

Navigating Complex OUD Treatment in Primary Care

A Case-Based Clinical Update



FOCUS AREAS:

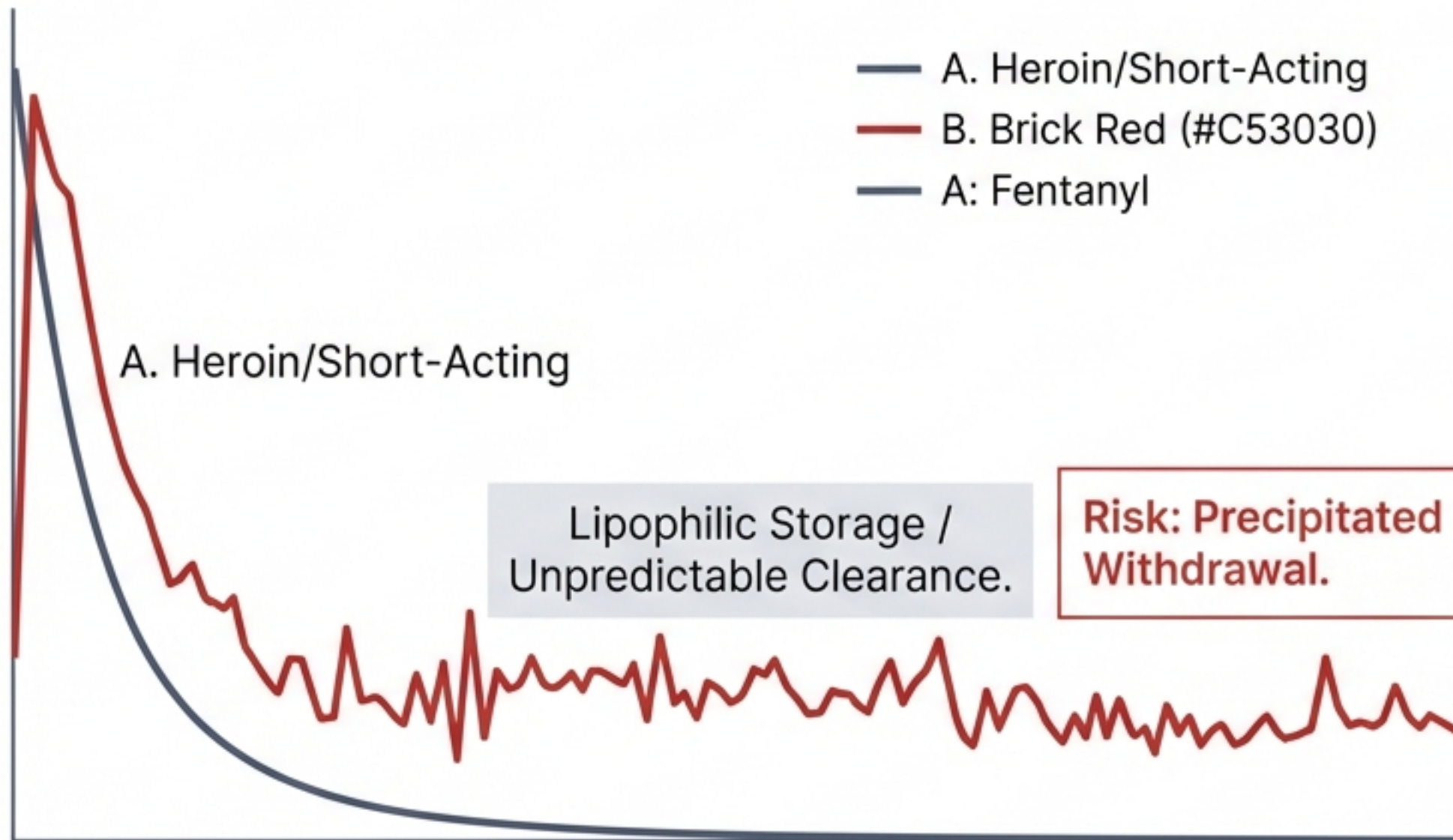
1. FENTANYL MANAGEMENT
2. SPECIAL POPULATIONS
3. HARM REDUCTION STRATEGIES

SOURCE AUTHORITY:

ASAM NATIONAL PRACTICE GUIDELINES
SAMHSA TIP 63
CDC 2022 GUIDELINES

The Landscape Has Shifted: Adapting to the Fentanyl Era

Opioid Clearance Profiles



Source: Clinical data and pharmacokinetic studies.

The Solution



Rapid Identification (DSM-5 Criteria)

Accurate diagnosis leads to appropriate care pathways.



Flexible Induction (Low-Dose vs. High-Dose)

Adapting dosage to individual patient tolerance and needs.



Stigma-Free Harm Reduction (Naloxone Standard)

Prioritizing patient safety and accessible life-saving measures.

Clinical Grand Rounds: A Case-Based Framework

Simulating the decision-making process from routine to complex.

Case 1: The New Standard



Daily Fentanyl
Roboto Mono

The Window



Case 2: Acute Withdrawal

Roboto Mono

Cases 3 & 8: High Stakes



Pregnancy &
Post-OD

Roboto Mono

Benzos &
Stimulants



Cases 4 & 7:
Polysubstance

Roboto Mono

Cases 5 & 6: Long-Term



Relapse & Social
Complexity

Roboto Mono

HOW TO USE THIS DECK: READ VIGNETTE -> IDENTIFY DECISION POINT -> REVIEW PLAN

Case 1: The New Standard—Daily Fentanyl Use

SUBJECTIVE:

28yo male. Requests help “getting off blues”. Smokes fentanyl 8-15x/day. Last use 4 hours ago.

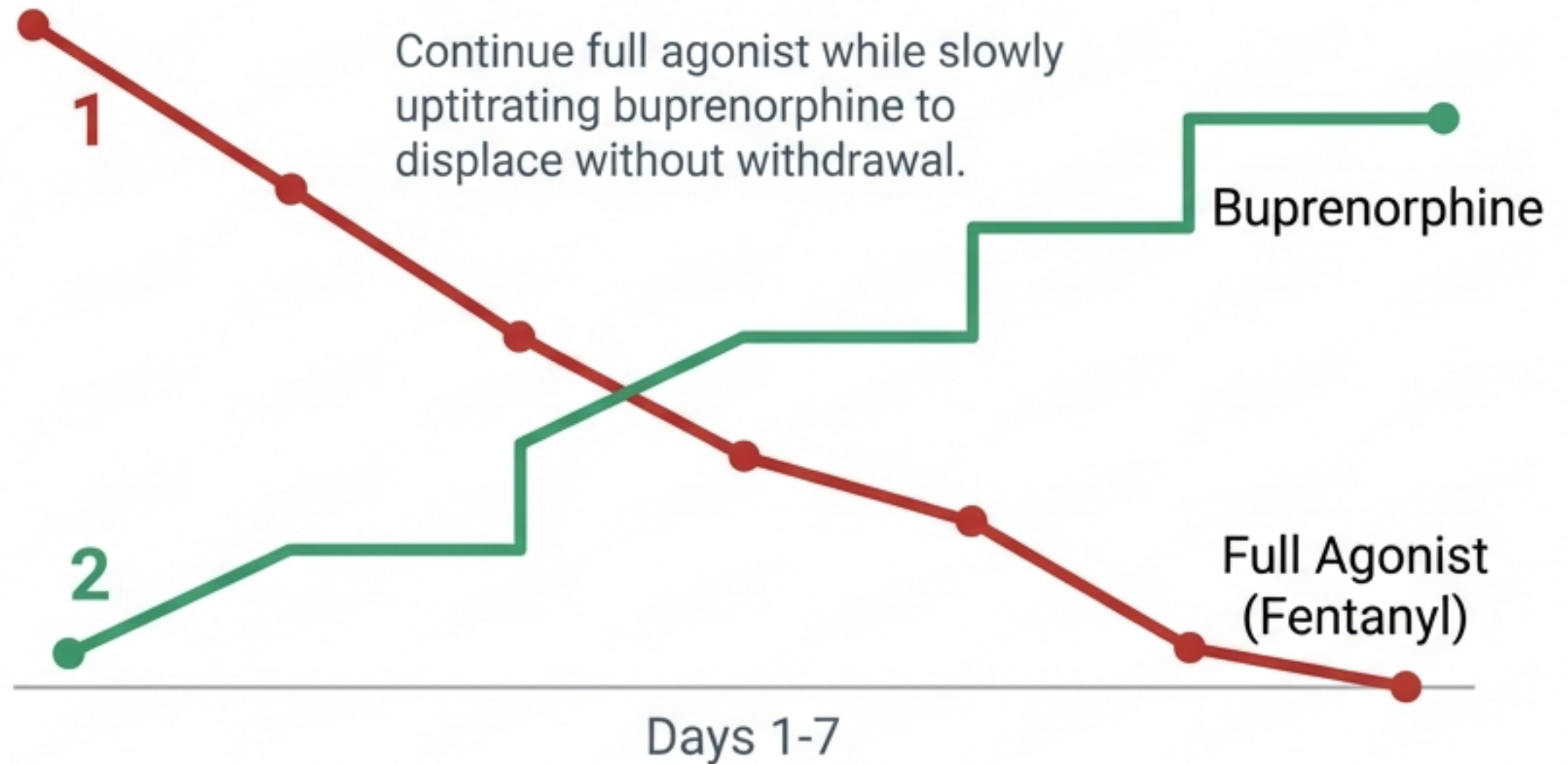
OBJECTIVE:

Mild anxiety. No significant withdrawal signs.

DECISION POINT: Is traditional induction safe?

RISK: High probability of precipitated withdrawal due to lipid storage.

Low-Dose Induction (“Microdosing”) Protocol



PLAN: Initiate Low-Dose Induction. Provide Clonidine/Hydroxyzine. Supply Naloxone & Test Strips.

Case 2: Seizing the Window—Acute Withdrawal

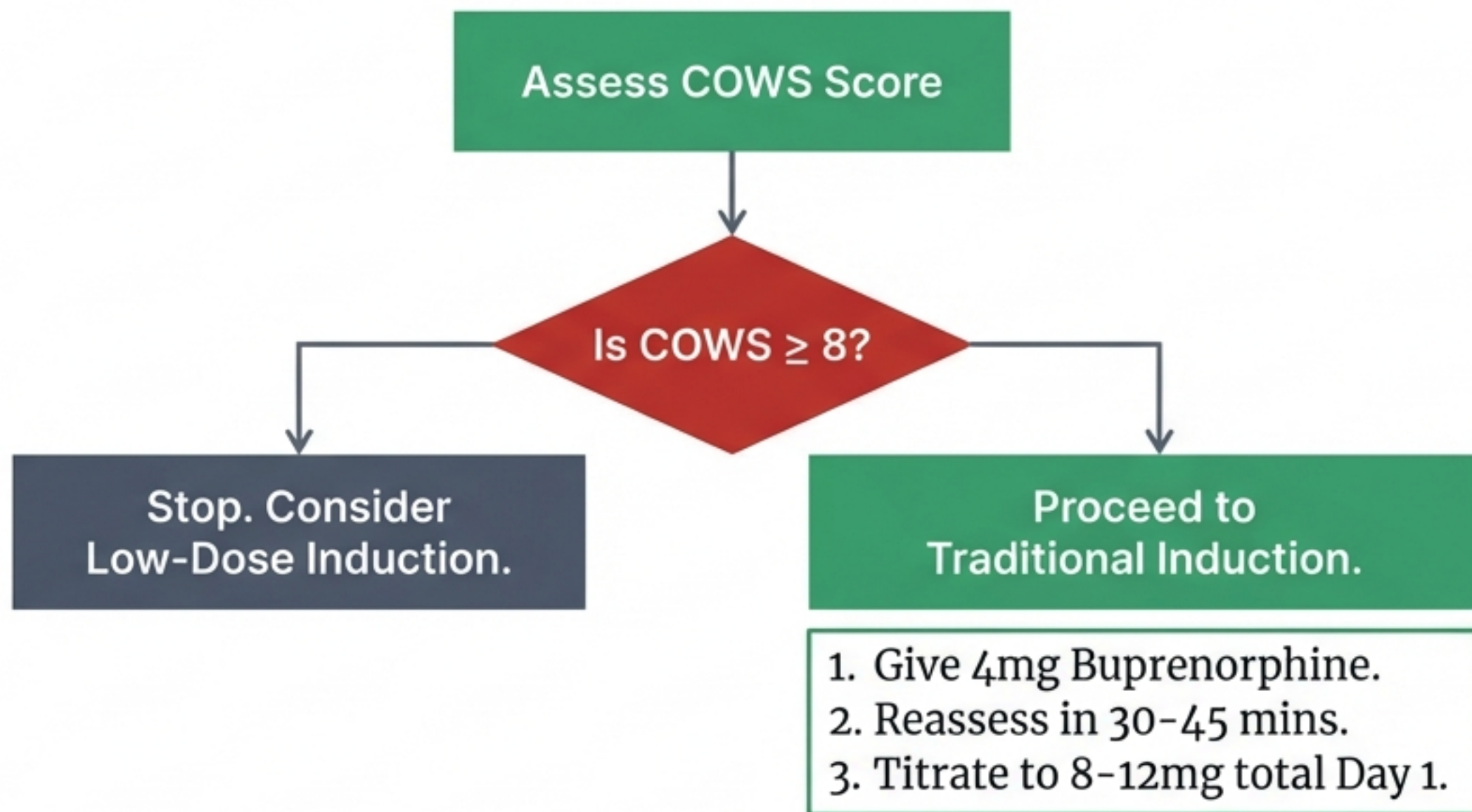
THE CHART

SUBJECTIVE: 34yo female. Daily fentanyl use. Last use 18 hours ago.

OBJECTIVE: Sweating, yawning, cramping. COWS Score = 12 (Moderate Withdrawal).

DECISION POINT: Low-Dose or Traditional Induction?

DECISION TREE



KEY INSIGHT: Do not use microdosing if the window for rapid stabilization is already open.

Case 3: The High-Stakes Patient—Pregnancy

THE CHART

SUBJECTIVE: 29yo female, 14 weeks pregnant. Uses fentanyl 5–10x/day.

PATIENT CONCERN: Fears withdrawal affecting fetus. Requests “detox”.

DECISION POINT:
Detox vs. MAT?

THE GUIDELINE

CRITICAL ALERT: Detoxification is NOT recommended.

Withdrawal causes fetal stress. Detox has high rates of relapse and subsequent overdose.

Guideline-Aligned Plan (ACOG/ASAM)

- ✓ Initiate Buprenorphine (Low-Dose) or Methadone.
- ✓ Coordinate with OB (Do not delay start pending clearance).
- ✓ Documentation: “Discussed MAT as standard of care to reduce fetal stress.”

Case 8: The Critical Window—Post-Overdose

THE SCENARIO

40yo patient revived with Naloxone. Discharged from ED with no meds. Presents to clinic next day.

DECISION POINT: Wait for stability or treat immediately?

40x

Higher mortality risk in the year following an untreated overdose.

THE ACTION PLAN

IMMEDIATE ACTION

- ✓ Initiate MAT immediately regardless of ED discharge summary.

NALOXONE WITHDRAWAL

- ✓ If in acute withdrawal from reversal, treat with traditional/high-dose buprenorphine.

SURVIVAL SUPPLIES

- ✓ Dispense multiple Naloxone kits.
- ✓ Schedule 24-hr follow-up.

Cases 4 & 7: Managing Polysubstance Use

The Anxious User

Profile: 42yo male. Daily Fentanyl + 2mg illicit Alprazolam (Benzos).

Common Fear: Respiratory depression risk.

Guideline: Not a contraindication. Withholding MAT increases death risk.

Plan:

Start Low-Dose MAT + Gradual Benzo Taper.

The Chaotic User

Profile: 31yo male. Injecting Fentanyl + Methamphetamine ("Goofballs").

Common Fear: Non-compliance / chaotic behavior.

Guideline: Not a contraindication. MAT reduces opioid mortality despite stimulant use.

Plan:

Start MAT + Contingency Management + Wound Care.

Unified Conclusion: Initiate MAT + Harm Reduction. Do not deny care.

Case 5: Reframing “Failure”—Return to Use

THE CHART

SUBJECTIVE: 36yo female. Stabilized on 16mg Buprenorphine. Returns to intermittent fentanyl use.

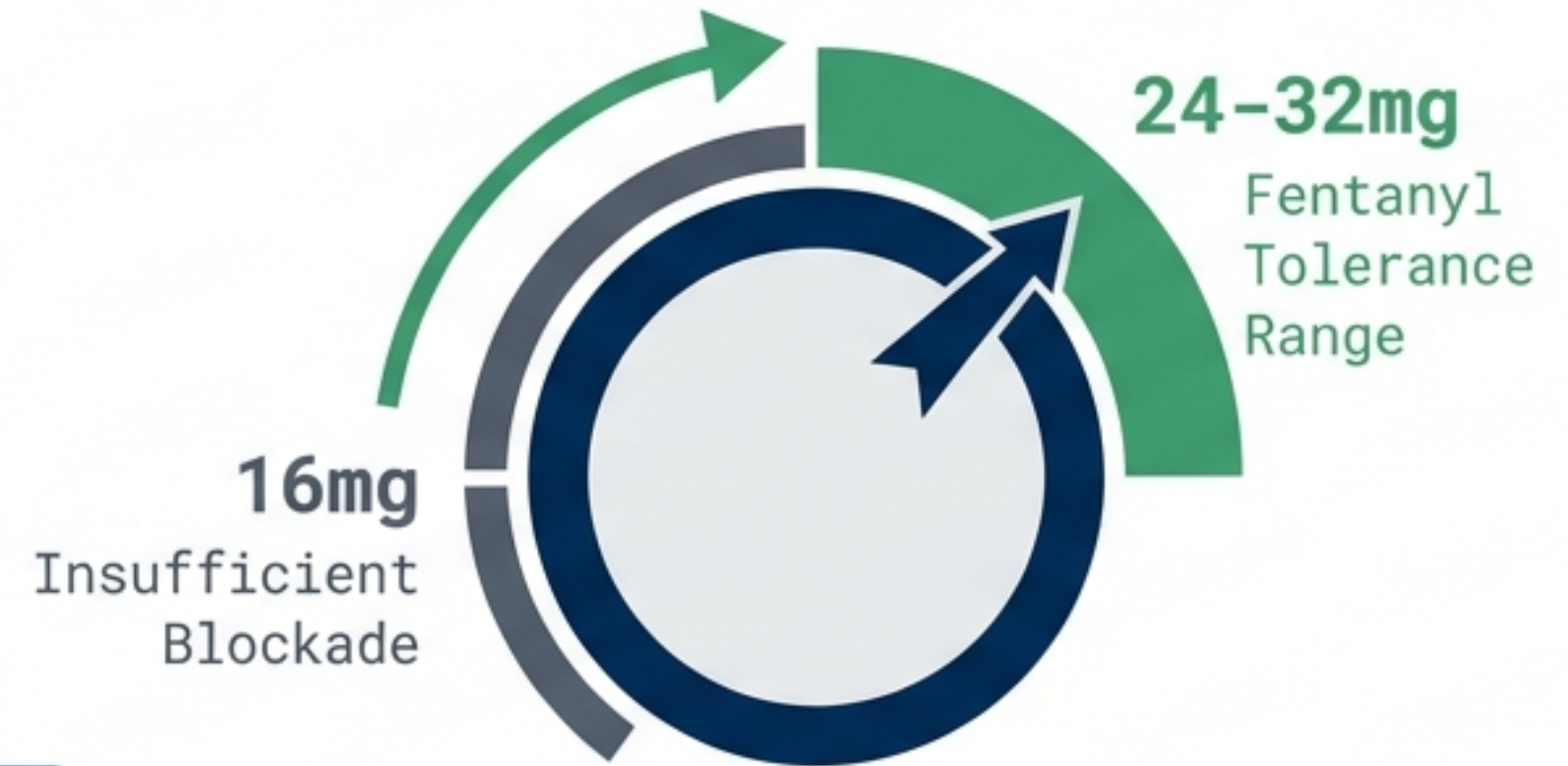
SYMPTOMS: Night-time cravings.

DECISION POINT: Punish/Discharge or Adjust?

ACTION PLAN

1. Increase Buprenorphine to 24–32 mg/day. ✓
2. Consider Methadone if cravings persist. ✓
3. **PROHIBITED:** Punitive discharge or shaming. ✗

THE REFRAME



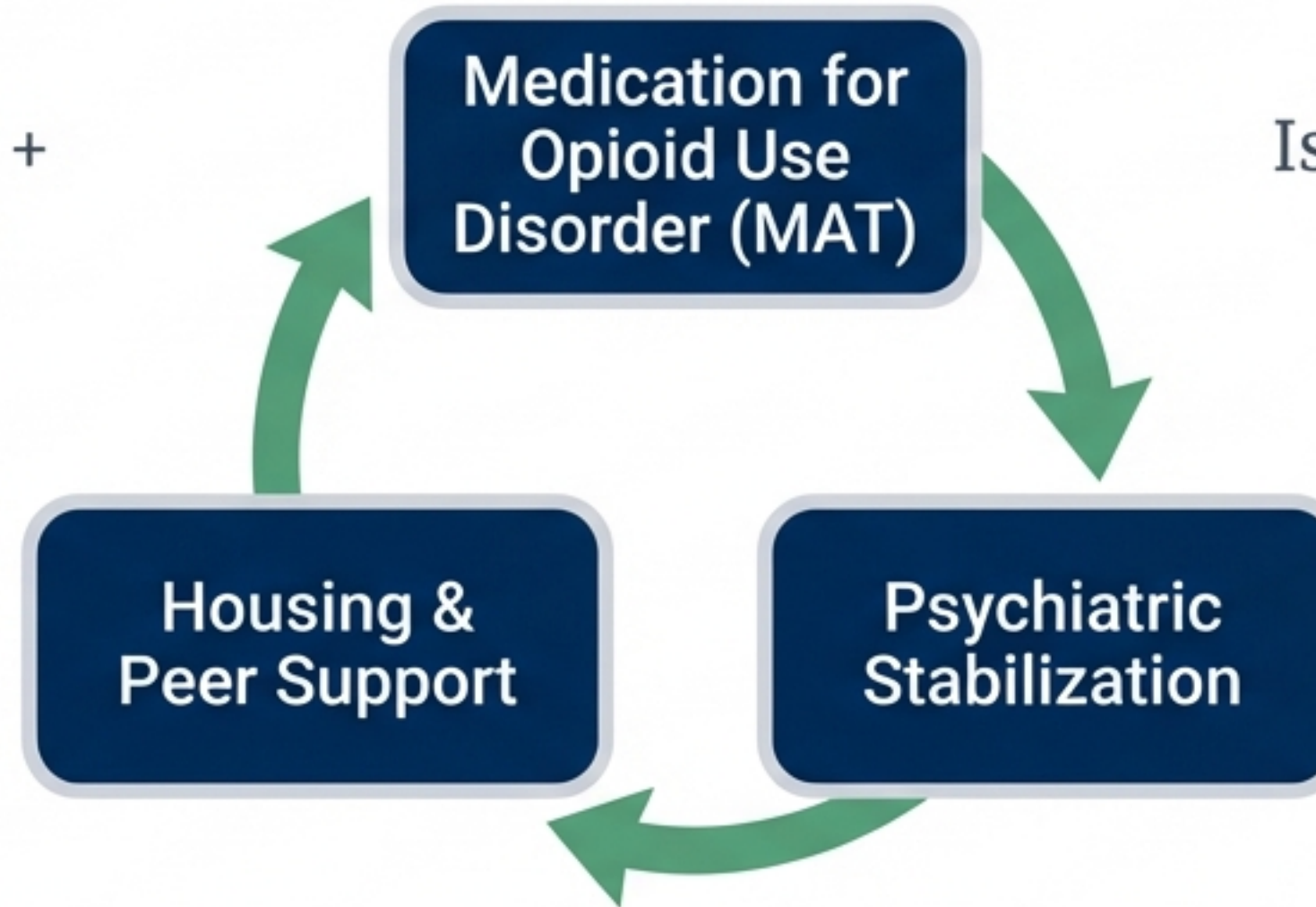
CLINICAL INSIGHT

Relapse is not a moral failure.
It is a physiological signal of
under-dosing.

Case 6: Systemic Complexity—SMI & Homelessness

VIGNETTE

33yo with Schizophrenia + Fentanyl use. Unhoused. Confused.



DECISION POINT

Is the patient “too unstable” for primary care MAT?

Stability is not a prerequisite for treatment.
Treatment is a prerequisite for stability.

Plan:

Evaluated for immediate crisis → Initiate Buprenorphine → Link to Case Management.

The Universal Prescription: Harm Reduction

Survival tools to integrate into every patient visit.

Naloxone



Prescribe multiple kits for patient and family.

Fentanyl Test Strips



Access to sterile supplies prevents infectious disease.

Syringe Services



Access to sterile supplies prevents infectious disease.

Safe Use Education



Education on spotting overdose and not using alone.

Communication is Treatment: Reducing Stigma

Language Swap

INSTEAD OF...	USE THIS...
Clean / Dirty Urine	Negative / Positive Result
Relapse	Return to Use / Recurrence
Addict / Substance Abuser	Person with Opioid Use Disorder

Patient Voice

“Acknowledge their language (e.g., ‘getting off blues’) to build rapport, but maintain clinical precision in documentation.”

Operational Checklist: Is Your Clinic Ready?

5 Action items for Monday Morning.



1. SUPPLIES

Stock Naloxone kits and Fentanyl Test Strips in the office for direct distribution.



2. PROTOCOLS

Ensure team is trained on Low-Dose (Microdosing) Induction protocols (5-7 day ramp-up).



3. ACCESS

Create workflow for same-day starts for walk-in patients.



4. COORDINATION

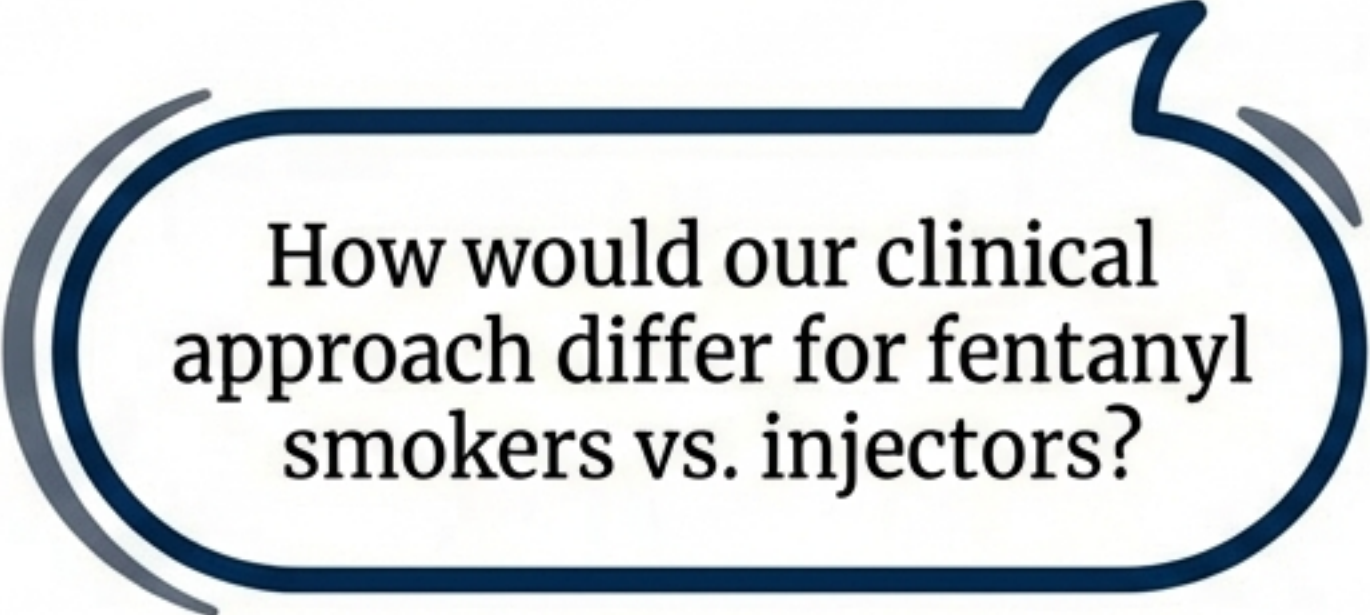
Establish direct contacts for OB (Pregnancy) and Crisis Services (SMI).



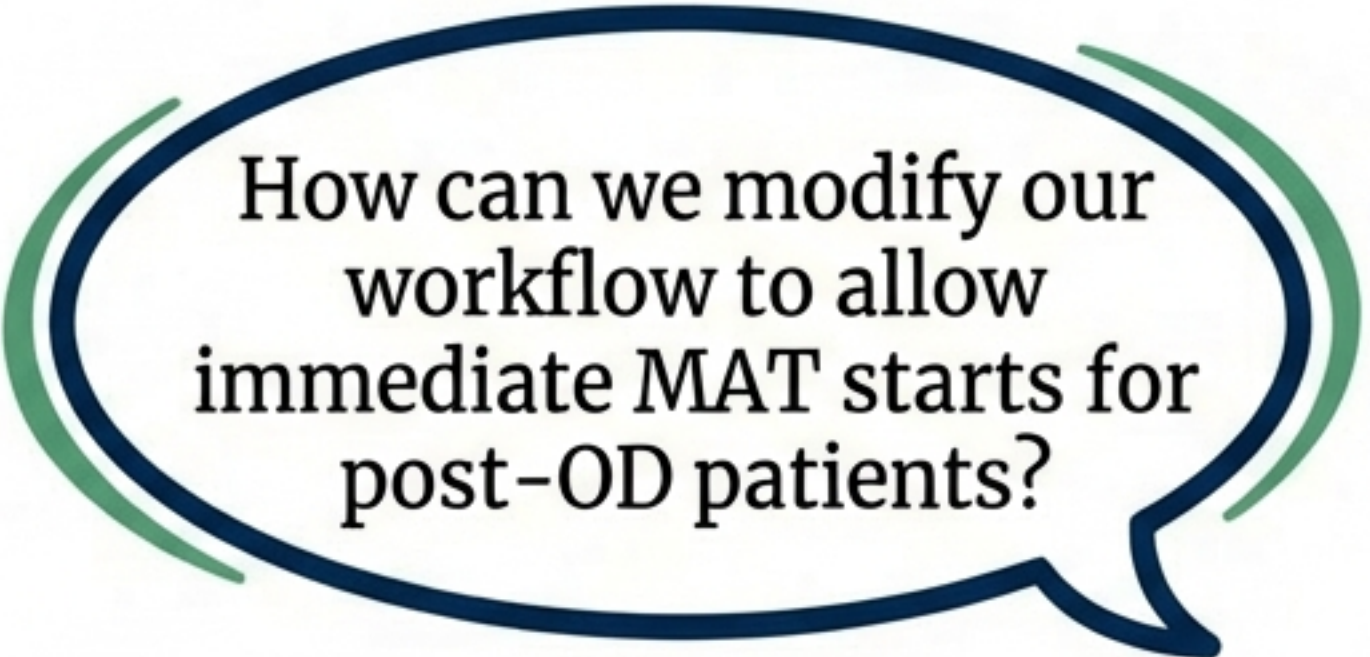
5. POLICY CHECK

Remove punitive policies (e.g., discharging for marijuana or benzo use).

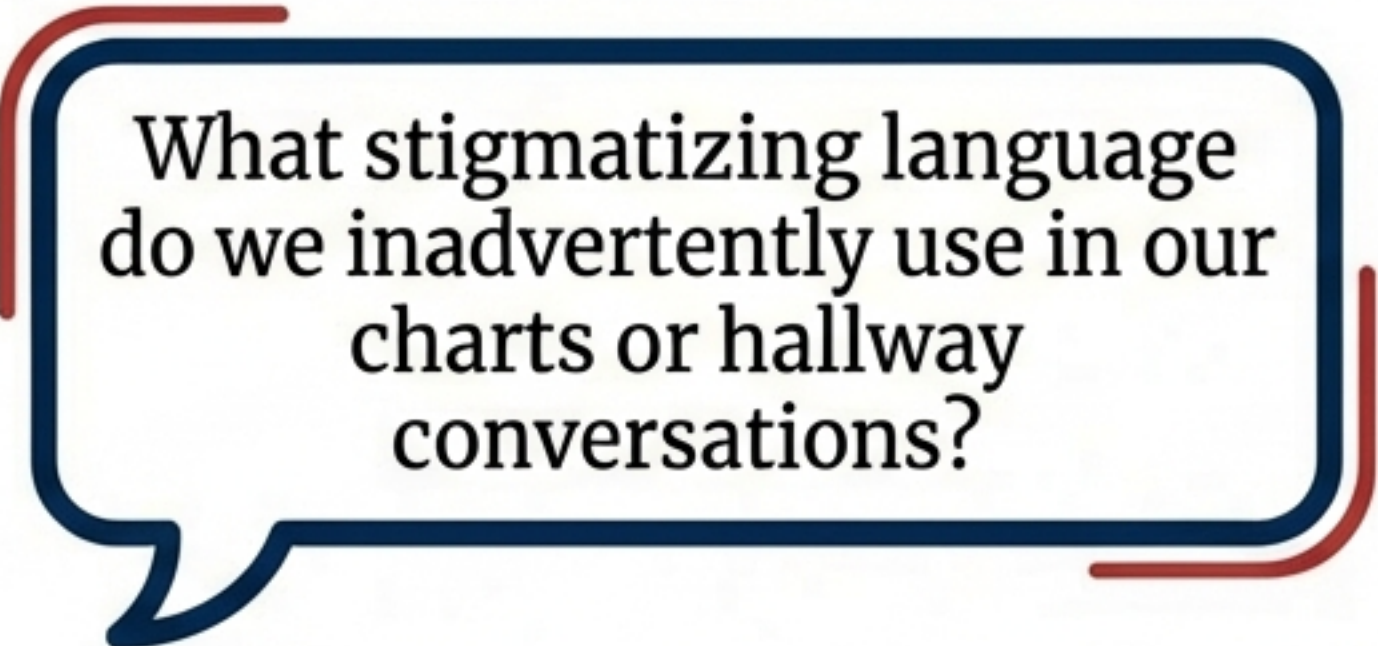
Discussion Prompts for Team Training



How would our clinical approach differ for fentanyl smokers vs. injectors?



How can we modify our workflow to allow immediate MAT starts for post-OD patients?



What stigmatizing language do we inadvertently use in our charts or hallway conversations?



How do we manage OUD treatment when chronic pain is also present?

Conclusion: Primary Care is the Front Line

“Most OUD patients—even complex ones—can effectively managed in primary care. Stability is not a prerequisite for treatment; treatment is a prerequisite for stability.”



Low-Dose
Induction



No Punitive
Discharge



Harm Reduction
Standard