ASAM Abstract Submissions:
Sample Poster Abstract

Preparing a strong abstract can be challenging, particularly when it is unclear what separates a good submission from an exceptional one. The annotations in this guide explain what made each section of this poster session abstract particularly effective, highlighting concrete strategies that can be applied to other submissions.

Section One

Background & Purpose

20–200 words

The presence of fentanyl in the drug supply has made buprenorphine initiation more challenging but also more important. Long-acting injectable buprenorphine (LAIB) formulations are clinically effective[3] but difficult for patients to start when fentanyl has bioaccumulated[5].

Define acronyms upon first use.

The discussion of literature is specific rather than broad or vague. The literature clearly establishes a specific problem, gap, or need that the study addresses.

Inpatient withdrawal management facilities and hospitals allow a safe place for patients to transition out of fentanyl dependence and onto buprenorphine[1]. However, these facilities are often separate from aftercare facilities, complicating coordination of care. Furthermore, insurance companies tend not to cover long-acting injectable medication during an inpatient stay, often requiring outpatient follow-up. Low-barrier bridge clinics are a new and evolving approach to help retain patients in treatment with MOUD but are not yet widespread[4].

Here we describe outcomes from a co-located addiction treatment unit ("ATU," ASAM Level 4.0) and a low-barrier bridge clinic ("bridge clinic," ASAM Level 1.0). This arrangement allowed patients to receive medically managed inpatient methadone to buprenorphine cross taper followed by discharge from the unit and an immediate clinic visit for long-acting injectable buprenorphine (LAIB) administration.

The aim is clear, concise, and attainable. It is relevant to an ASAM audience.

Our aims were twofold:

1. To demonstrate feasibility of LAIB directly after withdrawal management
2. To determine if LAIB was associated with fewer 30-day readmissions to the ATU

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Section Two
Methods

20–200 words

The methods are detailed and reproducible for an abstract. The authors describe the treatment protocol, study period, datasets, inclusion approach, readmission definition, and statistical comparison using Chi-square analysis.

Our hospital-based ATU uses methadone as its primary withdrawal management regimen to prevent buprenorphine precipitated withdrawal. For patients desiring buprenorphine maintenance, our usual three-night protocol is: Day 0: Methadone 0-30mg, Day 1: Methadone 30mg, Day 2: Buccal buprenorphine 150mcg q2h x 6 doses (patient can refuse), Day 4: Buprenorphine 8mg BID or Buprenorphine/naloxone 8/2mg BID.

Clear, specific protocol description.

Detailed description of datasets and inclusion criteria.

A retrospective chart review by 3 trained assistants was conducted from 2/1/2023 - 10/6/2025 joining two datasets. The first dataset comprised all inpatient admissions to the ATU who received at least one dose of methadone or buprenorphine. The second dataset comprised all outpatient visits at which LAIB was administered which included bridge clinic and our campus intensive outpatient (IOP). Descriptive statistics were measured for all LAIB administrations. LAIB visits on the same day as an ATU discharge were counted. Patient readmission rates were calculated based on admission dates that were within 30 days of each other. Readmission rates were compared using Chi-square analyses between all non-LAIB opioid dependent ATU patients and LAIB recipients within 30 days of their injections. LAIB recipients' pre-injection readmission rates were also compared to their post-injection readmission rates with the same technique.

Identifies the study period and personnel conducting the chart review.

Statistical tests were described.

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Section Three

Results

20–200 words

Data has been collected and analyzed. Submissions explaining future data collection or analysis that has not happened yet will not be accepted.

During the study period, 3,057 unique patients had 5,622 admissions to the ATU and 207 unique patients had 854 clinic visits for LAIB (741 in bridge clinic and 113 in IOP). The pathway of ATU discharge directly to clinic for LAIB administration occurred 75 times (74 times to bridge clinic and 1 time to IOP).

Includes specific n values throughout.

The dose of the 845 LAIB administrations was: Low Dose (64 mg) *n* = 8, Medium Dose (96 mg) *n* = 322, and High Dose (128 mg) *n* = 524.

Includes specific doses for patient groups.

The results provide substantial quantitative detail, including sample sizes, number of admissions, number of medication administrations, readmission rates, and statistical significance.

The baseline 30-day readmission rate for ATU patients who never received LAIB was 692/5148 = 13%. We analyzed the ATU patients who did receive an injection separately. For that cohort, the pre-LAIB 30-day readmission rate was 70/357 = 19.6%. The readmission of the same cohort was calculated for the 30 days following a LAIB administration and resulted 8/117 = 6.8% (ARR = 12.8, NNT = 7.8, p = 0.005). The difference in 30-day readmission rates between ATU patients who never requested LAIB and those who did request LAIB proved to have been significantly different at baseline, with LAIB-requestors having had a higher pre-injection 30-day readmission rate (p = 0.0048).

Findings are meaningful to an ASAM audience.

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Section Four

Conclusion & Discussion

20–200 words

Conclusion is specific rather than broad or vague. Conclusion is also directly related to the study question and the study results.

Initiation of LAIB on the day of discharge from the hospital withdrawal management program by way of the hospital low-barrier bridge clinic was both feasible and effective (n=75). Furthermore, patients who received LAIB had lower 30-day readmission rates compared to their pre-LAIB readmission rates. Such care coordination helps patients to quickly receive LAIB without delay and could save healthcare expenses by preventing hospital readmissions.

Limitations are explicitly acknowledged and described.

Our study was limited by its retrospective design, which only allows us to report on associations between receipt of LAIB and 30-day readmissions. A deliberate randomized trial would be necessary to demonstrate causality. The presence of some patients from the co-located IOP confounds some of the inferences about the bridge clinic, as we were unable to easily separate LAIB administrations from the two programs in the dataset.

Clear discussion of implications.

This study adds to the growing body of evidence for the role of bridge clinics in the care of people who use drugs. It is also the first study that we have seen to examine readmission rates as a measure of efficacy for LAIB. Such data could be used to support future cost-effectiveness arguments for payers to cover inpatient administration of long-acting injectable medications.

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Section Five

References

50–350 words

Includes 3-6 references from scholarly or scientific sources. At least 2 sources are from the past 3 years. Citations are in AMA format.

1. Arnouk S, Wunderlich JR, Sidelnik SA. Evaluation of low-dose buprenorphine initiation with buprenorphine buccal films in hospitalized patients: a retrospective cohort study. *J Addict Med.* 2024;18(1):42-47. doi:10.1097/ADM.0000000000001236
2. Lambert E, Irvin J, Regan S, et al. Evaluating the impact of low threshold bridge clinic expansion on equitable access to substance use disorder treatment. *Journal of Addiction Medicine.* Published online October 7, 2025. doi:10.1097/ADM.0000000000001596
3. Lofwall MR, Walsh SL, Nunes EV, et al. Weekly and monthly subcutaneous buprenorphine depot formulations vs daily sublingual buprenorphine with naloxone for treatment of opioid use disorder: a randomized clinical trial. *JAMA Intern Med.* 2018;178(6):764. doi:10.1001/jamainternmed.2018.1052
4. Taylor JL, Wakeman SE, Walley AY, Kehoe LG. Substance use disorder bridge clinics: models, evidence, and future directions. *Addict Sci Clin Pract*. 2023;18(1):23. doi:10.1186/s13722-023-00365-2
5. Thakrar AP, Christine PJ, Siaw-Asamoah A, et al. Buprenorphine-precipitated withdrawal among hospitalized patients using fentanyl. *JAMA Netw Open.* 2024;7(9):e2435895. doi:10.1001/jamanetworkopen.2024.35895

Section Six

Diversity, Health Equity, and Inclusivity

20–200 words

Study setting was chosen to help address healthcare disparities.

Inclusivity of multiple members of the care team in the study design and poster authoring including those with lived experience.

As evidenced by Lambert E et al., low-barrier bridge clinics have been demonstrated to increase the uptake of medications for opioid use disorder among patients from minority groups. Our implementation of a bridge clinic within a safety-net hospital system increases access for patients seeking continued care after the medically managed withdrawal admission and facilitates buprenorphine continuation. Our interprofessional team includes people with lived experience who serve as peers, navigators, and care coordinators, one of whom (Cronin K) is a co-author on this poster. She and the other navigators are responsible for coordinating appointments with appropriate timing for patients exiting the ATU and headed to the bridge clinic or the IOP. They also triage incoming patient phone calls using their peer knowledge of buprenorphine, ensuring that patients out of medication are promptly seen via telemedicine.

Sample poster abstract adapted from the ASAM 57th Annual Conference poster "Co-Located Bridge Clinic/Withdrawal Management Unit Reduces 30-Day Readmits Using LA-Bup Injections" presented by Anthony J. Accurso, MD, FASAM, AAHIVS and Kimberly L. Sue, MD, PhD.