Compass Opioid Stewardship in Practice Microlearning Series

Module 6: Identifying Opioid Use Disorder and Starting Buprenorphine

Welcome to Compass Opioid Stewardship in Practice. Each week, our Compass coaches will explore a real-world case, define a clinical goal, and walk through practical strategies to improve care. Whether you're tuning in via video, audio, or reading the summary, this session is built for busy clinicians like you.

This week's session is brought to you by Dr. Scott Weiner, MD, MPH, FAAEM, FACEP, FASAM; Clinical Coach in the Compass Opioid Stewardship Program.

Case Presentation

This week's case is about Bob is a 50-year-old man with chronic low back pain who has been taking oxycodone ER 20 mg three times daily for three years. He recently asked for early refills, reports lost prescriptions twice, and his urine drug screen shows fentanyl and benzodiazepines. The state prescription drug monitoring program indicates prescriptions from multiple providers. This constellation of behaviors—unapproved dose increases, obtaining opioids from multiple prescribers, and concurrent non-medical drug use may signal increased risk for OUD. Bob insists he is taking opioids for pain but admits buying additional pills to "avoid getting sick."

Goal

Our clinical goal is to determine whether Bob meets DSM-5 criteria for OUD, counsel him on treatment options, and start buprenorphine (MOUD) in primary care to improve his outcomes and reduce overdose risk.

Clinical Steps

1. **Recognize opioid use disorder.** The DSM-5 lists 11 criteria; the presence of ≥2 in 12 months indicates OUD (Note: tolerance and withdrawal do not, in themselves, count unless accompanied by other criteria). Concerning behaviors, such as using more opioids than intended, unsuccessful attempts to cut down, spending significant time obtaining opioids, craving, failure to fulfill obligations, continued use despite problems, tolerance and withdrawal—count toward these criteria. Bob buys pills from an illicit source, exhibits loss of control (using more than prescribed), and continues despite harms. He therefore meets criteria for at least moderate OUD.
2. **Discuss treatment and obtain consent.** Explain that OUD is a chronic brain disease; medication for addiction treatment (MAT) reduces mortality and improves retention. Emphasize that he will receive counseling and support, not judgment. Because he has benzodiazepines in his urine, caution that combined sedatives increase overdose risk; arrange for benzodiazepine taper as well. Provide naloxone nasal spray to Bob and his family, as patients on ≥50 MME/day or using benzodiazepines plus opioids should carry naloxone.

3. **Initial assessment before induction**. Confirm OUD diagnosis. Obtain collateral information (medical records, pharmacy), perform a physical exam and consider a baseline urine drug screen – not for punitive reasons but rather to see which substances need to be addressed. Assess for other substance use; high volume alcohol or benzodiazepine use may require inpatient induction. Evaluate support systems, housing stability and insurance; refer to counseling and recovery programs.
4. **Choose an induction strategy.** There are two main approaches: standard induction (wait for moderate withdrawal) and low dose microdosing cross taper. For most patients on short acting opioids, standard induction is recommended. Wait until the patient exhibits moderate withdrawal (Clinical Opiate Withdrawal Scale > 12), typically 12 hours after last use. Start with 8-16 mg sublingual buprenorphine, reassess after 1–2 hours, and give additional doses up to 24-32 mg on day 1. On day 2, take the total dose from day 1. You can consider clonidine, ondansetron and hydroxyzine for withdrawal symptoms.
5. **Low dose microdosing cross taper (optional).** If Bob cannot tolerate withdrawal or is on long-acting opioids/fentanyl, consider microdosing. There are lots of ways to do this, but they usually involve starting with 0.5 mg of buprenorphine twice a day, and then slowly ramping up over the course of 5-14 days. Patients continue using their full agonist opioid until they no longer feel the need, usually after 3-7 days. Low dose initiation allows overlap and prevents precipitated withdrawal but requires careful instruction and patient adherence.
6. **Follow up and harm reduction.** Schedule frequent visits or telehealth check-ins during the first month. Do not stop buprenorphine if urine screens show continued opioid or stimulant use; instead, assess adherence, consider dose increase and provide additional support. Encourage psychosocial treatment and address co-occurring mental health disorders. Continue naloxone distribution and counsel on overdose response.

Clinical Pearls

The clinical pearls we want you to remember are:

- Diagnose OUD using DSM-5 criteria, including loss of control, cravings, and continued use despite harm.
- Offer buprenorphine in primary care; any clinician with a Schedule III DEA registration can prescribe it for OUD.
- Provide naloxone to the patient and household; those taking ≥50 MME/day or combining opioids and benzodiazepines should have it on hand.

Thank You

This education has been brought to you through the generous support of the Centers of Medicare and Medicaid Services. Thanks for reading this week's Compass Opioid Stewardship in Practice Microlearning Series. Thank you for being part of the Compass Opioid Stewardship Program. And thank you for all you do caring for your patients.

Resources

- Opioid Use Disorder Diagnosis and Treatment