



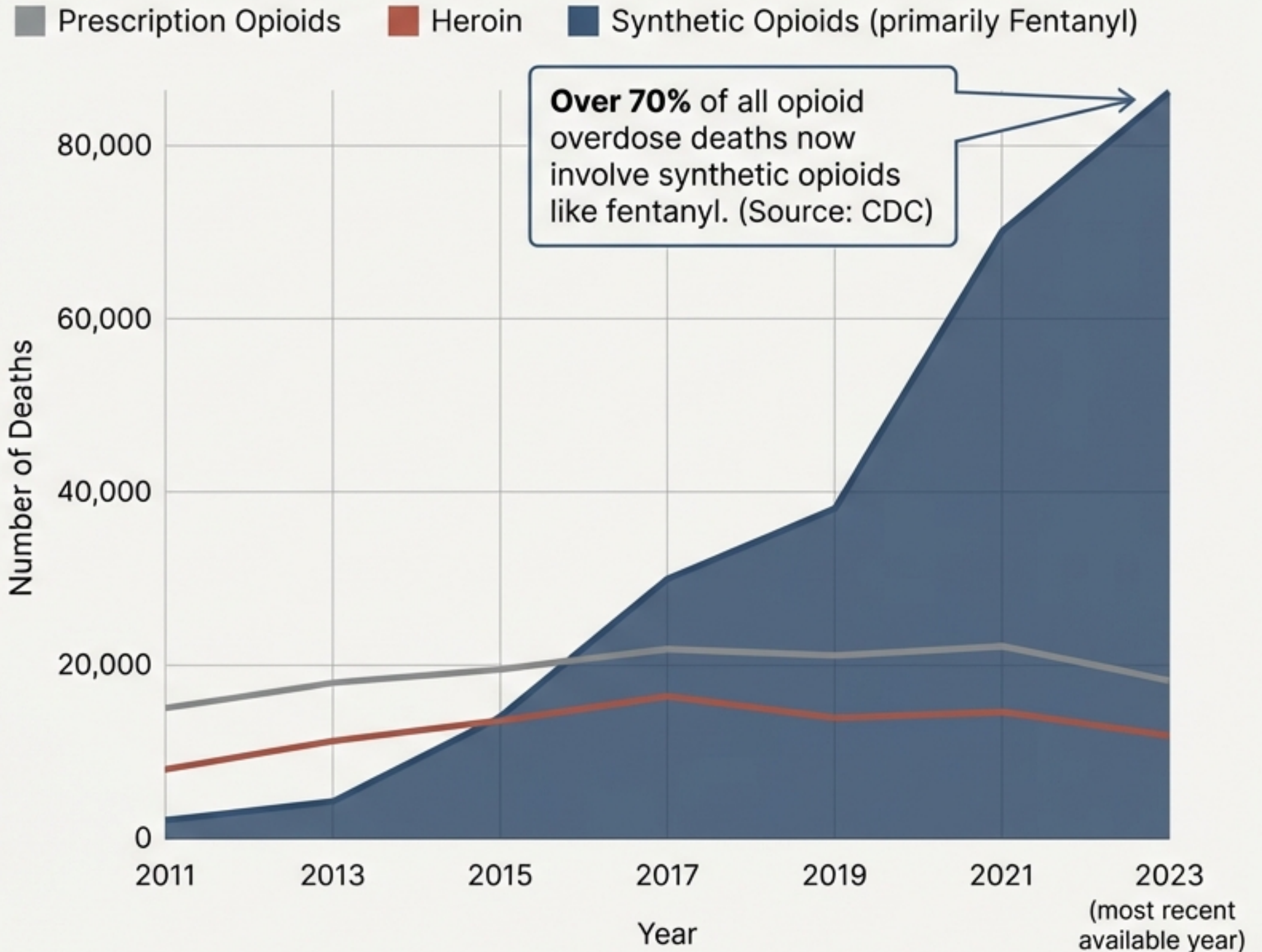
The New Frontline: A Modern Clinical Framework for Opioid Use Disorder in the Fentanyl Era

**A Guideline-Aligned Update for
Primary Care & Family Medicine Clinicians**

The Opioid Crisis Has Evolved. Our Clinical Approach Must Evolve With It.

The crisis is no longer primarily driven by prescription opioids or heroin. It is now a synthetic opioid crisis, dominated by illicitly manufactured fentanyl.

Overdose Deaths Involving Opioids, by Type



Meeting This Challenge Requires a Fundamental Shift in Our Clinical Model

Outdated Model

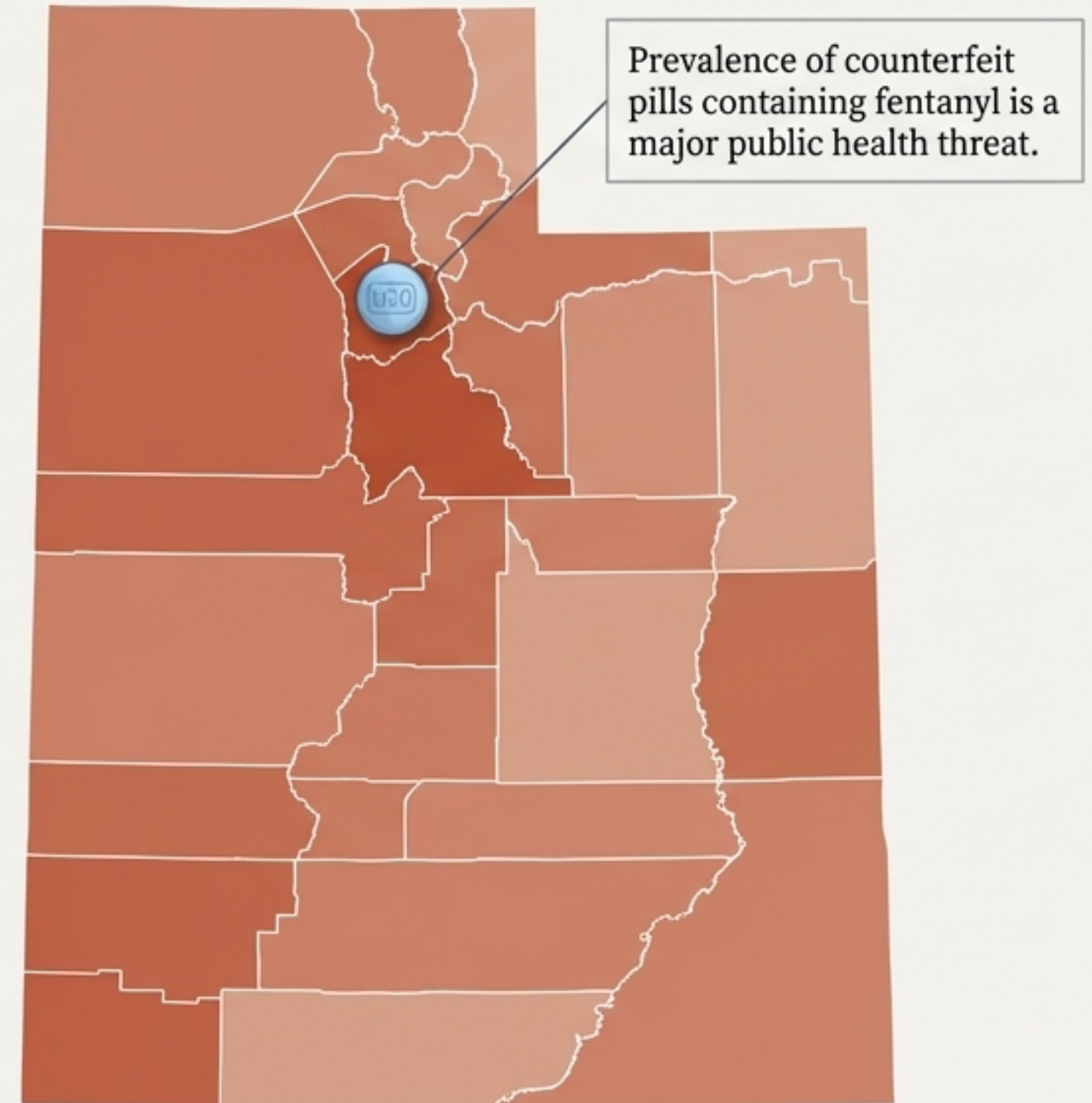
- **Core Belief:** OUD is a moral failing or a behavioral choice.
- **Treatment Goal:** Immediate and total abstinence.
- **Primary Intervention:** Referral for detox or counseling alone.
- **Clinician Role:** Refer out; not a primary care issue.

Modern Framework (Evidence-Based)

- **Core Belief:** OUD is a **chronic, treatable medical disease**. (Source: ASAM, SAMHSA)
- **Treatment Goal:** **Stability, safety, and harm reduction**.
- **Primary Intervention:** **Medication for OUD (MAT)** as first-line therapy.
- **Clinician Role:** **Frontline diagnosis and treatment**.

The Fentanyl Crisis is a Local Reality in Utah

- **Historical Context:** Utah has historically seen high rates of prescription opioid use. (Source: Utah DOH)
- **The Current Threat:** Fentanyl-related overdose deaths have increased significantly in Utah since ~2020.
- **Local Manifestation:** Counterfeit fentanyl pills, often marked as “M30s,” are a common and deadly presence in local communities.
- **The Care Gap:** Clinician training gaps in modern OUD care persist in Utah, mirroring national trends. (Source: AHRQ surveys)

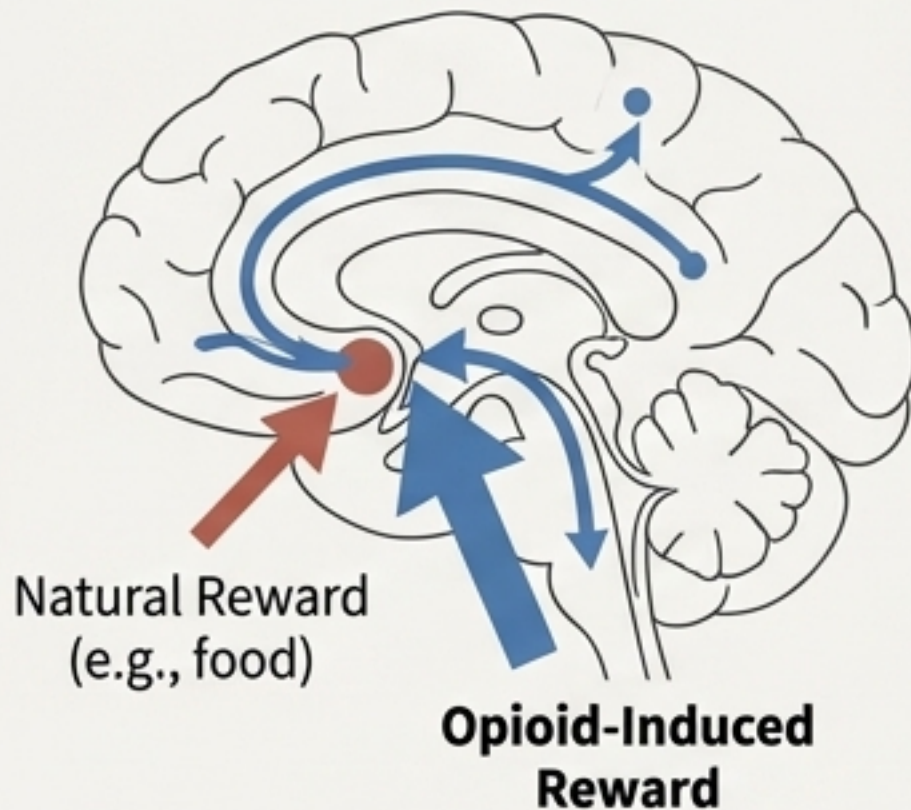


~~Myth: “It’s a failure of willpower.”~~

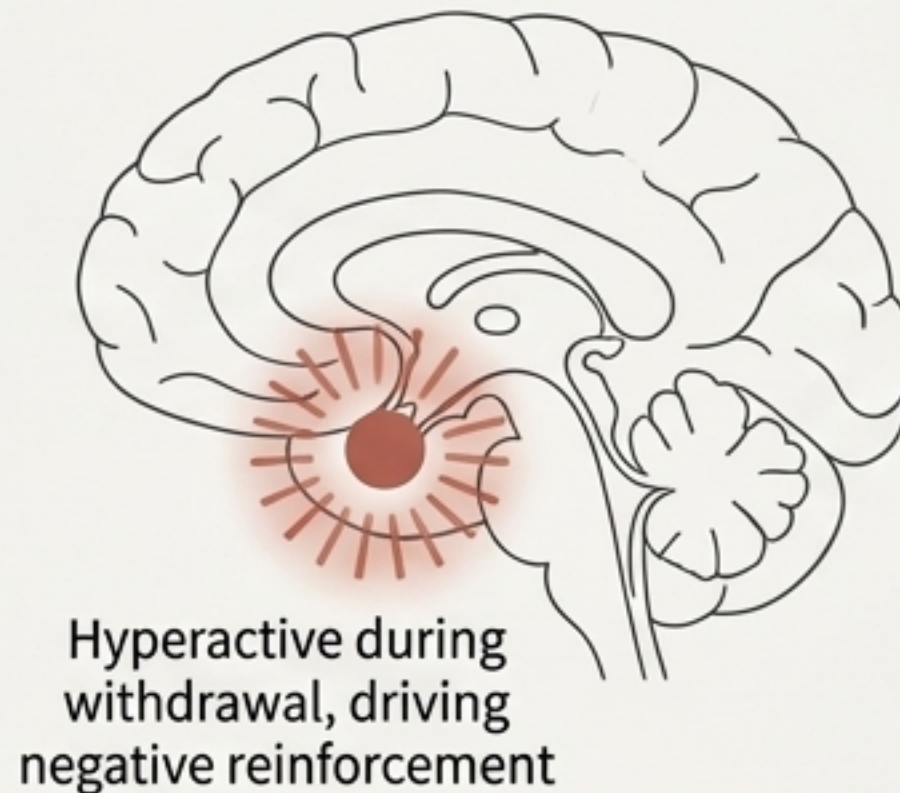
Reality: OUD is a Chronic Brain Disorder Driven by Neurobiological Changes

Repeated opioid exposure physically remodels key brain circuits, compelling continued use even in the face of negative consequences.

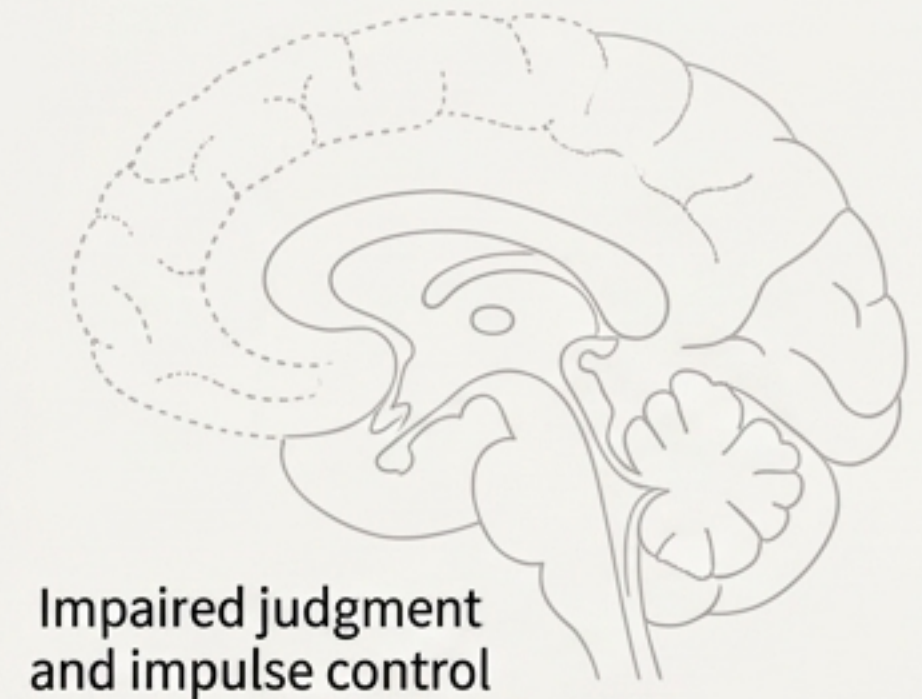
1. Reward Pathways



2. Stress Circuitry



3. Executive Function



Clinical Takeaway: Relapse is a manifestation of neurobiology, not a personal or moral failure. (Source: NIDA)

~~Myth: “It’s hard to tell who has a problem.”~~

Reality: We Have Clear, Standardized Criteria for Diagnosis

The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) provides a clinical checklist for OUD.

Diagnostic Criteria Summary: ≥ 2 of the following 11 symptoms within 12 months



Impaired Control

- Taking more than intended
- Unable to cut down
- Significant time spent obtaining/using
- Craving



Social Impairment

- Failure to fulfill major roles
- Continued use despite social problems
- Giving up important activities



Risky Use

- Use in hazardous situations
- Use despite physical/psychological harm



Pharmacologic

- Tolerance*
- Withdrawal*

Severity Specifiers

- Mild: 2-3 symptoms
- Moderate: 4-5 symptoms
- Severe: 6+ symptoms

*Note: For patients on chronic opioid therapy for pain, tolerance and withdrawal criteria do not count toward an OUD diagnosis.

A Critical Distinction: Physical Dependence is Not OUD

As emphasized in the CDC 2022 Opioid Prescribing Guideline, it is vital to distinguish the expected physiological response to chronic opioid therapy from the compulsive use that defines OUD.



Physical Dependence

- An expected physiological adaptation to chronic opioid therapy.
- Characterized by **tolerance** (needing higher doses for the same effect) and **withdrawal** (symptoms upon cessation).
- Occurs in patients taking opioids exactly as prescribed for pain.

DSM-5 Note: For these patients, tolerance and withdrawal criteria do *not* count toward an OUD diagnosis.



Opioid Use Disorder (OUD)

- A medical disorder characterized by a pathologic pattern of use.
- Involves **compulsive use**, **loss of control** over use, and **continued use despite demonstrable harm**.
- Can exist with or without physical dependence.

Myth: ~~“Treatment is just replacing one drug with another.”~~

Reality: Medication for OUD (MAT) is the Gold Standard and Saves Lives.

50-70%

Reduction in All-Cause Mortality

The Evidence is Overwhelming

- Large-scale studies demonstrate that buprenorphine and methadone are the most effective treatments for reducing mortality in patients with OUD. (Source: Sordo et al., BMJ; Larochelle et al.)
- In contrast, detoxification-only models are associated with extremely high rates of relapse and subsequent overdose mortality.

Clinical Analogy



MAT functions like insulin for diabetes or statins for heart disease. It is a **life-saving medication that stabilizes a dysfunctional organ system**—in this case, dysregulated brain circuits.

~~Myth: "You have to 'hit rock bottom' before treatment works."~~

Reality: Harm Reduction is an Evidence-Based Standard of Care.

Keeping people alive and safe is the non-negotiable prerequisite for recovery.
The goal is to meet patients where they are.

Guideline-Endorsed Components



Naloxone Distribution: To reverse overdoses.



Syringe Services Programs: To prevent infectious disease transmission.



Fentanyl Test Strips: To detect the presence of fentanyl in the illicit drug supply.

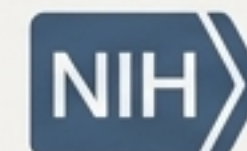


Direct Linkage to MAT: Providing immediate access without readiness requirements.



Safer-Use Education: To reduce the immediate risks of use.

Endorsed By:



National Guidelines Position Primary Care on the Frontline of OUD Care

A Unified Message from Key Health Authorities

ASAM (2020)

“MAT is the first-line treatment for OUD and is **appropriate to initiate and manage in the primary care setting**. Do not withhold medication due to ongoing substance use.”

SAMHSA (TIP 63)

“A core mission is to reduce stigma and remove punitive barriers to care. **Medication access should not be contingent on counseling participation.**”

CDC (2022)

“Emphasizes that MAT is the standard of care for OUD and warns against **rapid, involuntary tapers of opioids** for patients with dependence or OUD.”

NIDA / NIH

“A chronic disease framing improves outcomes. **Access to treatment, not a patient’s perceived ‘readiness,’** is the primary predictor of survival.”

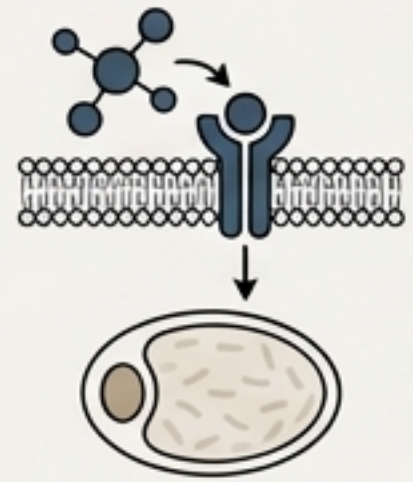
Navigating the Clinical Challenge of Fentanyl

Why Fentanyl is Different

Potency & Pharmacology



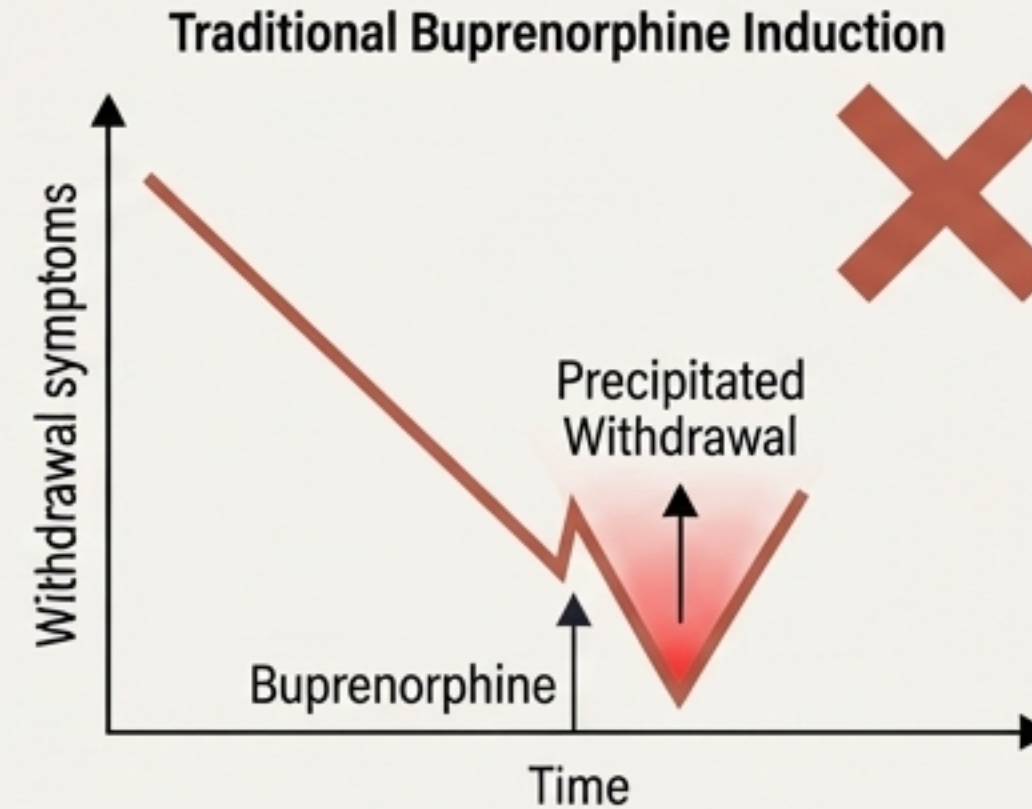
Potency: 50 to 100 times more potent than morphine.
(Source: DEA, CDC)



Pharmacology: A highly lipophilic compound... it redistributes into tissue, prolonging its presence and complicating the induction of buprenorphine.

The Clinical Consequence

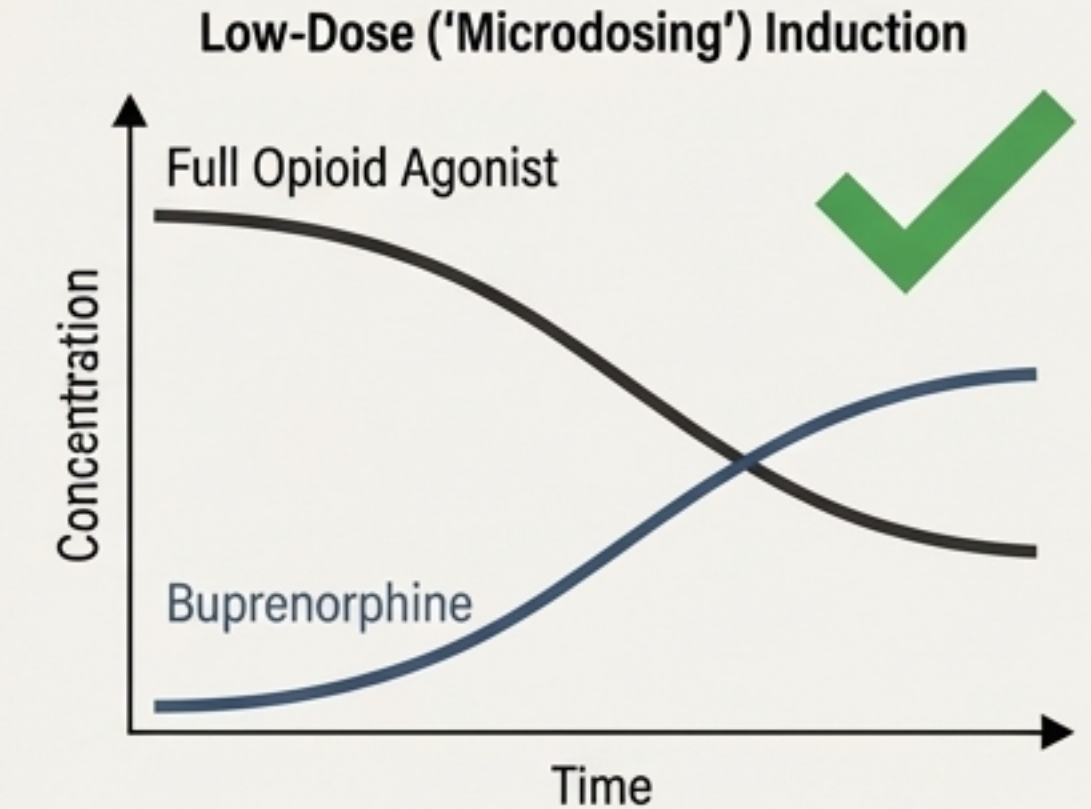
High Risk of Precipitated Withdrawal



Traditional inductions carry a high risk of severe, iatrogenic withdrawal.

The Evidence-Based Solution

Flexible, Low-Dose Induction



This strategy involves starting buprenorphine at very low doses while the patient continues their opioid of choice, then gradually titrating up to mitigate risk. (Source: ASAM, SAMHSA)

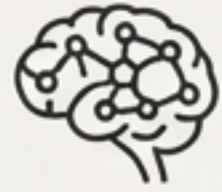
Language Matters: Shifting from Stigma to Support

The language we use has a profound impact on patient engagement, treatment outcomes, and the underlying stigma that serves as a major barrier to care. (Source: NIDA, SAMHSA)

A Practical Guide to Person-First, Medically Accurate Language

Instead of This (Stigmatizing)	Use This (Medically Accurate)
Addict, User, Abuser	Person with Opioid Use Disorder
Drug Abuse, Misuse	Use, Risky Use, Unhealthy Use
Clean / Dirty (Urine Test)	Positive / Negative
Relapse	Return to Use, Recurrence of Use
Medication-Assisted Treatment	Medication for OUD, MOUD
Replacing one drug with another	Gold-standard medical treatment

Your Modern OUD Clinical Toolkit: Key Takeaways



1. OUD is a **treatable chronic brain disorder**, not a moral failing. Relapse is an expected part of the disease, not a treatment failure. (Source: NIDA, SAMHSA)



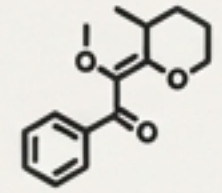
2. **Primary care is the frontline.** You are empowered by national guidelines to diagnose and treat OUD.



3. **Medication for OUD (MAT) is the first-line treatment** and reduces mortality by over 50%. (Source: ASAM, Sordo et al.)



4. **Harm reduction is the standard of care.** Keeping patients alive is the priority. (Source: CDC, SAMHSA)



5. **Fentanyl requires new clinical strategies**, such as flexible, low-dose buprenorphine inductions.



6. **Stigma is a primary barrier to care.** Your language and approach can dismantle it. (Source: SAMHSA)



7. **Routinely diagnose using DSM-5 criteria**, while carefully distinguishing OUD from physical dependence in chronic pain patients.