

The OUD Playbook

A Practical Guide for Primary Care



Your Waiting Room is the Front Line

Most individuals with OUD interact with primary care long before specialty services.

(Source: SAMHSA, NIDA, AHRQ data)

Patients prefer treatment from a familiar clinician they already trust.



“Primary care is an appropriate and recommended setting for both diagnosis and MAT initiation.” – ASAM & SAMHSA

You Can Screen for OUD in 60 Seconds

Primary Tool: The Single-Question Screen
“How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?”

Secondary Tools: DAST-10 and ORT are also SAMHSA/NIDA recommended options.

Who to Screen



Patients prescribed long-term opioids



Individuals with a history of substance use



Early refill requests or aberrant behaviors



History of overdose or frequent ED visits

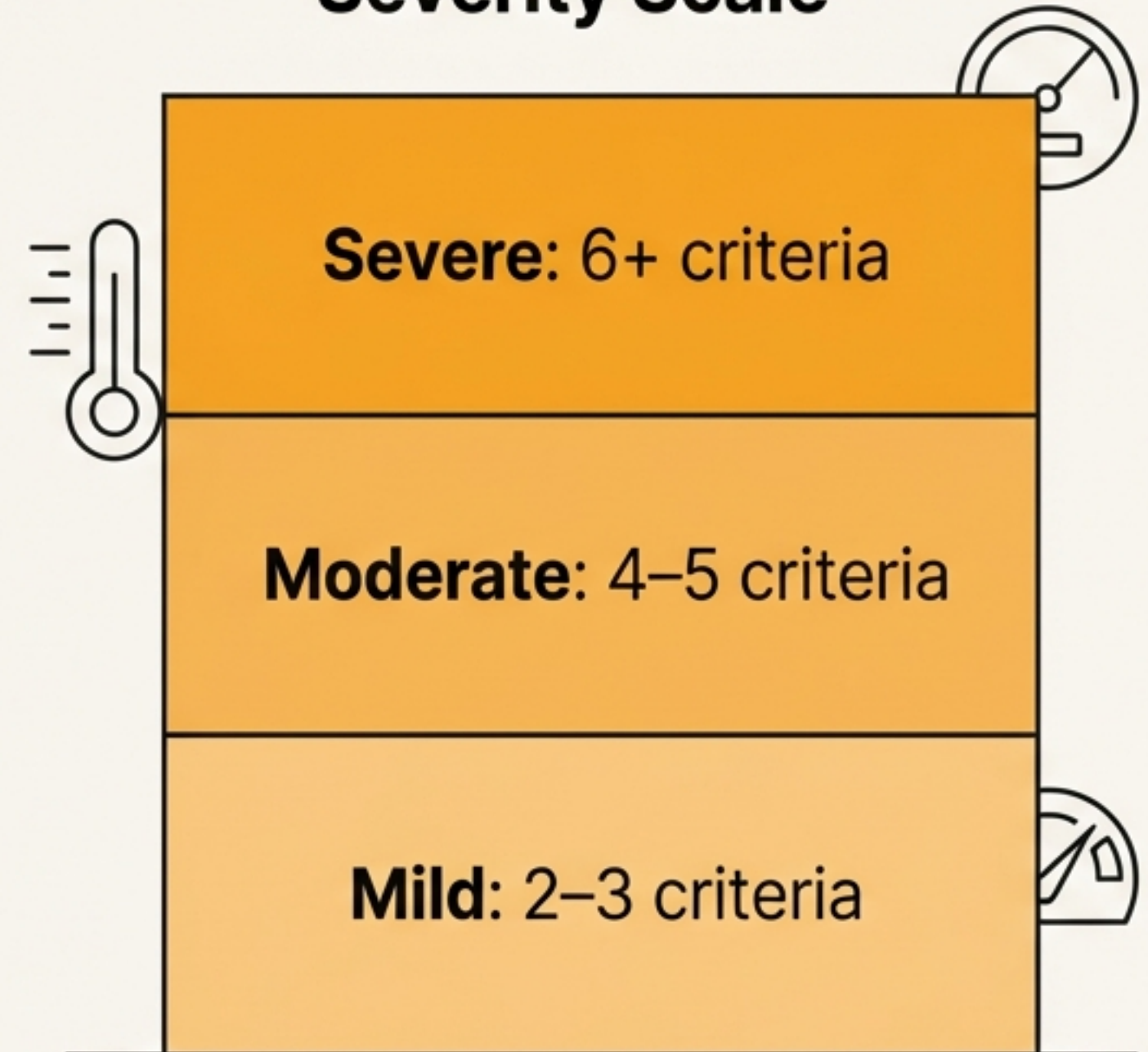
Diagnosis Is a Simple 2-Point Checklist

Core Criteria: Use DSM-5: A diagnosis of OUD is confirmed with **≥2 criteria met** in a 12-month period.

“These symptoms suggest your body and brain have developed dependence on opioids. The good news is we have treatments I can start today.”

(Source: SAMHSA MI Guide)

Severity Scale



Identifying the Right Patients to Start in Your Practice



Green Light: Proceed with Confidence

(Most patients can start MAT in primary care)

- Daily fentanyl users
- Prescription opioid users
- Pregnant individuals
- Patients with cravings/withdrawal



Yellow Light: Proceed with Caution / May Need More Support

- Uncontrolled psychosis
- Severe medical instability
- Current methadone treatment
- Acute intoxication requiring ED care

Choosing the Right Start: 3 Modern Induction Paths

Traditional Induction



Best For:

Short-acting opioid users.

Protocol:

Begin buprenorphine when patient is in moderate withdrawal (COWS score $\geq$ 8–12).

Low-Dose / Microdosing



Best For:

Fentanyl users, chronic pain patients, or those who fear withdrawal.

Protocol:

Allows for overlap with full agonist opioids, minimizing discomfort.

High-Dose / Rapid Induction



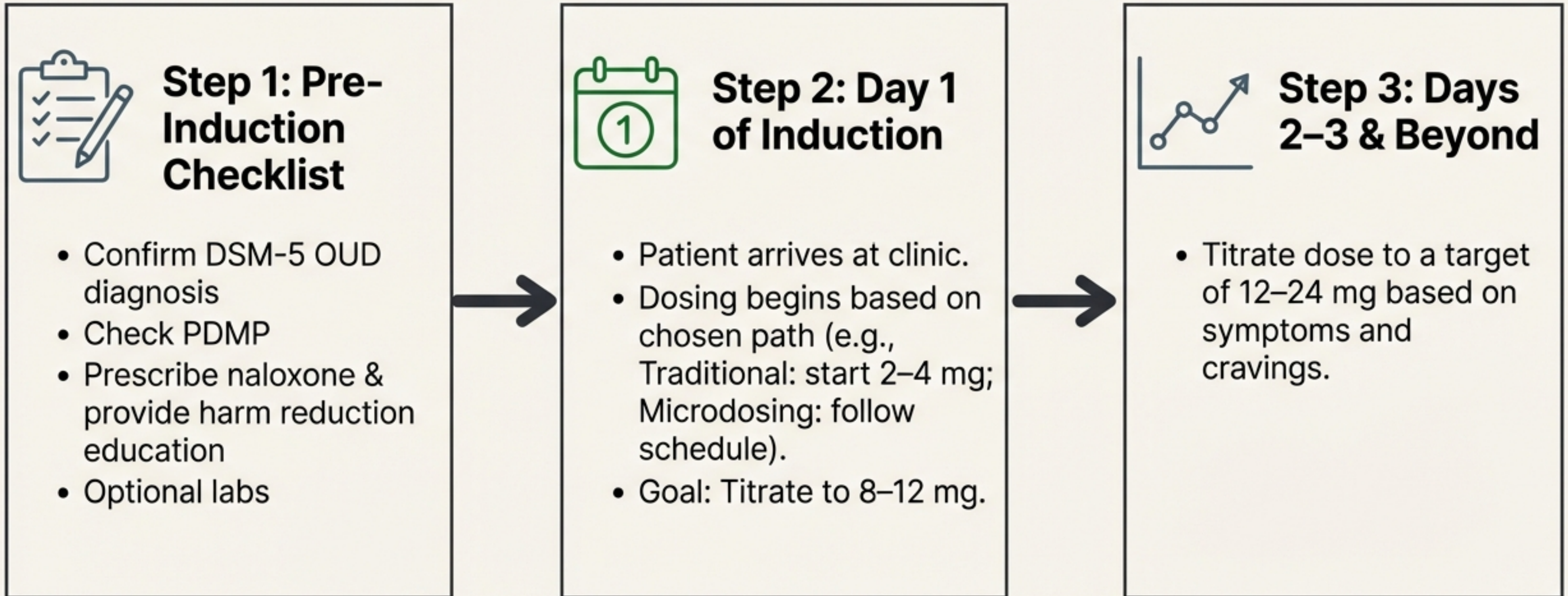
Best For:

Use in monitored settings (e.g., ED).

Protocol:

A single high dose (16–32 mg) on Day 1. (Source: CA Bridge/NIH)

The Step-by-Step Outpatient Induction Workflow



Turn Fear into Protocol: Managing Precipitated Withdrawal

Core Problem: Occurs when buprenorphine is started too early in a patient dependent on full agonist opioids.

**The Fix is Counterintuitive:
INCREASE the Buprenorphine Dose.**

DO NOT STOP the Medication.

Rationale: More buprenorphine will overcome the full agonist at the receptor site and resolve the withdrawal symptoms.

The Follow-Up Cadence: From Intensive Support to Stable Maintenance



Note: Telehealth follow-up is strongly supported by SAMHSA/DEA.

Treating the Whole Person: Managing Co-Occurring Conditions



Mental Health

Treat concurrently.
Benzodiazepine use is *not* a contraindication to starting buprenorphine.
(Source: FDA/ASAM)



Stimulant Use

Continue MAT for OUD.
Recommend behavioral treatment for stimulant use.



Alcohol Use

Continue MAT for OUD. Add evidence-based medications for alcohol use disorder as needed.



Chronic Pain

Buprenorphine provides analgesia. Continue treatment and consider split dosing for better pain coverage.

The Guiding Philosophy: High Support, Low Barrier

DO THIS

Patient-Centered Care

- ✓ Trauma-Informed Approach
- ✓ Flexible Care Plans
- ✓ Harm Reduction Focus

NOT THAT

Unnecessary Barriers to Avoid (per SAMHSA)

- ✗ Arbitrary dose caps
- ✗ Mandatory counseling as a condition of treatment
- ✗ Punitive policies for urine drug tests (UDT)
- ✗ Firing patients for relapse or return to use

Your Clinical Toolkit: Tools for Day One



Withdrawal Assessment Tools

COWS: Clinical Opiate Withdrawal Scale

SOWS: Subjective Opiate Withdrawal Scale



Go-To Scripts for Patient Conversations

“I can start treatment for you today.”

“We can use a low-dose induction method to avoid withdrawal and make this process more comfortable.”

“A return to use means we need to adjust the plan — not stop treatment. It’s part of the illness.”



Supportive “Comfort” Medications

Clonidine (for anxiety/autonomic symptoms)

Hydroxyzine (for anxiety/insomnia)

Ondansetron (for nausea)

Trazodone, Mirtazapine (for sleep)

Loperamide, Ibuprofen (for GI upset/pain)

Key Takeaways for Your Practice

1. Primary care is the front line for OUD treatment.
2. Brief, validated screens are highly effective.
3. DSM-5 allows for rapid and confident diagnosis.
4. Most patients can start MAT safely in your practice.
5. Low-dose induction is ideal for fentanyl-exposed patients.
6. Relapse is not a failure — it's a part of the illness that requires a plan adjustment.
7. Removing administrative and punitive barriers increases retention and reduces mortality.

You Have the Tools.

You Are the Front Line.

You Can Change the Outcome.