start with an injection of a subcutaneous dose of long.

Buprenorphine, typically one of the weekly formulations, and that is a very helpful option for when you're concerned that people aren't going to either pick up or take a sublingual dose of medication. On the other hand, there are people that have no interest in taking an injection of anything. You know, they don't want any injections at all.

And so that's not going to be a very patient centered option for every patient that comes into your door. So having a sublingual or in a case of Co occurring pain, transdermal buprenorphine option that can both have an analgesic effect and have the effect of initiating, you know a low dose of buprenorphine in somebody's.

Bloodstream can also be a helpful strategy, right? So the way that I think about it is look at the different protocols and have a menu of options. None of the protocols are actually that complicated, but rather than thinking from a program centered approach, we want to be a direct to inject clinic or we want to be a low dose sublingual buprenorphine.

Clinic think from the patient's perspective and different patients are going to want different approaches.

Dr. Buttlair 19:30

Are many patients scared of injections?

Dr. Hurley 19:34

It's really mixed. Some people like the convenience and some people don't want anything to do with injections. You know, I I'm an addiction psychiatrist and we've been dealing with injectable medications, say the atypical antipsychotics, which you can use for psychotic conditions and and certain types of mood disorders.

Dr. Buttlair 19:36

Yeah.

Dr. Hurley 19:52

We'll be dealing with that forever. And I'll be honest, like you just don't know which patients really want to take something orally or sublingually and which patients really want the convenience of an injection. So I don't think about it as patients do or don't like patients as a whole do or don't want injections. But there's some patients that just never want anything injected and there's some patients that never want.

Wanna take anything? But they'll accept an injection and honoring the patient's perspective. Because I sometimes get asked like, what's the most effective bed for whatever condition is? I'm like, well, you actually gotta start with what's the patient gonna take? Cuz it does not matter what a clinical trial shows. If the patient doesn't take it, it won't work.

Dr. Buttlair 20:29

I often found it ironic at the clinics that I oversaw that people would come up to me and say, Stuart, you know, this guy's coming in and he's injecting himself with all kinds of things, but he refuses to have injectables from us. I always thought that was ironic.

Dr. Hurley 20:43

Isn't it interesting?

Yeah.

Dr. Buttlair 20:46

But thank you for your response. In this fentanyl era, some patients present with extremely high opioid tolerance. How should systems think about methadone access and integration as part of the balanced MOUD strategy?

Dr. Hurley 21:04

So I'll give a practical answer and then I'll and then I have an additional answer on top of my practical answer. So the practical answer is understanding who your federally licensed opiate treatment programs are in your community and have relationships with them is really important.

Not that every patient has to be referred to an OTP, but OTP's can be vital partners in helping patients access methadone. And since the 42 CFR Part 8, which is the current federal or regulation covering methadone treatment, was adopted, OTP's can be much more flexible.

In take home dosing. So it's no longer true patient has to go to OTB every single that the OTB is open for a six month period no matter what right. Uh patients can be advanced as he comes much earlier in their treatment based on their clinical response and so that can make the patient the the treatment inherently more convenient and you know feel.

less like you're being you know pushed into a pre-prescribed follow-up visit strategy. So knowing who your area OTPs are are really important. ASAM is of the, and I'm on the board of ASAM, so you know, is of the opinion that the fact that methadone

Is gatekept behind an OTP license is itself a critical access issue and there is, you know, the last congressional term. I don't think it's been introduced this term yet, although check, check the latest ASIM advocacy website. Don't listen to me, which.

Dr. Buttlare 22:22

Mhm.

OK.

Dr. Hurley 22:36

Change statute to make methadone prescribable to treat opioid use disorder by addiction physician specialists. So just to be clear, like I also think that there's a potential advocacy angle in order to enhance access to this life saving medications, certainly through OTP's, but also through community based.

Addiction physician specialists.

Dr. Buttlare 22:58

You know, my next question for you is really in your wheelhouse. You know, we're seeing more fentanyl mixed with stimulants. You know, how does this complicate stabilization in longer-term treatment planning and what should leaders understand about evidence-based approaches to stimulant use?

Dr. Hurley 23:01

Yeah.

Dr. Buttlare 23:16

Disorder in this context.

Dr. Hurley 23:19

When I talk to legislators or state directors, when we talk about substance use involving more than one substance, right? So you and you gave the perfect example, which is fentanyl and stimulants. And in my jurisdiction, it's fentanyl and methamphetamine. Those are the top two.

Saying if you could pick two molecules, those are the two molecules that people are dying of most, right? And people can get the sense of despair. Oh goodness, you know what I mean? Like, well, like, this is so complicated. What are we to do? And fortunately, opioid use disorder is treatable. We've.

Kind of emphasize that point. Medication of sopiate use disorder or the standard of care. There is a standard of care for stimulant use disorder and actually ACM and AAAP came out with this in 2023, the standard or 24, sorry 2024, the standard of care.

Or stimulant use disorder is contingency management, which you can do alongside medications or opiate use disorder, which you can do alongside everything else like cognitive behavioral therapy and counseling and IOP and you know, there's all the the sort of what we do in in in treatment.

But contingency management so so strongly outperforms treatment as usual that it is it is sort of recommended as a standard of care that can be combined with everything else. So what do we do when people using fentanyl are also using methamphetamine offer them?

Medications or OB disorder and contingent management. Now that's very easy to say. The build out and accessibility of contingent management is still in its relatively early stages across the United States. I live in California. Our state has a waiver to use our Medicaid funding to pay for contingent management.

Which is saving like, I think it's like now thousands of lives. It's touching like huge numbers of people across California and certainly here in Los Angeles. And so I'm really glad that we have both tools. What I what I'd say is depending on where you're working.

Understand what your continuous management options are, where your OTP is and your own prescribing ability and do the best that you can. Nothing I'll say on this. I mentioned earlier, how do you get people started on buprenorphine? Make sure they know they're alone, right? Make sure you have frequent contacts. I don't necessarily mean you have to come in every single day, but yeah, even brief check in.

Can be helpful. The same is true for patients using stimulants. Simple clinical contact can make a difference when people are making are interested in change oriented treatment, right? Just a conversation. What's going with stimulant use? What are your goals? What progress have you made?

Can be reinforcing for people who are oriented towards change.

Dr. Buttlair 26:01

As a fellow Californian and was involved with the state, I'm curious, has there been any follow up studies on contingent management? I know that was initially somewhat controversial, you know, giving people some.

Money or support for staying on, staying off stimulants and or at least getting tested for it. Is there has there been any follow-up studies that makes the case?

Dr. Hurley 26:22

Mhm.

There are. So the evaluation of California's contingency management program is being managed by UCLA that it's somewhere now over 1000 patients have been treated through the contingency management program here in LA with, you know, 95 plus percent.

Dr. Buttlair 26:27

OK.

Dr. Hurley 26:46

Of urines, if I'm remembering the data correctly, are negative for stimulants. So these are people who have urine

toxicology verified stimulant abstinence and these are people who were diagnosed with moderate to severe stimulant use disorder, right. So this was already a patient population and people who would really benefit from this treatment, so showing a great clinical outcome.

Improved treatment retention and very high rates of satisfaction. People are really, really satisfied with this program. The state intentionally named this the Recovery Incentives Program because you're not just paying people, you know, outside of a protocol. There's a very regimented protocol designed to support people's recovery from stimulus disorder.

Right. So what are you paying for? You, you know, in this case, Medicaid funding is being used to pay for people to stay off stimulants. And it is remarkably less expensive than most other things that we do in terms of mental health visits, hospitalizations, emergency, you know, like.

Calling 911, right? EMS runs. I mean, this is a substantially less expensive program to operationalize with, for the people who are impacted. A substantial clinical result.

Dr. Buttlare 27:58

I often thought the opposition to that was more to do with stigma and really criminalization of drug use. So I'm happy to see that, you know, we're starting to see such good research that actually goes beyond some of those criticisms that really gets into the drug.

Dr. Hurley 28:06

Yeah.

Dr. Buttlare 28:18

So thank you for that. And also, you know, I'm so curious about Los Angeles County because you've done so much, Doctor Hurley, on, you know, harm reduction and harm reduction services.

How should health systems and public programs think about embedding naloxone distribution, overdose education, community based harm reduction services into the core treatment continuum?

Dr. Hurley 28:47

Well, there's a principle in substance use treatment. One of the principles is no one recovers if they've died, right? So if part of our goal is to help save lives and as a health system, that it's hard to argue with that as one of the key outcomes, right? Keeping people alive.

Then making sure that everyone has access to naloxone, people have access to test strips, people have access to the tools and resources to help keep themselves alive makes sense. Where I see people get hung up is this idea that what I want somebody to change their substance use. I'm really focused on change oriented treatment.

And if I give people the long zone or support people with test strips or support people with outreach and engagement or services and supplies, that is not contingent upon their making change, but I'm just gonna make them not change. And so the idea is if you do more of harm reduction, then somehow you're gonna do less treatment.

If you do, you know more treatment than you should be doing less hard like there's an idea that these things are like opposed. But the truth is when you if we think about the patient right as the center of our, as the center of our intervention.

Patients come into and out of readiness to change all the time, right? It is. It is pretty rare for somebody to decide they're going to make a change, sustain that change, and never, ever, ever do anything to look back or change that. Like people come into and out of readiness all the time. So the fact is.

Harm reduction interventions and treatment interventions are complementary to each other, right? The more harm reduction you do, the more people alive, more people can get into treatment. And if people come out of treatment, which happens, right, people start treatment and then leave. Then you have a network of resources that people can connect to that doesn't rely on them not using in order to be able to support them. And in fact.

We think of these things as blended together, right? How do we blend harm reduction and treatment in a way where everyone has access to overdose prevention, just as you mentioned, naloxone test strips, the tools and resources to keep themselves alive? Because again, no one's recovers if they've died.

Dr. Buttlare 30:58

You know, I always have thought about harm reduction as reducing shame.

Dr. Hurley 31:02

Yeah.

Dr. Buttlare 31:04

Which I think that keeping people engaged in some way and allowing them to keep in contact, whatever they can do to do, I think is so important. So along with that, you know, overdose risk is highest following emergency department discharge.

Dr. Hurley 31:14

Yeah.

Dr. Buttlare 31:22

Inpatient release and incarceration. What has your system? What has LA counties learned about initiating MOUD rapidly and ensuring continuity during these transitions?

Dr. Hurley 31:36

So I in our correctional health system, we had a program where have a program where anyone with opioid use disorder gets initiated on opioid meds on opioid use or doesn't necessarily matter if they want to like continue in treatment.

Our system very strongly used injectable buprenorphine as a way of making sure that people had buprenorphine on board on their transition out when people are leaving treatment programs. Same same principle. It doesn't have to be injectable buprenorphine, but the people have been initiated on and have access to a prescription for a medication that they can.

Go pick up like that day on their discharge from the hospital, on their discharge from residential, on their discharge from any other congregate setting or on their release from custody. One other thing that we did is we created a telephone line that anyone can call if they needed.

Dr. Buttlair 32:30

Mhm.

Dr. Hurley 32:31

A refill, right. So the idea was we wanted to make sure that anyone in any kind of publicly funded system of care had universal access to like an on-call prescribing clinician that could evaluate the patient. And oftentimes these are quick conversations. Yes, I have opioid addiction. Yes, this is my dose of buprenorphine.

This is why I need a refill now like it is not very sophisticated amount of evaluation that's necessary when a patient knows what they want and has prior treatment experience. So you can have a really focused conversation and thankfully.

The prior and current administrations have enabled ongoing telehealth prescribing of buprenorphine in order for people to have access to buprenorphine through that kind of flexibility. Last thing I'll throw out is our jail has vending machines for naloxone, not for buprenorphine, but for naloxone. So literally on your way out of custody, you hit a button.

Get a dose of naloxone. It is the single biggest of all the sites in LA that's the single biggest source of naloxone is through those vending machines, highlighting just how important it is to make sure that overdose prevention is accessible to people leaving custody.

Dr. Buttlair 33:42

What a great idea. What a great idea. And you know, we talked, we touched on this a little bit earlier, but I do want to go back to it a little bit is what what new competencies must today's addiction workforce develop to practice safely?

And effectively in a fentanyl dominated, dominated environment.

Dr. Hurley 34:05

I think the substance use disorder workforce has evolved. It's come from a history of usually being non-medical or non-clinical, right? So our federally licensed OTPs have long standingly dispensed medications to patients who are there for dosing, but our non OTP agents.

Dr. Buttlair 34:09

Mhm.

Dr. Hurley 34:25

Agencies, you know in in California are in a part of the health and safety code of non medical treatment. I mean literally it's in, it's in the regulatory framework, right. So, so one of the big areas.

That our specialty addiction treatment system really needs to understand is the principles of medication management, which are not universally understood to make sure that those medical clinicians as member of the workforce, they can provide, you know, on demand medical care to people and that the treatment of opioid use is sort of starts with medications or opioid use, right.

That is sort of like the foundation of, you know, successful recovery for so many patients is access to medication therapy service. So in some ways it's medicalizing. I don't mean like entirely transforming, but including a medical component among the medications counseling support that's available to people. And I think demist.

Defying all of those things. And people think that an MOUD program is about a prescriber, a doctor, a practitioner, a PA, you know, another prescriber. But the truth is that the prescriber is necessary. You can't prescribe anything without a prescriber. But.

It is an entire team activity. Medications are over. You sort of start with the security guard that's out front of your waiting room. It starts with the receptionist. It starts with the first counselor that's oftentimes doing screening or the licensed clinician supervising that counselor, right. It starts with, you know, from soup to nuts.

Dr. Buttlare 35:44

Hmm.

Dr. Hurley 35:55

Because people need, everyone on the team needs to know that this is part of what we offer here, because you will be surprised at what people will say if they don't know. No, we don't do that here. That's not really sobriety, whatever, right? So much stigma around addiction medications.

Persists in the addiction treatment system. So understanding that we actually have service standards and expectations. And then I'll also say, according to National Survey and Drug Use on Health, less than 20% of people with opioid use disorder get these medications and less than 20% of people with substance use problems.

get treatment for their substance use problems. So there's a huge need to then make sure our hospital, primary care, especially medical care and community mental health and our carceral health, like the entire sector of healthcare understands that opioid use disorder can be diagnosed in any setting of care and treated in any setting of care, right? And that it is

The responsibility of the team working there, which is again, it includes the medical clinicians, but also includes everybody else. Nursing staff, Mas, LVNS, you know, other support staff, receptionist staff. I mean, it means the entire system actually understanding how to effectively treat opioid use disorder.

Dr. Buttlare 37:11

You're really describing, you know, the the standard of team-based care, right? And I think that's so important in all aspects of treating somebody who has a serious mental illness or a serious substance abuse.

Dr. Hurley 37:16

That's right. That's right.

Dr. Buttlare 37:27

Standard now and practice and the research really highlights that team based approach. So I appreciate that. And now I'm going to ask you something that I think you're really well suited for about policy and finance. You're not only a.

Dr. Hurley 37:43

Mhm.

Dr. Buttlair 37:46

Clinician and a physician, but you're also an administrator, right? You're a leader in your system, so.

Dr. Hurley 37:49

Mm-hmm. That's right.

Dr. Buttlair 37:54

This is an important public issue is where our reimbursement and regulatory frameworks still misaligned with what frontline clinicians need to do. And if you could change one policy lever tomorrow, what would you, what would you do and what would it be?

Dr. Hurley 38:12

Oh goodness, I would one. I would ask for more than one, but let me so, yeah, yeah, yeah. So again, I I the space that occupies an administrator is LA County's specialty SUD system as the medical director of that system.

Dr. Buttlair 38:16

You can. You can give more than one, please.

Dr. Hurley 38:32

And that that we are subject to the state of California's laws and regulations. And so the state of California enabled us through something called payment reform.

So start paying rates differently and setting rates differently. So we've built in a number of incentive payments into our system so that if your agency treats more than and we pick numbers and it changes each fiscal year more than a certain threshold of.

Dr. Buttlair 38:58

Hmm.

Dr. Hurley 39:07

Opioid use disorder are offered medications or abuse order and receive medications. We have sort of tears in the way we operationalize the payments. Your agency gets more funding and it's amazing when it actually impacts the bottom line, how quickly an agency can actually align its protocols because it's no longer the right thing to do, although it is the right.

Dr. Buttlair 39:16

Hmm.

Dr. Hurley 39:27

Thing to do. It is also a financial driver, right? It's also something that enables your agency to grow your services, right? So we have an entire value based incentive framework. We also, but having those value based incentives is insufficient.

If agencies don't have enough capital to be able to like hire the workforce and you know, like do the enhancement activities. So there's a need for both like kind of upfront capacity building funding, value based incentives so that you actually see the system performing the way that you do. None of this would be possible without the state.

Enabling payment reform to take place at the county level. So like like as an administrator, you know, yes, I know what I want to do with patients, but how do I operationalize that in a payment methodology that brings us closer to that is something that I feel very privileged to work on.

I mentioned, you know, the Modernizing Opiate Treatment Access Act, MOTTA, which would enable methadone to be prescribable through addiction physical specialists, which I think would be an important improvement.

But I think there's so much state and federal language. This sort of assumes that treatment has to be focused on full, sustained abstinence. And like in no other area of health care do we require people to kind of already be in remission.

Before they can start treatment, like we don't require people with diabetes to have the blood sugar under control before they start to room for diabetes or people with high blood pressure to have their blood pressure better in order start blood pressure. But we sort of have a history of doing that. Let me know when you're ready to never smoke, inject or use any drugs ever for the rest of your life and no more caffeine.

And no more tobacco and no more anything at all whatsoever. And then we'll have a conversation with you about whether to start. And so one other policy I'd say is how do we reach the between 80 and 95% of people that aren't in treatment? We make treatment easier. We lower the threshold.

And help work with people much upstream in terms of their readiness to make changes. And we prioritize to the point you made earlier, engaging with people rather than you have to be perfectly compliant with everything on my checklist or else you're out. It's how do we build treatment around people as opposed to expecting people to comply with everything that we want them to.

To do.

Dr. Buttlare 41:58

And it sounds like your incentive program sort of aligns with that because it really is encouraging providers to actually allow more people to get treatment. So, yeah, so I I think that's important and I I'm sort of curious about.

Dr. Hurley 42:10

Exactly.

Dr. Buttlare 42:16

Because I know you're involved with, you know, the state in many ways and are your colleagues creating value based programs in other counties?

Dr. Hurley 42:28

We're, to my knowledge, the only county that's adopted A value-based framework. We presented at conferences other counties go to. I get asked questions about it a lot, but it really speaks to the need for there being leadership at the county level to operationalize this work. And we're the only county.

That has our substance use system that's separate from our Department of Mental Health, which on one hand doesn't make a lot of sense because a lot of patients need integrated care. On the other end though, it enables us to innovate in the specialty SDD system to achieve that client level service integration, right? So what we all want is for people to get integrated care from an integrated care team like that.

That's clearly a goal, but you don't necessarily get that by pretending that every managed care organization or every, you know, behavioral plan is going to focus on substance use. You need a dedicated champion to be able to operationalize that. And I actually think LA County's administrative structure enables that in a way that.

Helps this innovation move forward. No other county has a separate, departmentally distinct substance use program compared to the special mental health program. And I think as a result, in many other counties we see mental health services get all the priority in terms of the talent and the attention and the innovation in some ways because it's.

Not there's not an equivalent attention to the substance use system.

Dr. Buttlair 43:54

Well, it's really interesting that LA has really been in the lead of this and it sounds like your structure really supports the innovation.

Dr. Hurley 44:03

We're very lucky to have the structure we do.

Dr. Buttlair 44:03

Yes, I, I, you know, I, you know, we joke in California, if you know one county, you know one county and I think that's unfortunately, unfortunately that's the the case in in a lot of ways. But it sounds like you guys are able to really innovate which is terrific and.

Dr. Hurley 44:12

That's right.

Dr. Buttlair 44:23

You know, I'm going to ask you now about strategic priorities for leaders. If you are advising, and this is the magic wand question, CEOs and Medicaid directors or public health leaders today, what two or three strategic priorities should they focus on to improve outcomes?

Dr. Hurley 44:27

Mhm.

Dr. Buttlair 44:42

In the fentanyl era.

Dr. Hurley 44:43

Mhm.

So a universal access to addiction medications, which I think we've I've mentioned several times, but that really being a key priority and it that does not mean going and hiring a bunch of new people because you have to have a whole separate workforce on it. It's how do we take advantage of the resources we have and adapt.

Dr. Buttlair 44:50

Yeah.

Dr. Hurley 45:02

And create expectations for our existing prescribing workforce in order to make this life-saving treatment available, right. So it's it's really more of a change management thing than it is. I need a bunch of new resources thing, but are being very focused on a universal access to addiction pharmacotherapy as a standard of care for opioid use disorder.

Our initiative here around lowering barriers to admission, we call reaching the 95%, which is basically how do you make treatment more accessible and discharge harder. When I say harder, it doesn't mean people can't step down from residential to non residential, but the idea is you create a system where the.

Dr. Buttlair 45:27

Hmm.

Dr. Hurley 45:41

Expectation is that people are going to be connected long term to your system of care. That addiction isn't an infection you can treat with an antibiotic or a, you know, a time limited condition that you're fixed when you leave any particular setting, right? It's a chronic medical disease that needs long term treatment.

And to understand that that working with people with non abstinent goals of care, right, so people have access to, you know, naloxone and test strips, but working with people that might still be drinking or using is not actually going to take away from the benefits people get in abstinence focused or change oriented treatment.

But if we're really, you know, serious about building a system that helps protect the health and Wellness of entire community means working with people well upstream of their readiness to, you know, commit to full sustained abstinence. So going upstream, connecting to the entire community and that oftentimes means.

Sort of understanding and embracing harm reduction in a way that isn't always well understood, but is so, so important.

Dr. Buttlare 46:42

This was a terrific discussion and I want to thank you, Doctor Hurley, for sharing your experience and insights, and thank you to everyone who joined us today. We hope this conversation provided practical perspectives on how organizations can adapt.

Induction protocols integrate harm reduction into core operations, strengthen transitions of care, align clinical practice with realities of fentanyl era, and some additional perspectives on engagement.

So this webinar is part of the RE Academy 12 part series for 2026 and we invite you to join us for our next session, Why Opioid Use Disorder is best understood and treated as a chronic brain disease.

That session will examine the neurobiology of opioid use disorder and explore why framing OUD as a chronic brain disease has important implications for stigma reduction, long term treatment engagement.

Workforce education and system design, and I want to thank you again for being part of today's discussion.

Dr. Hurley 47:55

Thanks again for having me.