

Treating Opioid Use Disorder (OUD) in Primary Care: A Clinical Workflow

1. Identify & Screen Patients



Screen Patients At-Risk for OUD

Screen those on long-term opioids, with a substance use history, or with frequent ED visits.



Use a Simple, Validated Screening Tool

Start with a single question: "How many times in the past year have you used a non-prescription drug?"

2. Diagnose & Initiate Treatment



Diagnose Confidently with DSM-5 Criteria

An OUD diagnosis is met if a patient has 22 criteria in a 12-month period.



Most Patients Can Start MAT in Primary Care

This includes daily fentanyl users, pregnant individuals, and those with cravings or withdrawal.



Traditional

Patient must be in moderate withdrawal (COWS $\geq$ 6–12)

BEST FOR
Short-acting opioid users



Low-Dose / Microdosing

Allows overlap with full-agonist opioids to avoid withdrawal.

BEST FOR
Fentanyl users, chronic pain patients



High-Dose / Rapid

Achieves therapeutic dose on Day 1 (16–32 mg).

BEST FOR
Monitored settings (ED/clinic)

3. Follow-Up & Long-Term Management



Follow-Up Cadence: Frequent at First, Then Taper

Start with daily/weekly check-ins, tapering to monthly visits as the patient stabilizes.



Treat Co-Occurring Conditions Concurrently

Do not delay OUD treatment for mental health, stimulant, or alcohol use.



Use Telehealth for Follow-Up

Telehealth is strongly supported by SAMHSA/DEA for ongoing OUD care.

4. Adopt a Patient-Centered Approach



A return to use means we adjust the plan — not stop treatment.

Relapse is a recognized part of the illness, not a treatment failure.



Remove Unnecessary Barriers to Care

Avoid punitive policies, mandatory counseling, and firing patients for relapse.