



Managing opioid use disorder
across the care continuum

Treating OUD and supporting recovery



Diagnosing opioid use disorder (OUD)

OUD is problematic opioid use that leads to significant impairment or distress.

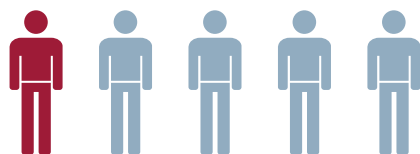
TABLE 1. OUD is marked by at least two of the following over the past 12 months:¹

<input type="checkbox"/>	using opioids at higher doses or longer than intended
<input type="checkbox"/>	unsuccessful attempts to control or reduce use
<input type="checkbox"/>	significant time spent obtaining, consuming, or recovering from opioids
<input type="checkbox"/>	cravings for opioids
<input type="checkbox"/>	failure to fulfill obligations because of opioid use
<input type="checkbox"/>	persistent social or interpersonal problems caused by opioids
<input type="checkbox"/>	opioid use displaces social, work, or recreational activities
<input type="checkbox"/>	using opioids in hazardous situations (e.g., while driving)
<input type="checkbox"/>	use continues despite physical or psychological problems caused or worsened by opioids
<input type="checkbox"/>	tolerance: a reduced effect of the drug despite increasing dosages (in patients taking opioids other than as prescribed)
<input type="checkbox"/>	withdrawal (in patients taking opioids other than as prescribed)

Mild: 2-3 criteria; Moderate: 4-5 criteria; Severe: 6 or more criteria

Nearly 6 million Americans have opioid use disorder.²

Even though medical treatment greatly improves outcomes, only 1 in 5 people with OUD receives such treatment.³






Medications for OUD are effective

Three medications are FDA-approved to treat OUD.

Each one reduces the risk of death, improves treatment retention, and decreases opioid misuse. Methadone and buprenorphine are first-line choices for OUD treatment and are more effective at preventing overdose than long-acting naltrexone.⁴⁻⁹

TABLE 2. Tailor the choice of medication for OUD (MOUD) to the patient.

Medication	Buprenorphine*	Methadone	Naltrexone injection
Mechanism of action	 <p>Partial agonist: partially activates opioid receptor</p>	 <p>Full agonist: activates opioid receptor</p>	 <p>Antagonist: blocks opioid receptor</p>
Who can provide treatment	any prescriber with a DEA license**	federally-regulated opioid treatment program or inpatient/emergency department	any prescriber
Dosage forms	sublingual film or tablet, buccal film, or long-acting injection	liquid or tablet	long-acting intramuscular injection†
Treatment delivery	no daily clinic visits required	supervised daily administration or limited take-home treatment	monthly injection
Patient characteristics	patients who prefer an opioid agonist without frequent clinic visits	patients with multiple unsuccessful prior treatment attempts, and/or who need daily structured support	<ul style="list-style-type: none"> patients who can be abstinent from opioids for 7-10 days prior to starting patients who cannot use agonist therapy

Keep abreast of changing regulations regarding access to MOUD.

*Buprenorphine is often combined with naloxone in a sublingual formulation (e.g., Suboxone) to prevent misuse if injected; naloxone in sublingual formulations has little or no effect if taken as prescribed. **The DEA license needs to have Schedule III authority. †While not recommended, oral naltrexone may be use for patients unwilling or able to use other options.

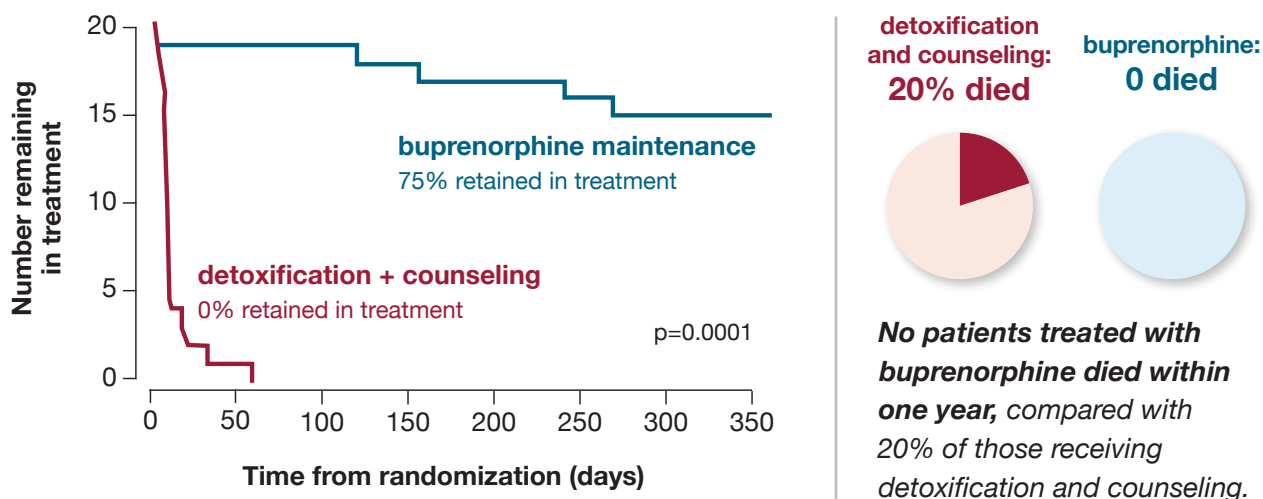


Detoxification alone is *not* effective. Without medications, patients with OUD are > 2.5 times more likely to die of an overdose.⁸

Detoxification = observed opioid withdrawal with medical management of symptoms

Buprenorphine saves lives

FIGURE 1. In a randomized trial, buprenorphine kept more patients alive and engaged in treatment compared to detoxification and counseling.⁶



Buprenorphine is more effective than many other interventions prescribed in primary care.

TABLE 3. Fewer patients need to be treated to provide a mortality or morbidity benefit with buprenorphine compared to commonly used cardiovascular medications.¹⁰⁻¹³

INTERVENTION	Outcome	Number needed to treat (NNT) to prevent one outcome	Timeframe
Buprenorphine for OUD	death	5	1 year
Anticoagulation for lower extremity deep vein thrombosis	recurrent venous thrombosis	17	3 months
Aspirin for secondary prevention (i.e., prior myocardial infarction [MI] or stroke)	subsequent MI	77	2 years
	subsequent stroke	200	
	death	333	

Expanding access to treatment

➔ Steps when starting treatment with MOUD

- Check the prescription drug monitoring program for any prescribed opioids or prior MOUD.
- Get a pregnancy test, when appropriate.
- For complex patients (e.g., co-occurring substance use disorder), start MOUD and consult with or refer to an addiction treatment specialist for support managing polysubstance use, as needed.



➔ Behavioral treatment not required

Treatment such as cognitive behavioral therapy (CBT) in addition to medical management does not significantly impact abstinence from opioids.¹⁴

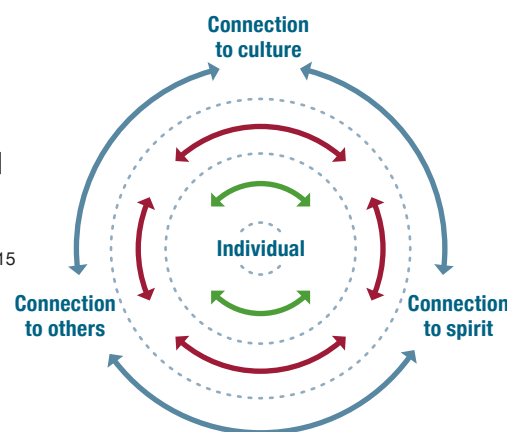
Clinicians can prescribe MOUD even without access to concurrent behavioral treatment.



➔ Engagement at any step in the journey

Care of patients with OUD is not linear or one size fits all. Options to engage in recovery services should be flexible and community focused.

- Focus on treatment successes rather than problems.¹⁵
- Help communities build positive connections with events that do not center around opioid/substance use.



➔ Emergency department and urgent care—a critical link

- Patients who present with opioid related adverse events present an opportunity to offer OUD treatment.
- Peer support specialists can help meet patients in the community and find resources and supports to help move toward recovery.

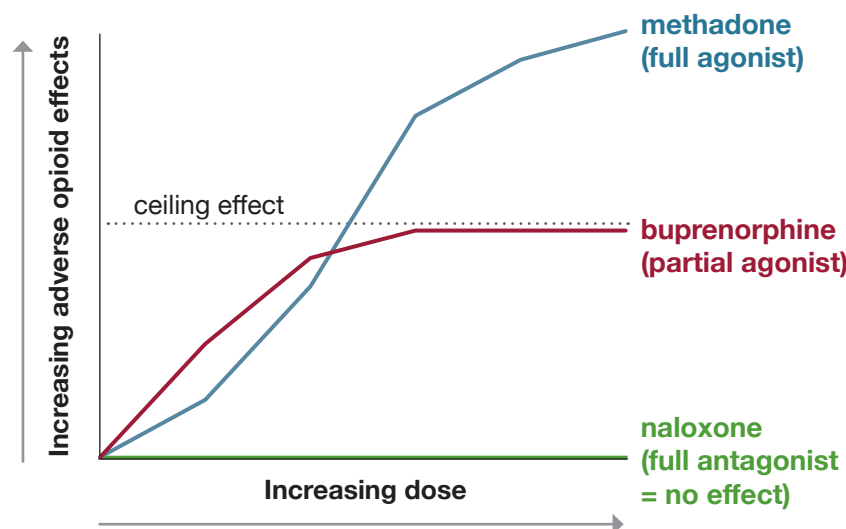


Buprenorphine is safer than other opioids

It is unlikely to cause overdose, even at high doses.

- When used alone, buprenorphine has a **very low risk for respiratory depression or overdose**. In combination with non-opioid respiratory depressants (e.g., benzodiazepines), respiratory depression or overdose are possible.
- Overdose risk and death for patients taking medications for OUD is highest immediately after these medications are stopped.

FIGURE 2. Respiratory depression is less likely with buprenorphine because its risk for respiratory depression has a ceiling, unlike other opioids.¹⁶



Precipitated withdrawal is easily avoidable.

- If a patient starts using buprenorphine while they are still experiencing the effect of another opioid, buprenorphine's high binding affinity for opioid receptors will displace the other opioid from the opioid receptor.
- This rapid displacement can precipitate opioid withdrawal, which can be unpleasant for the patient but is not life-threatening.
- Precipitated withdrawal can usually be avoided by waiting to initiate buprenorphine until the patient is already in withdrawal.

Other side effects of buprenorphine are similar to those of other opioids, including headache, abdominal discomfort, nausea, flushing, constipation, and insomnia.

Getting started with buprenorphine

The medication's success is similar whether it is started in the emergency department (ED) or at home.¹⁷⁻¹⁹

Avoid precipitated withdrawal.



OPTION 1: Wait for the patient to have at least **moderate symptoms** of opioid withdrawal: Measure withdrawal symptoms using the Clinical Opioid Withdrawal Score (COWS).



COWS: A score of 13 or more equates to moderate withdrawal.



OPTION 2: Wait for a period of time based on the last opioid used:

Category	Examples	Time to wait before initiating buprenorphine
Short half-life	hydromorphone, oxycodone, heroin	12-24 hours
Long half-life	extended-release oxycodone or morphine	36 or more hours
Extremely long half-life*	methadone, fentanyl	48 hours or more

*Highest risk of precipitated withdrawal



OPTION 3: Use a low dose or microdose of buprenorphine and slowly increase the dose (see Table 4).

Prescribe enough buprenorphine for one week and follow up within one week.

- Typically, buprenorphine is supplied as **buprenorphine/naloxone** 8 mg/2 mg films.
- The average patient will take 2 films (16 mg buprenorphine) per day. Doses up to 3 films (24 mg buprenorphine) are safe and may be needed for some patients.
- Therefore, a typical 1-week supply is 14 films of buprenorphine 8 mg/2 mg.



Dosing options for starting buprenorphine

Expanding strategies to initiate buprenorphine can help patients find the one that works best for them.

TABLE 4. Dosing strategies for starting buprenorphine²⁰

	Low dose “microdose”	Low-dose / classic dose	High dose “macrodose”
Duration of initiation period	Days to weeks	1 day	2-3 hours
Withdrawal severity to start	None	Moderate	Moderate
Initial dose of buprenorphine	< 1 mg	2-4 mg	8-16 mg
Usual maintenance dose	16-24 mg		
Benefits	<ul style="list-style-type: none"> • Patients with chronic pain do not need to stop opioid medications during initiation 	<ul style="list-style-type: none"> • Dosing strategy with most experience 	<ul style="list-style-type: none"> • Can be initiated in many settings (e.g., ED, primary care) • Simple steps to start • Short time to achieving maintenance dose
Challenges	<ul style="list-style-type: none"> • Complex dosing schedule • Requires cutting films 	<ul style="list-style-type: none"> • Withdrawal symptoms likely over first two days 	<ul style="list-style-type: none"> • Withdrawal symptoms after initial dose of buprenorphine
Resources	Bridge to treatment qrco.de/lowdose	SAMHSA Quick start guide qrco.de/SAMHSA_quickstart	Bridge to treatment qrco.de/highdose

Sustaining patients on buprenorphine

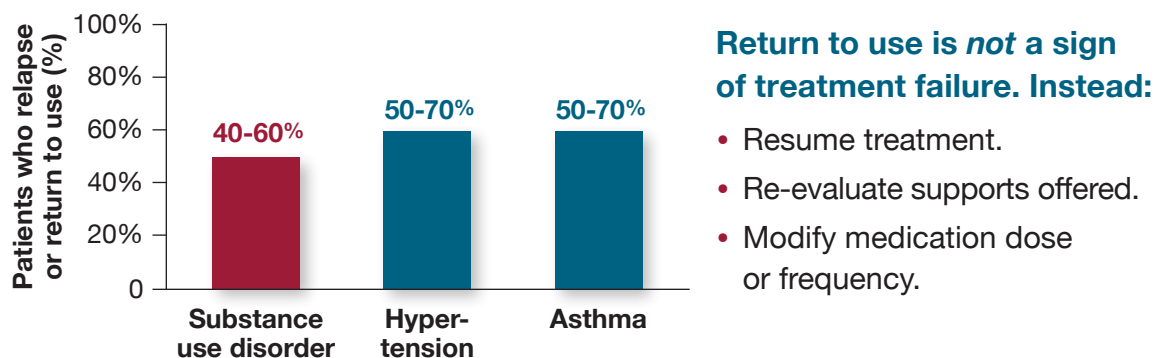
➔ Establish a follow-up plan.

- There is no strict rule for follow-up intervals. Ensuring ease of access to this lifesaving medication should be a priority.
- It can be helpful to see patients weekly until they reach a stable dose. Once stable, patients can typically follow up monthly or bi-monthly.

➔ Support patients even if they return to using opioids.

As with any chronic disease, the goal of OUD treatment is not to cure, but to reduce harm, prevent complications, and improve function and well-being.

FIGURE 3. Return to use rates are similar to relapse rates in other chronic conditions.²¹



➔ Use toxicology testing to assist recovery.

Involve patients in discussions about toxicology test results.

Results can:

- Help make therapeutic decisions about treatment.
 - Determine whether buprenorphine is being taken.
 - Identify whether other opioids are present.
- Explore factors contributing to a return to opioid use (i.e., inadequate pain management).



Don't discharge a patient due to an unexpected toxicology result.

Stopping buprenorphine because of an abnormal toxicology test is akin to stopping a statin for an abnormal LDL or withholding metformin for an abnormal HgbA1c.

Discuss harm reduction strategies with all patients

Like seat belts, sunscreen, or safer sex practices, simple steps can help all patients with OUD reduce risks to their health.



Prescribe intranasal naloxone (e.g., Narcan) to prevent overdose



Recommend or provide immunizations
(hepatitis, pneumococcus, tetanus)



Screen for infections
(especially HIV, hepatitis C)

Other harm reduction strategies:

- For patients who use opioids alone, recommend **www.neverusealone.com** or the 1-800-484-3731 hotline to prevent unintentional overdose.
- For those who inject, **discuss sterile injection practices** to reduce the transmission of bloodborne pathogens like HIV and hepatitis C; link with a syringe exchange program or prescribe insulin needles.
- **Recommend fentanyl test strips**, if available.
- Evaluate whether **pre-exposure prophylaxis (PrEP)** is indicated for HIV prevention.

Use “person-first” language to reduce stigma.

TABLE 5. Words can impact a patient’s perceptions of their treatment:

Language to avoid	Recommended language
addict, abuser, user, junkie	a person with OUD
clean/dirty urine	urine positive/negative for opioids or other substances
treatment failure	return to use, recurrence

Key points

- Although there are effective medications to treat OUD, access to treatment remains limited and **only 1 in 5 patients with OUD is treated.**
- **Buprenorphine can be safely prescribed** in primary care and emergency room settings.
- **Home buprenorphine induction is safe** and can be accomplished by providing patients with tools, information, and support.
- **Support patients if they return to drug use while on treatment.** An unexpected toxicology result is not a reason for discharging a patient from treatment. Rather, it is an opportunity to discuss and change the treatment plan if necessary.
- **Discuss and encourage harm reduction strategies with all patients** regardless of their current level of engagement in treatment.

Visit www.ihs.gov/opioids
for links to resources to support recovery.

References:

(1) American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 5th Ed., Text Revision*. Arlington, VA: American Psychiatric Publishing; 2022. (2) Substance Abuse and Mental Health Services Administration. *Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health*. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration; 2021. HHS Publication No. PEP24-07-021, NSDUH Series H-59. (3) Substance Abuse and Mental Health Services Administration. 2023 NSDUH Detailed Tables. <https://www.samhsa.gov/data/report/2023-nsduh-detailed-tables>. July 30, 2024. Accessed Oct 2, 2024. (4) Fudala PJ, Bridge TP, Herbert S, et al. Office-based treatment of opiate addiction with a sublingual-tablet formulation of buprenorphine and naloxone. *N Engl J Med*. 2003;349(10):949-958. (5) Gunne LM, Gronblad L. The Swedish methadone maintenance program: a controlled study. *Drug Alcohol Depend*. 1981;7(3):249-256. (6) Kakko J, Svanborg KD, Kreek MJ, Heilig M. 1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomised, placebo-controlled trial. *Lancet*. 2003;361(9358):662-668. (7) Krupitsky E, Nunes EV, Ling W, et al. Injectable extended-release naltrexone for opioid dependence: a double-blind, placebo-controlled, multicentre randomised trial. *Lancet*. 2011;377(9776):1506-1513. (8) Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *Bmj*. 2017;357:j1550. (9) Strain EC, Stitzer ML, Liebson IA, Bigelow GE. Dose-response effects of methadone in the treatment of opioid dependence. *Ann Intern Med*. 1993;119(1):23-27. (10) Antithrombotic Trialists' Collaboration. Collaborative meta-analysis of randomized trials of antiplatelet therapy for prevention of death, myocardial infarction, and stroke in high risk patients. *Bmj*. 2002;324(7329):71-86. (11) Kirkilesis G, Kakkos SK, Bicknell C, et al. Treatment of distal deep vein thrombosis. *Cochrane Database Syst Rev*. 2020;4(4):Cd013422. (12) Larochelle MR, Bernson D, Land T, et al. Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality: A Cohort Study. *Ann Intern Med*. 2018;169(3):137-145. (13) Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. *Cochrane Database Syst Rev*. 2014(2):Cd002207. (14) Fiellin DA, Barry DT, Sullivan LE, et al. A randomized trial of cognitive behavioral therapy in primary care-based buprenorphine. *Am J Med*. 2013;126(1):74.e11-77. (15) Johnson F Jr, RedCloud A, Mootz J, et al. Community member perspectives on adapting the cascade of care for opioid use disorder for a tribal nation in the United States. *Addiction*. 2023 Aug;118(8):1540-1548. (16) Golembiewski J, Rakic AM. Sublingual buprenorphine. *J Perianesth Nurs*. 2010;25(6):413-415. (17) Doolittle B, Becker W. A case series of buprenorphine/naloxone treatment in a primary care practice. *Subst Abuse*. 2011;32(4):262-265. (18) Lee JD, Grossman E, DiRocco D, Gourevitch MN. Home buprenorphine/naloxone induction in primary care. *J Gen Intern Med*. 2009;24(2):226-232. (19) Sohler NL, Li X, Kunins HV, et al. Home- versus office-based buprenorphine inductions for opioid-dependent patients. *J Subst Abuse Treat*. 2010;38(2):153-159. (20) Randall A, Hull I, Martin SA. Enhancing Patient Choice: Using Self-administered Intranasal Naloxone for Novel Rapid Buprenorphine Initiation. *J Addict Med*. 2023 Mar-Apr 01;17(2):237-240. (21) McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. *JAMA*. 2000;284(13):1689-1695.

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Page 3 (medication classes): © 2016 The Pew Charitable Trusts. pewtrusts.org/-/media/assets/2016/11/medicationassistedtreatment_v3.pdf

These are general recommendations only; specific clinical decisions should be made by the treating clinician based on an individual patient's clinical condition.



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