Protocols and lessons learned in integrating long-acting buprenorphine and antiretrovirals in HIV primary care

Disclosures and Acknowledgements

- We have nothing to disclose.

- Acknowledgments
  - Madison and MOD Providers and Nurses
  - Dr. Eve Lake
  - Emma Joubert, Madison LAI RN
  - Madison LAI ART Team

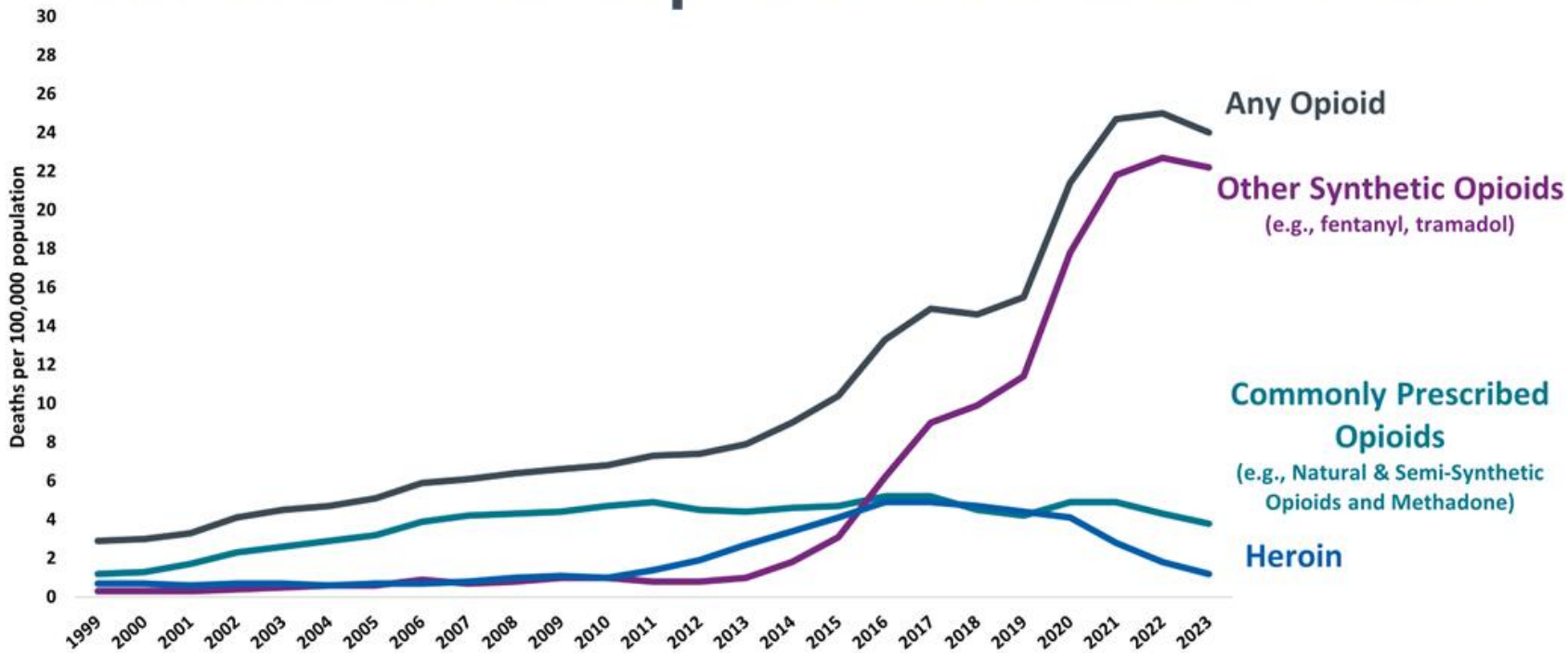
Objectives

- Describe the epidemiology, risks, and clinical outcomes for people with HIV who use opioids
- Recognize the evidence-base for medications for opioid use disorder and describe the pharmacology of long-acting injectable buprenorphine
- Identify how long-acting injectable buprenorphine can be integrated with long-acting injectable antiretroviral therapy through nurse-driven protocols

Substance Use Epidemiology

UNIVERSITY of WASHINGTON

Three Waves of Opioid Overdose Deaths



Wave 1: Rise in Prescription Opioid Overdose Deaths Started in the 1990s

Wave 2: Rise in Heroin Overdose Deaths Started in 2010

Wave 3: Rise in Synthetic Opioid Overdose Deaths Started in 2013

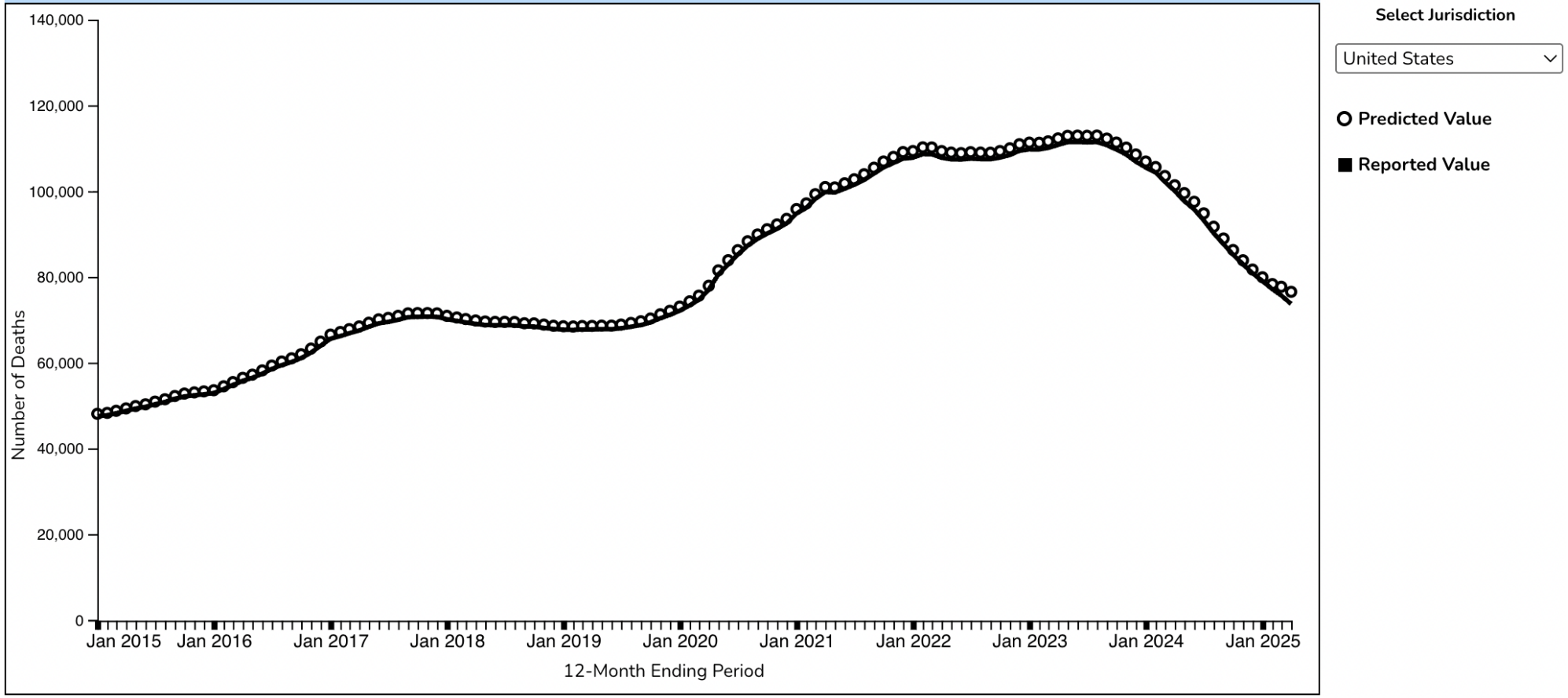
SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2024. https://wonder.cdc.gov/.

CDC

12 Month-ending Provisional Number and Percent Change of Drug Overdose Deaths

Based on data available for analysis on: September 7, 2025

Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: United States



King County Fatal Overdose Dashboard

Updated 5/12/2026

Public Health
Seattle & King County

Click boxes for more information

Summary of Overdose Deaths in King County

Drugs Involved — Multiple types of drugs are usually involved in a fatal overdose.

Trends — The number of overdose deaths has fluctuated since peaking in 2023.

Demographics — Overdose incidence varies by age, sex, race, and presumed living situation.

Geography — Overdose deaths most frequently occur in Seattle and South King County.

Methods Report — This report describes the data sources, definitions, and measures utilized in this dashboard.

Monthly Trends in Fatal Overdoses in King County

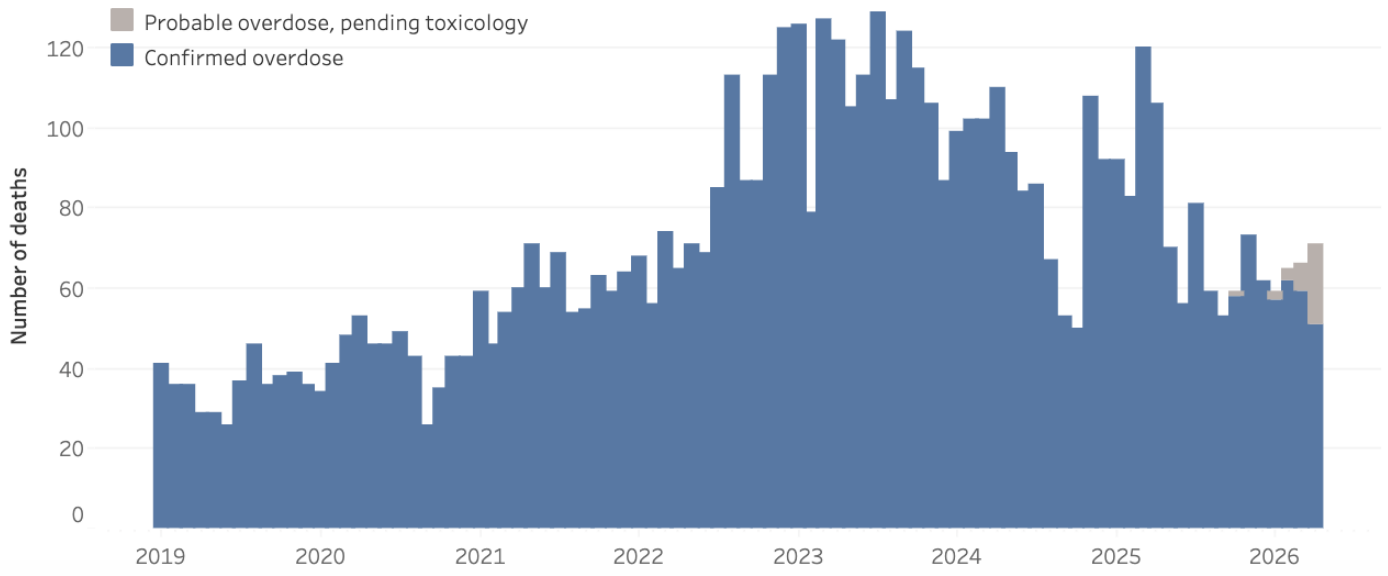
Data source: King County Medical Examiner's Office

View data by:

- ○ Week (rolling average)
- ◉ Month
- ○ Quarter
- ○ Year

Filter data by:

- ◉ All
- ○ Fentanyl
- ○ Fentanyl not detected



Are we in a 4th wave?

Preventive Medicine 152 (2021) 106541

Contents lists available at ScienceDirect

Preventive Medicine

journal homepage: www.elsevier.com/locate/ypmed

The fourth wave of the US opioid epidemic and its implications for the rural US: A federal perspective

Richard A. Jenkins *

National Institute on Drug Abuse, Bethesda, MD, United States of America

ARTICLE INFO

Keywords:
Opioid epidemic
Rural health
Stimulant/opioid epidemic
Drug/mental illness

ABSTRACT

The current opioid epidemic in the United States has been characterized as having three waves: prescription opioid use, followed by heroin use, and then use of synthetic opioids (e.g., fentanyl), with early waves affecting a population that was younger, less predominantly male, and more likely to be Caucasian and rural than in past opioid epidemics. A variety of recent data suggest that we have entered a fourth wave which can be characterized as a stimulant/opioid epidemic, with mental illness co-morbidities being more evident than in the past. Stimulant use has introduced new complexities in terms of behavioral consequences (e.g., neurological deficits, suicidal ideation, psychosis, hostility, violence), available treatments, and engagement into services. These compound existing issues in addressing the opioid epidemic in rural areas, including the low density of populations and the scarcity of behavioral health resources (e.g., fewer credentialed behavioral health professionals, particularly those able to prescribe Buprenorphine). Considerations for addressing this new wave are discussed, along with the drawbacks of a wave perspective and persistent concerns in confronting drug abuse such as stigma.

Drugs involved in overdose deaths in King County

Data Source: King County Medical Examiner's Office

→ Next tab: Trends

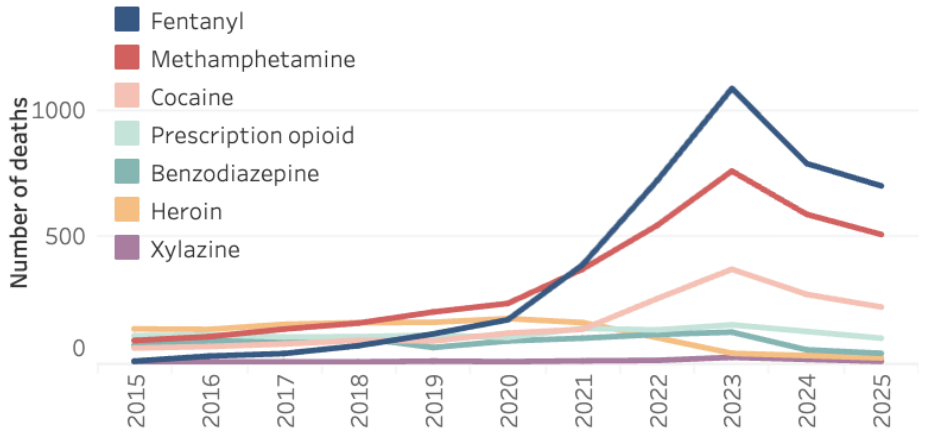
Click to view interpretation of the data

Drugs Involved in King County Overdose Deaths, 2015-2025

Drug overdose deaths typically involve multiple drug classes - most commonly opioids and stimulants.

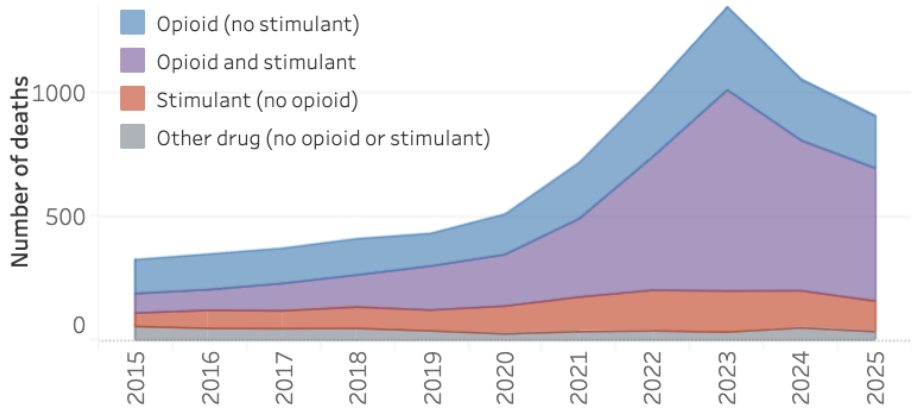
Specific drug classes involved in overdose deaths

Note: Individuals can be represented in more than one line



Number of Overdose Deaths Involving Opioids and/or Stimulants

Note: Individuals are represented only once; **Opioid** = Fentanyl, Heroin, an/or Prescription Opioids; **Stimulant** = Methamphetamine and/or cocaine



Drug combinations in 2025 overdose deaths

This bar chart enables viewers to see which drug combinations cause overdose deaths. Click on a drug listed on the left-hand side to see the other drugs also present at time of death.

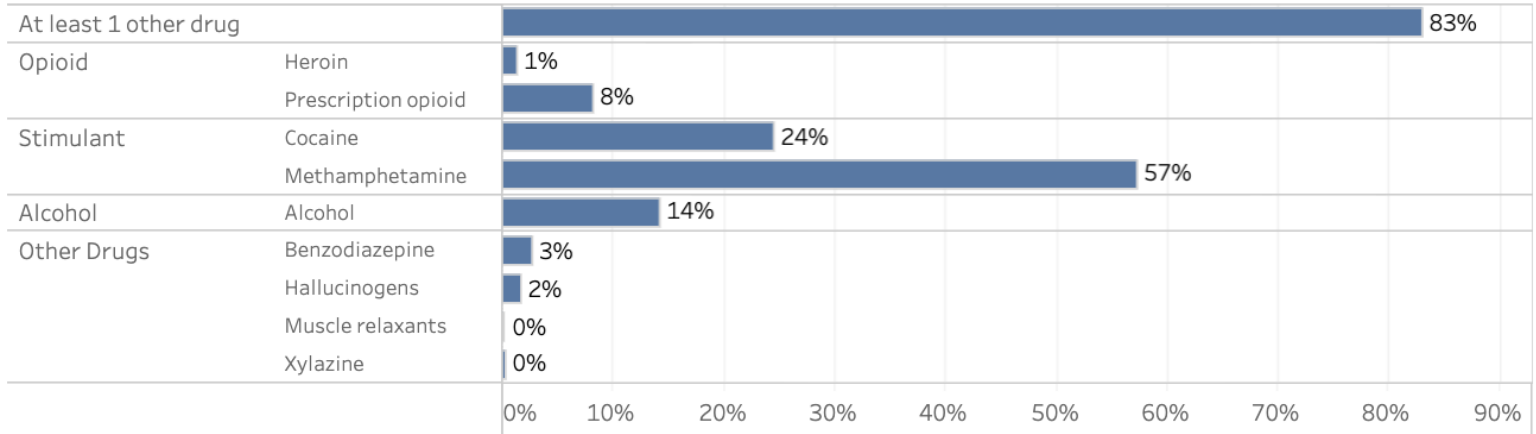
Select drug to view:

- (•) Fentanyl
- ( ) Methamphetamine
- ( ) Cocaine
- ( ) Prescription opioid
- ( ) Benzodiazepine
- ( ) Heroin
- ( ) Xylazine

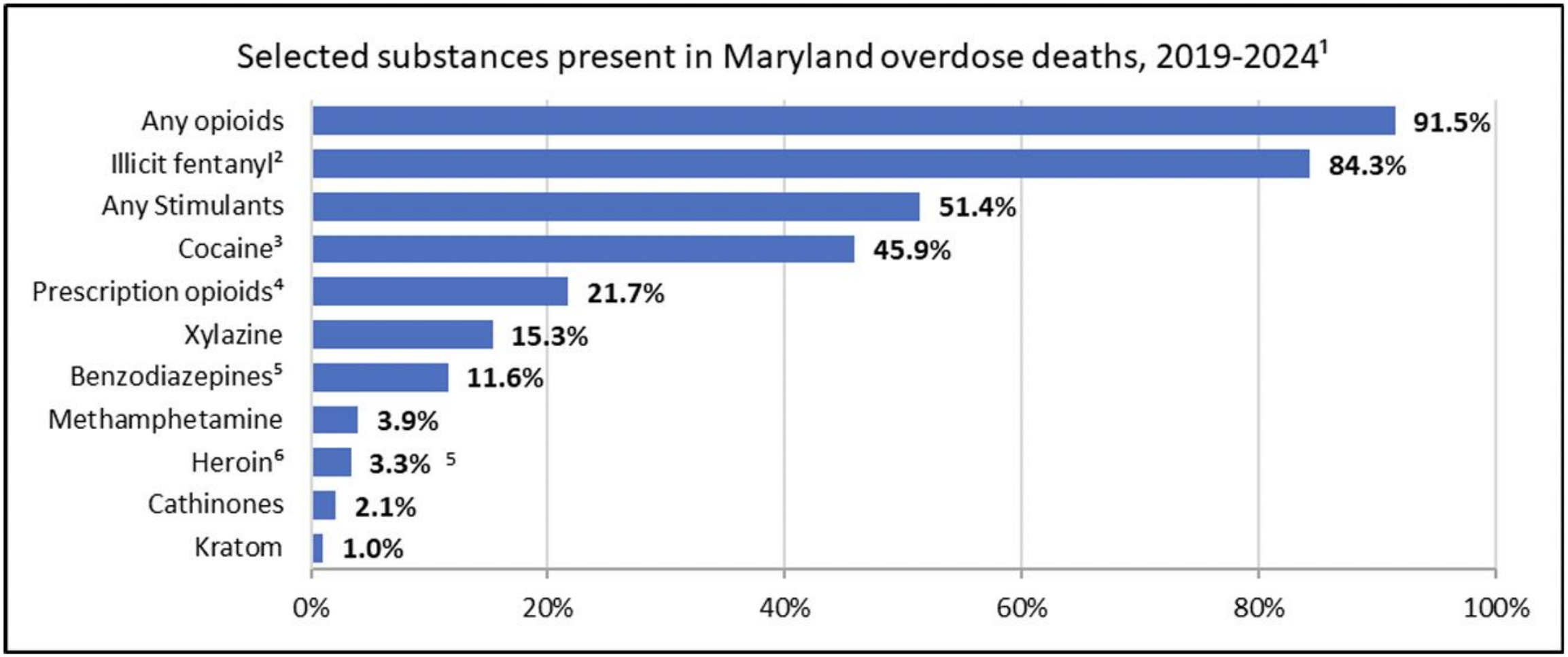
*__Cocaine:__ this includes both powder cocaine and rock-like cocaine commonly referred to as crack.
__Note:__ Drugs are included here if they were indicated on the death certificate as a cause of death.

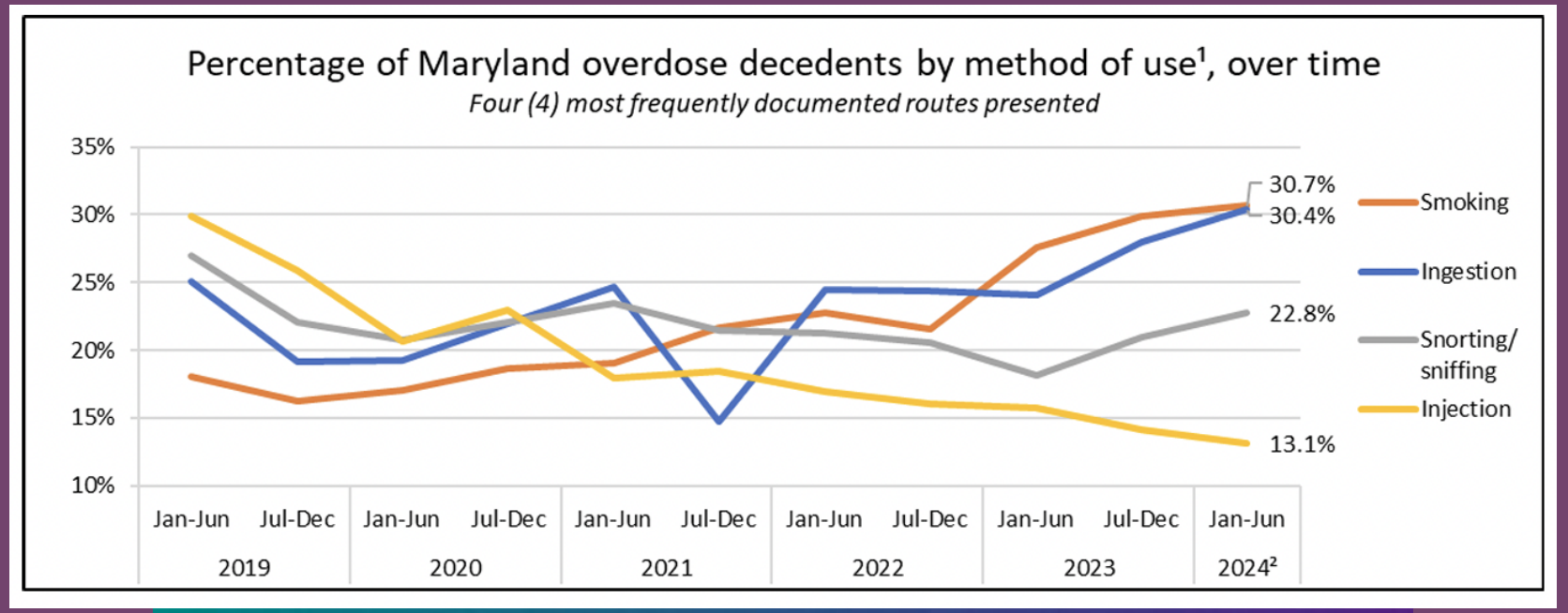
Drugs detected in: Fentanyl-involved deaths

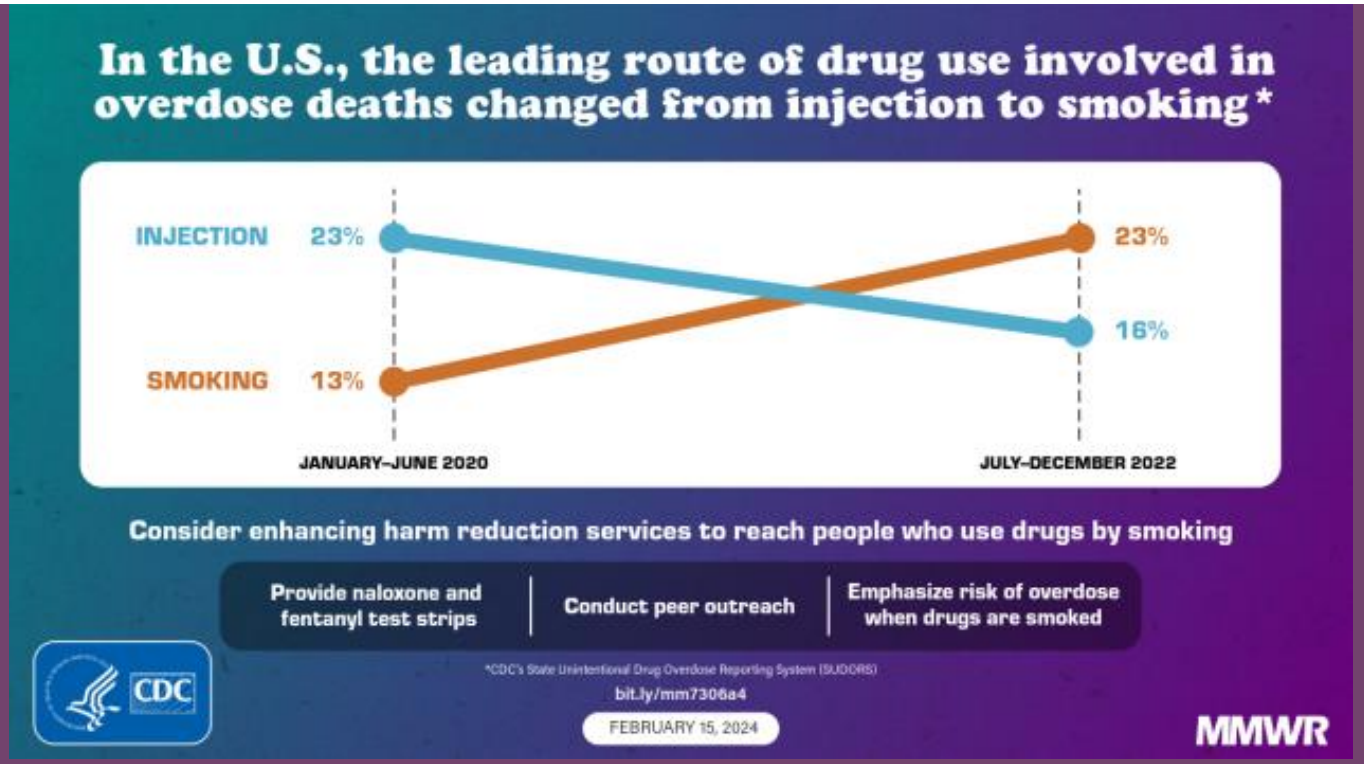
In 2025, there were 699 overdose deaths that involved Fentanyl, representing 78% of all overdose deaths in King County. These deaths also involved:



- About 17 out of 20 overdose deaths involved illicitly manufactured fentanyl (84%).
- Over half of all overdose deaths involved a stimulant (51%); with 46% including cocaine.
- Just over 1 in 5 overdose deaths was positive for a prescription opioid (22%).




Percentage of Maryland overdose decedents by method of use[1], over time
Four (4) most frequently documented routes presented
35%
30%
25%
20%
15%
10%
30.7%
30.4%
22.8%
13.1%
Smoking
Ingestion
Snorting/ sniffing
Injection
Jan-Jun
Jul-Dec
2019
2020
2021
2022
2023
2024[2]


In the U.S., the leading route of drug use involved in overdose deaths changed from injection to smoking*
INJECTION
23%
23%
16%
SMOKING
13%
JANUARY–JUNE 2020
JULY–DECEMBER 2022
Consider enhancing harm reduction services to reach people who use drugs by smoking
Provide naloxone and fentanyl test strips
Conduct peer outreach
Emphasize risk of overdose when drugs are smoked
*CDC's State Unintentional Drug Overdose Reporting System (SUDORS)
bit.ly/mm7306a4
FEBRUARY 15, 2024
CDC
MMWR

HIV and Opioid Use

- People who use opioids are at increased risk of worse HIV care outcomes:
  - > Increased risk of HIV infection
  - > Decreased access to prevention, including testing
  - > Lower rates of HIV viral load suppression

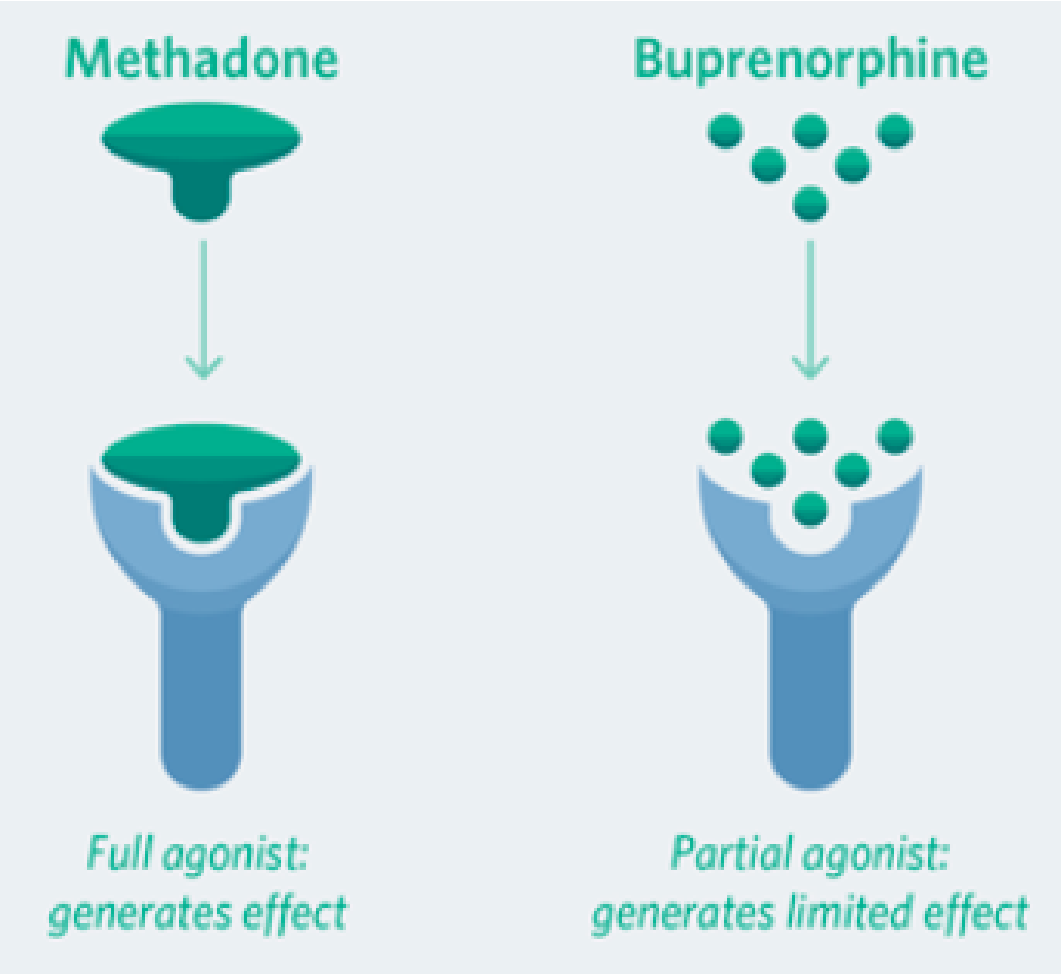
- While integrated HIV care (treatment and prevention) with OUD treatment improves care outcomes:
  - > Access to treatment continues to be limited
  - > 1 year retention in treatment care is low

- Limited evidence of co-delivered HIV care and opioid treatment, particularly extended-release formulations

Opioid Use Disorder Management

MOUD

- Medication for opioid use disorder (MOUD) is the gold standard treatment for people with opioid use disorder (OUD).
  - Associated with decreases in future drug use, risk of infectious disease transmission, and adverse drug use events, including overdose.
  - However, access to MOUD is limited for many patients.



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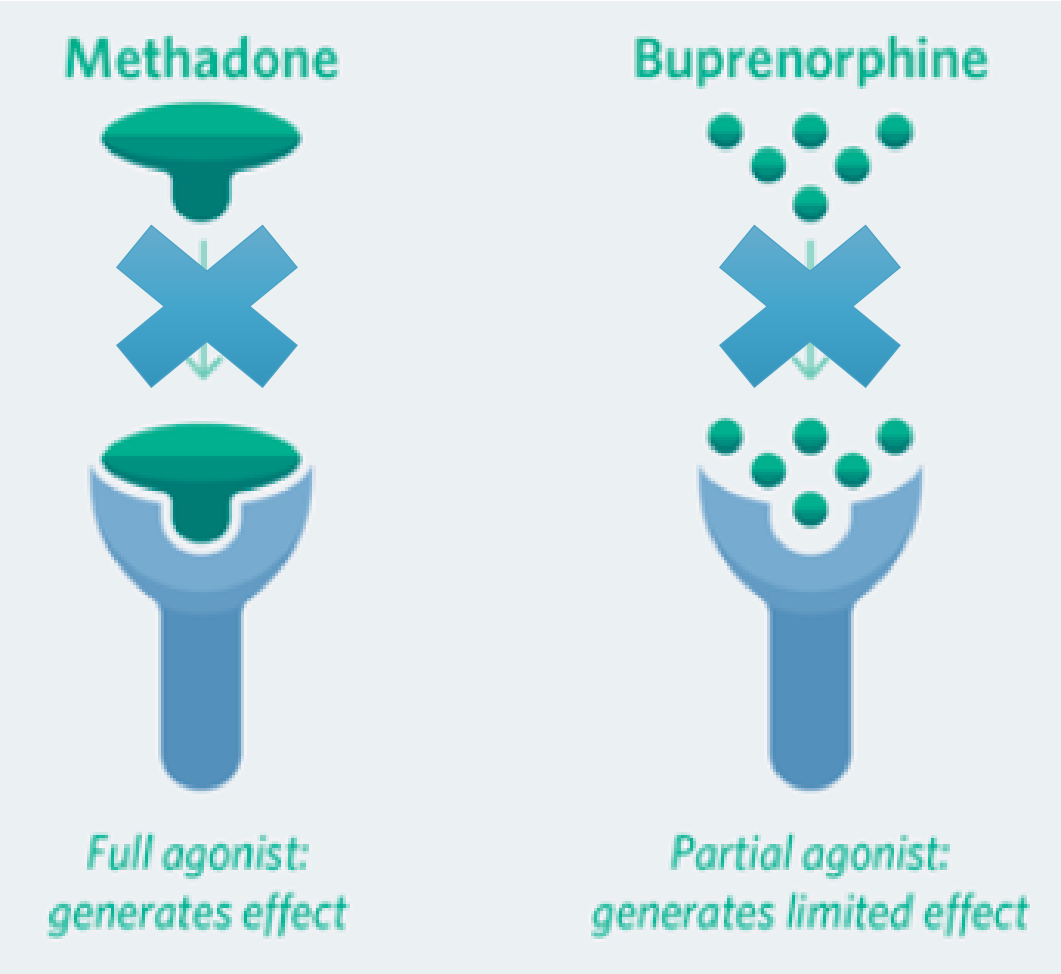
  - Associated with decreases in future drug use, risk of infectious disease transmission, and adverse drug use events, including overdose.
  - However, access to MOUD is limited for many patients
  - Not on Naltrexone in OUD



Health systems break

Where can patients get these medications?

- **Opioid Treatment Programs (OTPs)**
- **Office-based therapy**
  - **Office-based opioid treatment (OBOT)**
    - **Role of Nurses care-managers**

Quick Methadone Note

- It interacts with EVERYTHING!
- Okay not really
- But make sure to document when patients are in a methadone program
- Dose adjustments of methadone needed for some classes of ART (particularly some NNRTIs and PIs)
- Methadone can also cause QT prolongation

SCREENING

- Alternatives
  - Alcohol to ask the number of standard drinks per week
    - Outside of the 7-14 range per week is also considered problematic
  - Recreational drugs
    - Opioids (heroin, fentanyl, prescription pills not prescribed to you)
    - Stimulants (cocaine, crack, methamphetamine)
    - Benzos

Brief health screen

We ask all our adult patients about substance use and mood because these factors can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

Alcohol: One drink = 

12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

How many times in the past year have you had **4** or more drinks in a day? _____

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons? _____

Mood:

	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○

OUD Diagnosis

DSM-5 Criteria for Diagnosis of Opioid Use Disorder

Diagnostic Criteria*

These criteria not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Check all that apply

	Opioids are often taken in larger amounts or over a longer period of time than intended.
	There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
	Craving, or a strong desire to use opioids.
	Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
	Important social, occupational or recreational activities are given up or reduced because of opioid use.
	Recurrent opioid use in situations in which it is physically hazardous
	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
	*Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid
	*Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms

Total Number Boxes Checked: _____

Severity: **Mild**: 2-3 symptoms. **Moderate**: 4-5 symptoms. **Severe**: 6 or more symptoms

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Clinical Opiate Withdrawal Scale (COWS)

1. Resting pulse rate:
Measured after patient is sitting or lying for 1 minute

Pulse rate 80 or below ❑0
Pulse rate 81-100 ❑1
Pulse rate 101-120 ❑2
Pulse rate greater than 120 ❑4

___ ___ ___ bpm

2. GI upset:
Over last ½ hour

No GI symptoms ❑0
Stomach cramps ❑1
Nausea or loose stool ❑2
Vomiting or diarrhea ❑3
Multiple episodes of diarrhea or vomiting ❑5

3. Sweating:
Over past ½ hour not accounted for by room temperature or patient activity

No report of chills or flushing ❑0
Subject report of chills or flushing ❑1
Flushed or observable moistness on face ❑2
Beads of sweat on brow or face ❑3
Sweat streaming off face ❑4

4. Tremor:
Observation of outstretched hands

No tremor ❑0
Tremor can be felt, but not observed ❑1
Slight tremor observable ❑2
Gross tremor or muscle twitching ❑4

5. Restlessness:
Observation during assessment

Able to sit still ❑0
Reports difficulty sitting still, but is able to do so ❑1
Frequent shifting or extraneous movements of legs/arms ❑3
Unable to sit still for more than a few seconds ❑5

6. Yawning:
Observation during assessment

No yawning ❑0
Yawning once or twice during assessment ❑1
Yawning three or more times during assessment ❑2
Yawning several times per minute ❑4

7. Pupil size

Pupils pinned or normal size for room light ❑0
Pupils possibly larger than normal for room light ❑1
Pupils moderately dilated ❑2
Pupils so dilated that only the rim of the iris is visible ❑5

8. Anxiety or irritability

None ❑0
Patient reports increasing irritability or anxiousness ❑1
Patient obviously irritable or anxious ❑2
Patient so irritable or anxious that participation in the assessment is difficult ❑4

9. Bone or joint aches:
If patient was having pain previously, only the additional components attributed to opiate withdrawal is scored

Not present ❑0
Mild diffuse discomfort ❑1
Patient reports severe diffuse aching of joints/muscles ❑2
Patient is rubbing joints or muscles and is unable to sit still because of discomfort ❑4

10. Gooseflesh skin

Skin is smooth ❑0
Piloerection of skin can be felt or hairs standing on arms ❑3
Prominent piloerection ❑5

11. Runny nose or tearing:
Not accounted for by cold symptoms or allergies

Not present ❑0
Nasal stuffiness or unusually moist eyes ❑1
Nose constantly running or tears streaming down cheeks ❑4

The total score is the sum of all 11 items.

Total Score: ___ ___

SCORE:

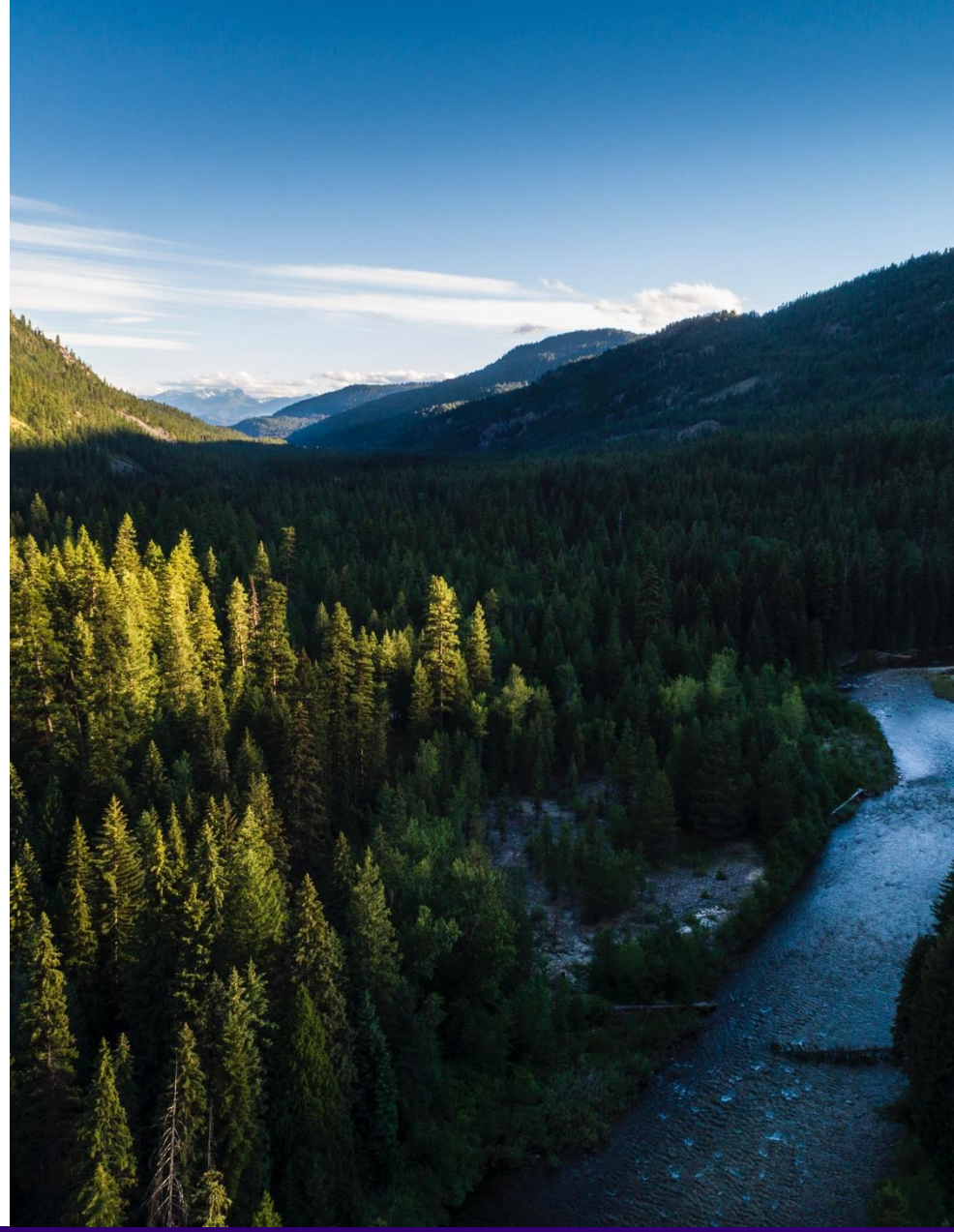
5-12=mild
13-24=moderate
25-36=moderately severe
more than 36=severe withdrawal

Other Important Pieces of Information

- Amount of opioid used per day
- Method of use
- History of injecting
- Overdose history
- Other substance use (don’t forget alcohol!)
- Co-morbidities
- Substance use treatment history
- Check Prescription Drug Monitoring Program

Principles for Prescribing

- Precipitated withdrawal is a concerns, but should not inhibit prescribers
- During initiation, you want to replace mu receptors bound by fentanyl (or unbound) with buprenorphine
- Buprenorphine is competitively binding
- Is the patient experiencing withdrawals or willing to go into withdrawals before starting?
- Note: Many patients will have more experience in starting buprenorphine and know how to titrate



High Dose Initiation

Table
Instructions for a High-Dose Buprenorphine-Naloxone Initiation[10]

Day	Buprenorphine-Naloxone	Quantity of Films per Day	Dosing Frequency	Maximum Buprenorphine Dose	Full Agonist Opioid
0	0	0	0	0	0
1	One or two 8-2 mg films to start then one 8-2 mg film every 1-2 hours up to 32 mg	Up to 4	As rapid as every 1-2 h	32 mg	0
2+	One 8-2 mg film up to 3 times daily (TID)	Up to 3	Up to 1 film TID	24 mg	0

- Best for patients currently in withdrawals or able to wait
- Full agonist use not recommended with this protocol
- Day 0 is a full day of abstinence from a full opioid agonist (typically fentanyl)
- Higher dose on day 1 allows for better saturation of receptors
- 24mg-32mg is sometimes needed as a maintenance dose
- Check-in with patient by day 3

Low Dose Initiation

3-day Sublingual Cross Taper Start

Prescribe 2 mg buprenorphine films #6, 8 mg buprenorphine films #4 for 3 day supply)[4]

- Day 1: 0.5 mg (1/4 of 2mg strip) SL buprenorphine q3 hours (4 mg total daily dose), continue full opioid agonists
- Day 2: 1 mg (1/2 of 2 mg strip) SL buprenorphine q3 hours (8 mg total daily dose), continue full opioid agonists
- Day 3: 8-16 mg (1-2 8 mg strips) SL buprenorphine once daily and 4 mg SL q6h prn withdrawal (max 32 mg total daily dose), wean or stop full opioid agonists

7-day Sublingual Cross Taper Start

Prescribe 2 mg buprenorphine SL strips # 15, 8 mg buprenorphine SL strips #4 for 7 day supply

- Day 1: 0.5 mg (1/4 of 2 mg strip) buprenorphine SL daily (0.5 mg total daily dose), continue full opioid agonist
- Day 2: 0.5 mg (1/4 of 2 mg strip) buprenorphine SL BID (1 mg total daily dose), continue full opioid agonist
- Day 3: 1 mg (1/2 of 2 mg strip) buprenorphine SL BID (2 mg total daily dose), continue full opioid agonist
- Day 4: 2 mg buprenorphine SL BID (4 mg total daily dose), continue full opioid agonist
- Day 5: 3 mg (1+1/2 of 2 mg strip) buprenorphine SL BID (6 mg total daily dose), continue full opioid agonist
- Day 6: 4 mg (2 of 2 mg strip) buprenorphine SL BID (8 mg total daily dose), continue full opioid agonist
- Day 7: 6 mg (3 of 2 mg strip) buprenorphine SL BID (12 mg total daily dose), continue full opioid agonist
- Day 8: 16 mg (2 of 8 mg strip) buprenorphine qday and 4mg (1/2 of 8 mg strip) q6h prn withdrawal (max 32 mg total daily dose), wean or stop full opioid agonists

- Difficulty starting buprenorphine in the past
- Transitioning from prescribed full agonists to buprenorphine (including methadone)
- Patient wants to continue full opioid agonist use during transition
- Not currently in significant withdrawals
- Able to self-administer doses on a more difficult schedule

Injectable Buprenorphine

- Can be dosed weekly or monthly
- Typically, 7 days of SL buprenorphine needed before transitioning
- Two brands: Sublocade (monthly doses) and Brixadi (weekly and monthly doses)
- Sub-cutaneous injection
- Lidocaine recommended

Daily Sublingual Buprenorphine Dose*	BRIXADI Weekly	BRIXADI Monthly
≤6 mg	8 mg	-
8-10 mg	16 mg	64 mg
12-16 mg	24 mg	96 mg
18-24 mg	32 mg	128 mg

3 Day Long-Acting Injectable Buprenorphine Protocol

Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9
Brixadi 8 mg given	Give Brixadi 16 mg	Give Brixadi 16 mg	Restart at Brixadi 8 mg					
Brixadi 8 mg given	**Brixadi 16 mg given**	Give monthly injection	Give monthly injection	Give monthly injection	Repeat Brixadi 16 mg	Repeat Brixadi 16 mg	Repeat Brixadi 16 mg	Restart at Brixadi 8 mg

- For individuals with heavy fentanyl use
- Full agonist likely needed during protocol
- Use of 3 injections
- Limit risk of precipitated withdrawals
- Increase success of saturating mu receptors with buprenorphine
- Preliminary data shows good retention in protocol

Waters RC, Hoog J, Bell C, et al. Injectable-Only Overlapping Buprenorphine Starting Protocol in a Low-Threshold Setting. *JAMA Netw Open.* 2025;8(8):e2527016. doi:10.1001/jamanetworkopen.2025.27016

Buprenorphine dosing and pharmacokinetics

SUBLOCADE

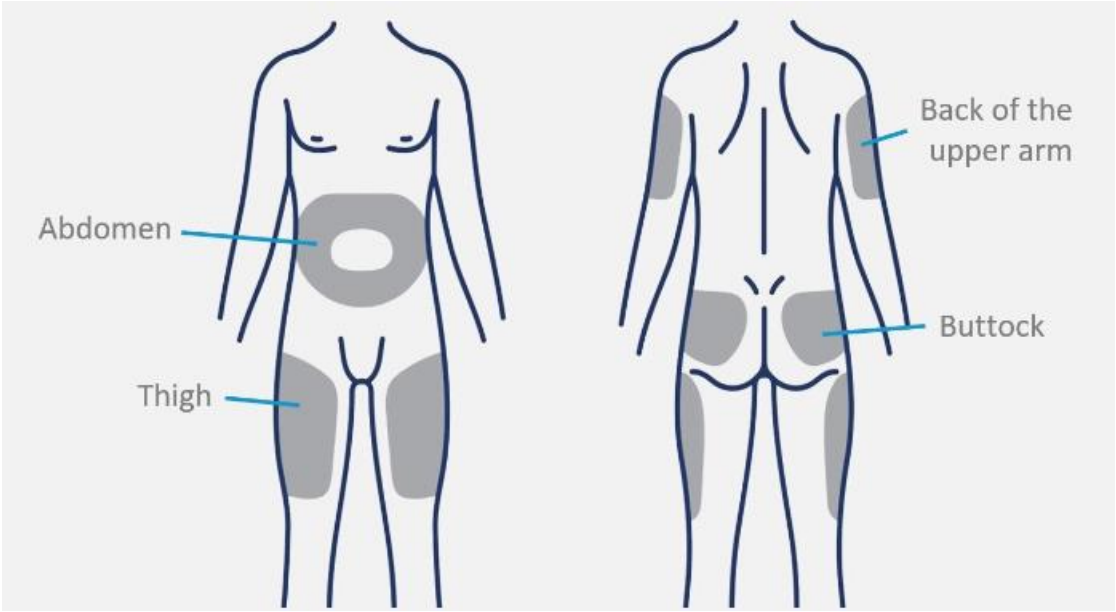
- Monthly
- Before starting: 4 mg SL bupe
- Large injection volume
  - 300 mg is 1.5 mL
  - 100 mg is 0.5 mL
- Half-life
  - 43-60 days
- Elimination period
  - 215-300 days

BRIXADI

- Monthly or weekly
- Before starting: 4 mg SL bupe
- Small injection volume
  - Weekly 0.16 mL - .64 mL
  - Monthly 0.18 mL – 0.36 mL
- Half-life
  - Weekly 3-5 days
  - Monthly 19-26 days
- Elimination period
  - Weekly 15-25 days
  - Monthly 95-130 days

Injection sites and process

- Color of medication can vary
- Subcutaneous tissue
- Tissue site should be free of skin conditions
- Medication is viscous, will take time for bubble to rise, will be a hard push
- Use SQ lidocaine prior to administration- 1% 2mL; 27 gauge 5/8 inch needle
  - Sublocade
- Angle of injection
  - ~ 45 degrees (Sublocade)
  - ~90 degrees (Brixadi)
- Count to 2 before removing needle
- Monitor for 15 minutes after 1st dose



Patient education

- Injection might be painful, you might feel a burning sensation
- There will be a lump that you can see and feel
- You will feel the most effect from this medication 24 hours later
- The first few doses are loading doses and you may need SL bupe
- Once loaded this will last a longtime

Commonly Prescribed Comfort Medications

Muscle Aches, Cramps

- **Methocarbamol** – 500–750 mg PO q6-8h PRN
- **Cyclobenzaprine** – 5–10 mg PO q8h PRN

Anxiety, Agitation, Restlessness

- **Hydroxyzine** – 25–50 mg PO q6h PRN
- **Trazodone** – 25–100 mg PO qHS PRN (for sleep)

Nausea, Vomiting

- **Ondansetron** – 4–8 mg PO q8h PRN
- **Diarrhea, GI Upset**
- **Loperamide**– 4 mg PO x1, then 2 mg PO after each loose stool (max 16 mg/day)

Abdominal Cramps

- **Dicyclomine** – 10–20 mg PO q6h PRN

Insomnia

- **Trazodone** – 25–100 mg PO qHS PRN
- **Melatonin** – 3–10 mg PO qHS

Goosebumps, Sweating, Elevated BP, Tachycardia

- **Clonidine** – 0.1–0.2 mg PO q6-8h PRN

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Nausea, Vomiting

- **Ondansetron** – 4–8 mg PO q8h PRN
- **Diarrhea, GI Upset**
- **Loperamide**– 4 mg PO x1, then 2 mg PO after each loose stool (max 16 mg/day)

Abdominal Cramps

- **Dicyclomine** – 10–20 mg PO q6h PRN

Insomnia

- **Trazodone** – 25–100 mg PO qHS PRN
- **Melatonin** – 3–10 mg PO qHS

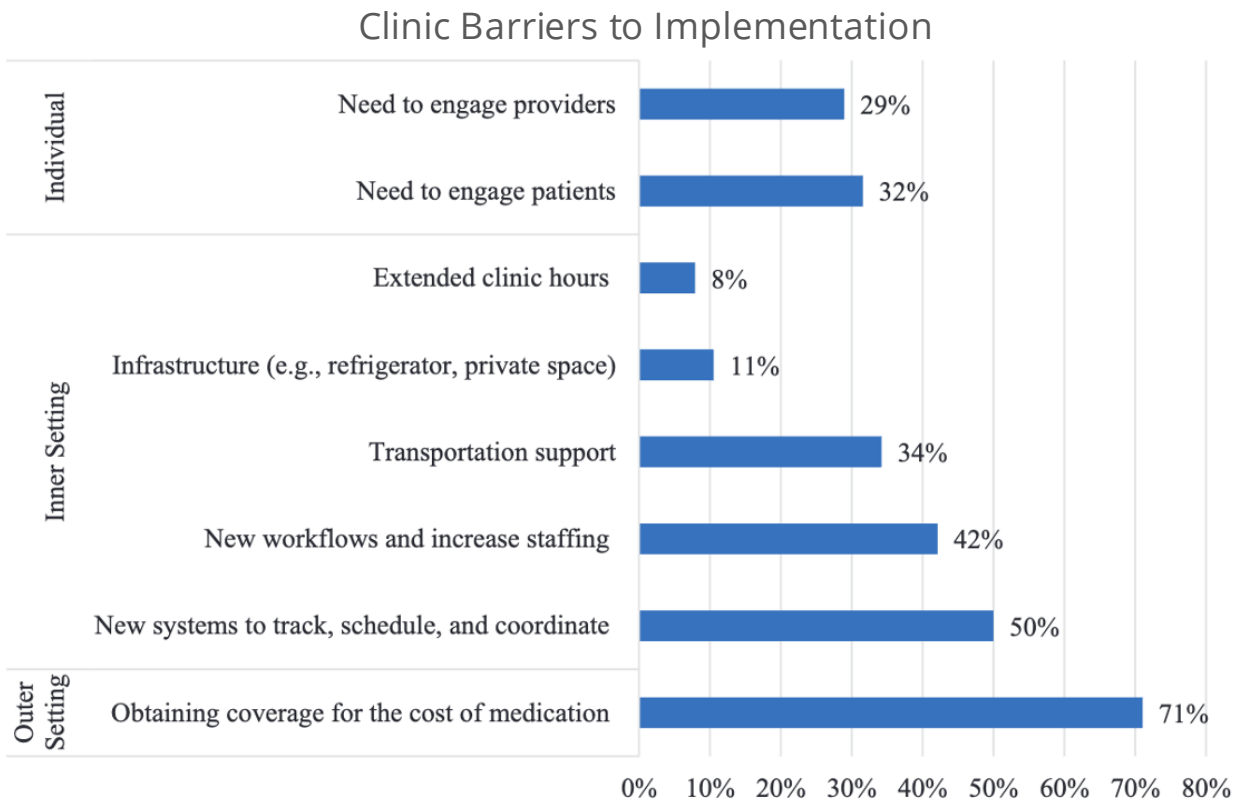
Goosebumps, Sweating, Elevated BP, Tachycardia

- **Clonidine** – 0.1–0.2 mg PO q6-8h PRN

LAI ART in Practice

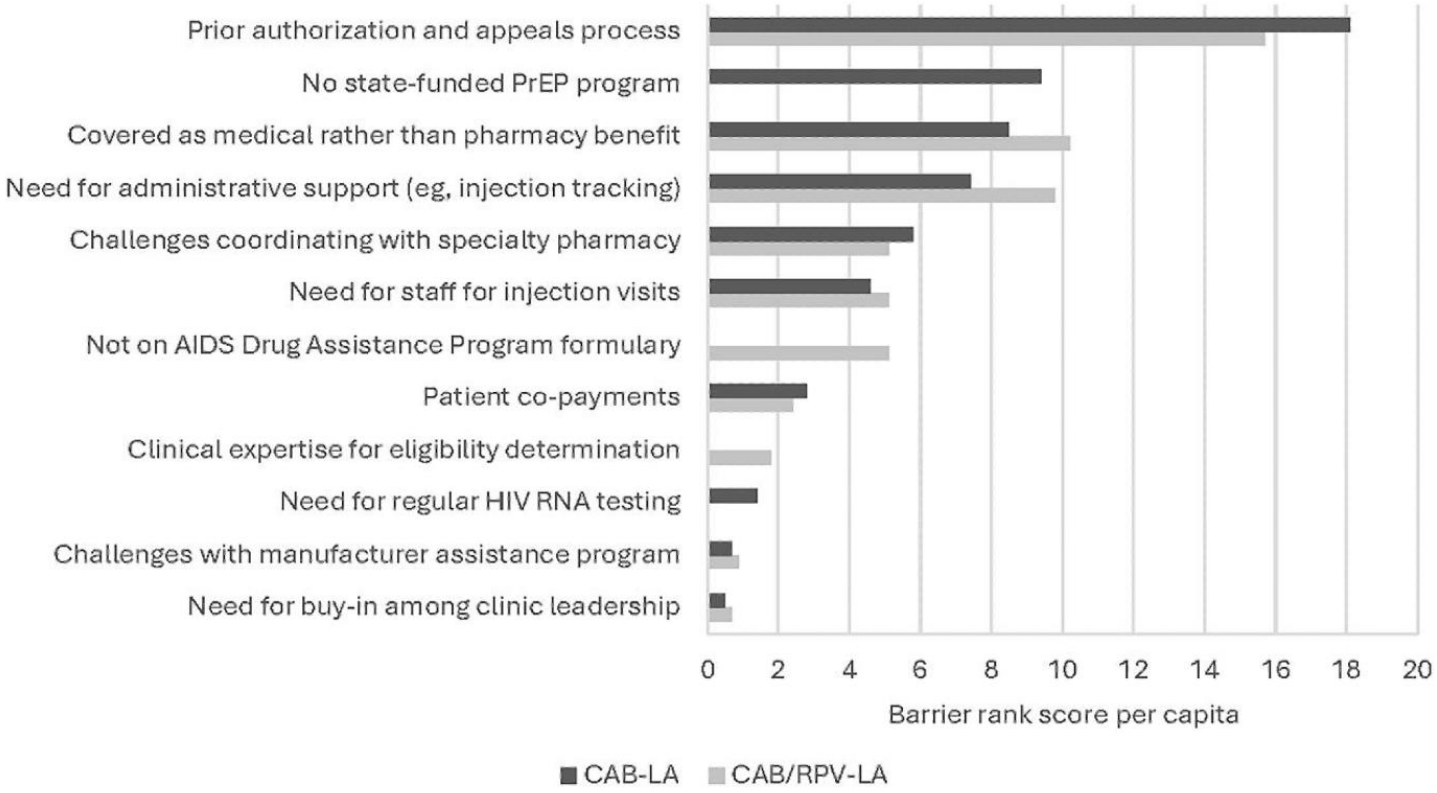
UNIVERSITY of WASHINGTON

Implementation of LAI ART has been Challenging



Nguyen N et al, JIAS, 2024.

Ranked Barriers to Implementation from HIVMA Survey



Marcus JL et al, CID, 2025.

What is Happening at Madison Clinic

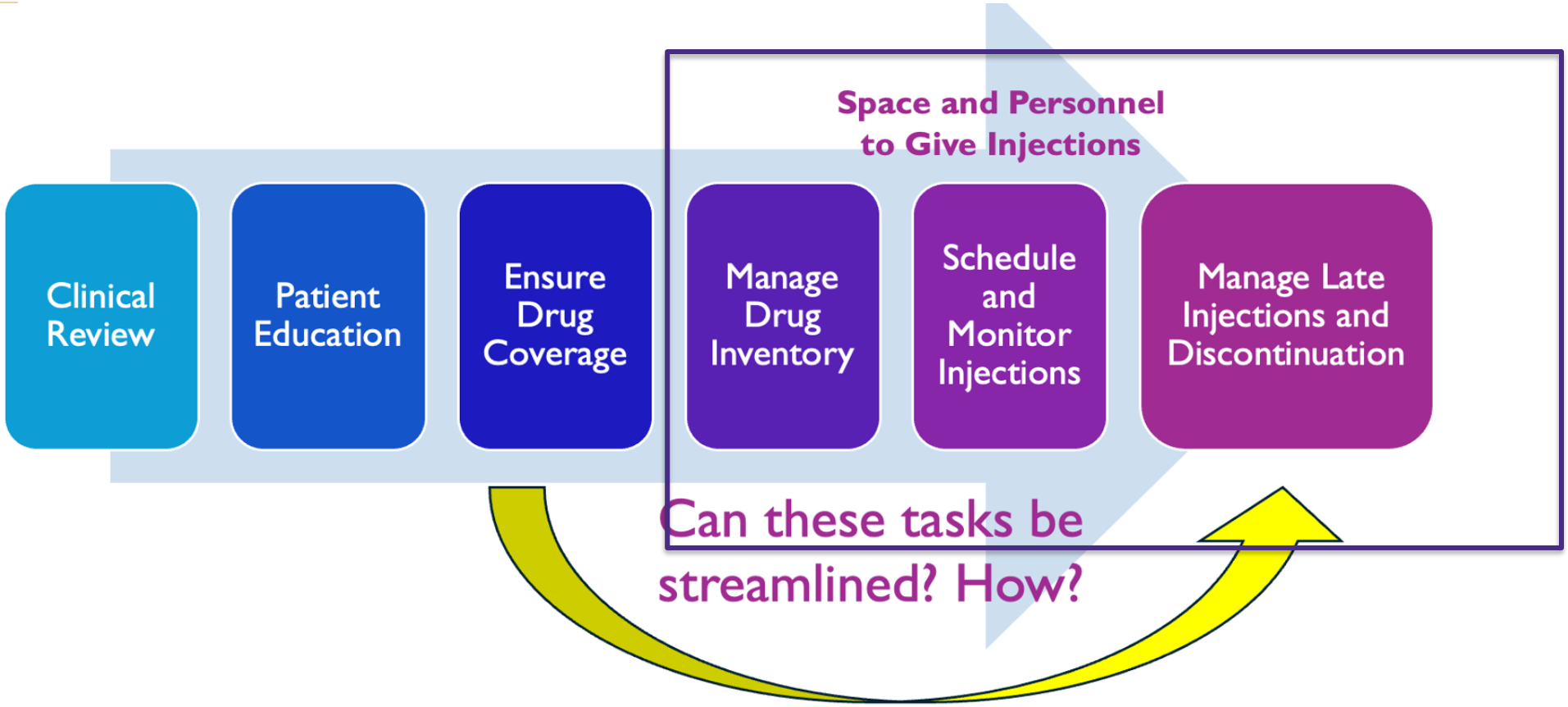
Differentiated LAI ART Model		
Madison Clinic	**MOD Clinic**	**Max Clinic**
Virally suppressed patients	Prioritizes patients with viremia	Prioritizes patients with viremia
Pharmacy-led workflow	Expedited review pathway	Expedited review pathway
Standard flow	Multidisciplinary	Multidisciplinary

Team and Workflow Infrastructure
Multidisciplinary Team: Clinical Pharmacists + Program Coordinator + Pharmacy Tech + RN
Patient Flow: PC scheduling → Injectables RN is primary patient interface

LAI ART RN Tasks

- Tracks patients on a shared excel, including schedule for the week with resultant need for inventory and stocking
- Vital signs, labs, vaccines, administers injectable ART
- Schedules follow up
- Pends labs

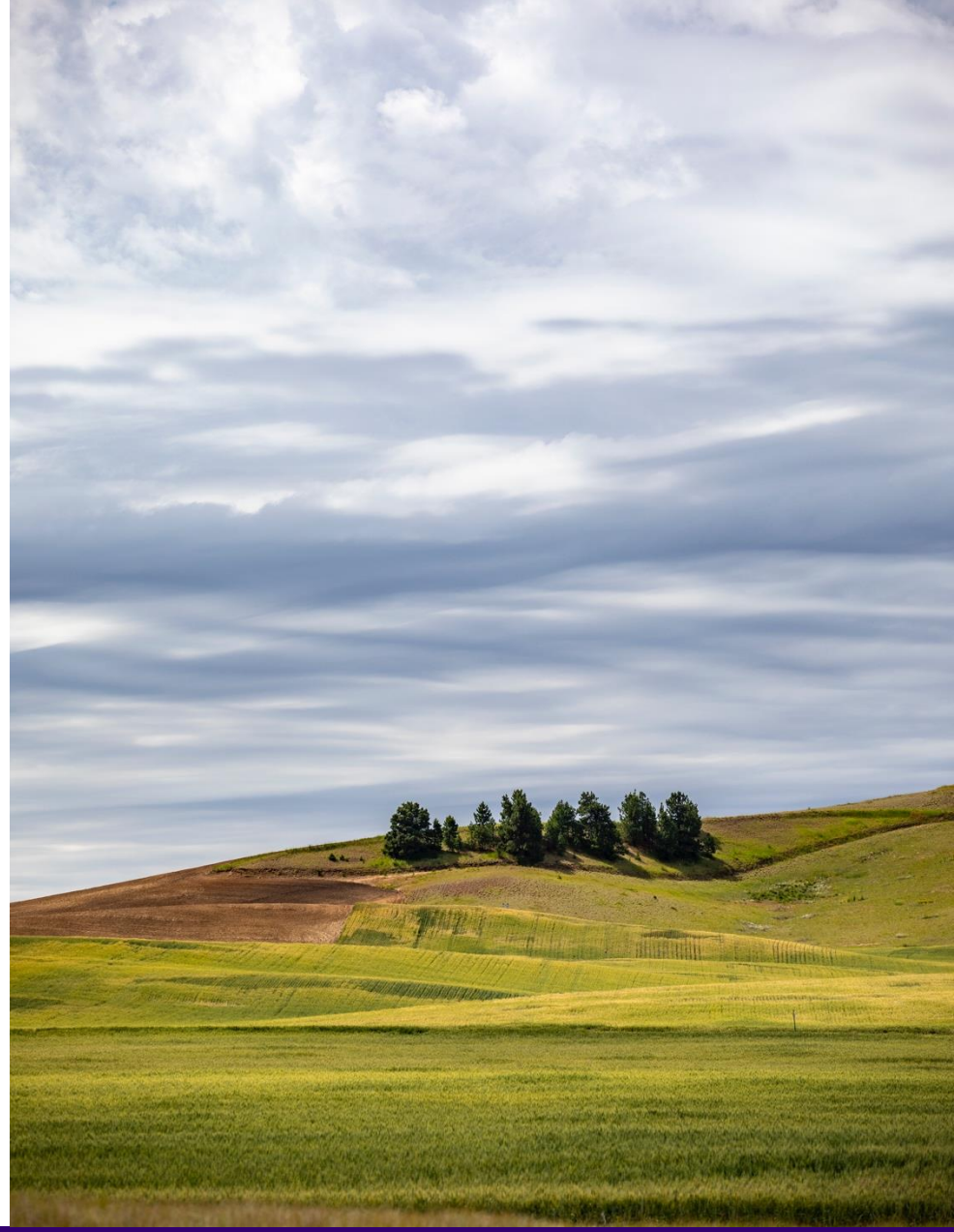
LAI Clinic Workflow: Common Threads



Slide from Christopolous K, Colasanti J. Optimizing LAI Patient Care and Program Features. ID Week 2024.

What is happening at Madison/MOD

- This is a work in progress and evolving
- Existing LAI Buprenorphine patients
- Transitioning Oral-> LAI Buprenorphine
- Driven by nurses
  - SBIRT
  - Recommendations to providers
  - Counseling patients



2 WEST CLINICS
BUPRENORPHINE ER (SUBLOCADE) INJECTION NURSE VISIT

*** presents to clinic for sublocade injection.

CHART REVIEW
- Confirmed patient's name and date of birth: saYES/NO
- Confirmed orders were placed: saYES/NO
- Reviewed allergies with patient: saYES/NO
- Confirmed comfort medications/sublingual buprenorphine ordered if needed (1 to 3 months): sa2WCYESNONA

ASSESSMENT
- Sublocade injection
- Any other medical concerns today? Yes Addl Default No: Yes, ***
- Urine performed HcG if indicated sa2WCYESNONA
- Any complaints of medication side effects? saYES/NO
- SUBLOCADE SIDE EFFECTS
- Reports recent drug use saYES/NO ***

VITALS

TREATMENT
- Administer 2 mL injectable lidocaine 1% to subcutaneous tissue saYES/NO
- Sublocade subcutaneous injection 2wcsublocadedose administered.
- Medication administered without complication: YES NO-VARIABLE: Yes

Comments: ***

Labs drawn in clinic?
2WCLAB

RECOMMENDATIONS
- Patient directed to wait 15 minutes before leaving clinic: YES/DECLINED
- Patient scheduled for next injection: (doses administered every 28 days, no sooner than every 26 days unless part of): YES NO-VARIABLE: Yes
- Next injection scheduled on: ***

Eve Lake, MD 4/23/2026 1:27 PM

Lessons Learned

- Structural growing pains
  - Medication storage
  - Approval from insurance
    - $7500 bills for injection!
- Initiation and re-initiation
  - Timing availability of medications
  - Full agonists and counseling
- Partners for initiation
  - Taking over and transitions
- Tracking and maintenance

Questions?

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