## Provider Guidelines-complete list

* **Become educated on the latest evidence-based guidelines** for diagnosing, treating and managing opioid use disorder, including use of medications such as methadone and buprenorphine, and the importance of approaching opioid use disorder as a chronic condition. See **Appendices** for list of updated guidelines.
* **Universally screen in primary care at least annually for substance use disorders including opioid use disorder using a validated instrument** (see [NIDA Screening and Assessment Tools](https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools)) **following the** [**United States Preventative Task Force recommendations**](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening)**. Providers not in primary care settings should also routinely screen for substance use disorders using validated instruments.** Screening may be done by another care team member, clinic staff, or online/on paper prior to appointments. Screening should be done in a straightforward, nonjudgmental manner while asking about other health behaviors.
  + While current USPSTF recommendations do not endorse screening for adolescents, Washington overdose related deaths have increased especially in youth. Providers caring for pediatric patients should consider routinely screening for and have high clinical suspicion for substance use, and MOUD is recommended for adolescents with opioid use disorder.
  + **Ensure older adults are screened for unhealthy substance use.** Older adults are less likely to be screened for unhealthy substance use than younger individuals, but overdose rates in older adults are increasing.[[1]](#endnote-2) If screening on paper, ensure print on screening is large enough for older adults to read easily.[[2]](#endnote-3)
* **If a patient screens positive, or independently brings up concerns about their opioid use, ask about frequency, amount, and route of opioid use,** **perform comprehensive assessment, and discuss medications for opioid use disorder.** Many people may only be familiar with abstinence-based approaches and unaware that using buprenorphine or methadone may reduce risk of overdose by about 50%.[[3]](#endnote-4) **Do not delay medication until a comprehensive assessment can be performed.** Use an evidence-based patient decision aid to support the conversation (some are certified by the Washington HCA, see more [here](https://www.hca.wa.gov/about-hca/programs-and-initiatives/making-informed-health-care-decisions/patient-decision-aids-pdas)). The conversation should include:
  + Risks and benefits of available medications.
  + How treatment setting can impact which medication might best meet their need (e.g., whether the patient can do daily visits) as well as the patient’s use of other substances (e.g., alcohol, benzodiazepines)
  + Ensure that the patient and members of their support system (e.g., family, partners, etc.) understand the risk of adverse events, including recurrent substance use and fatal overdose, are increased when treatment does not include the use of buprenorphine or methadone.
  + Assess and address patient comorbidities including poly-substance use and any untreated mental health or physical health conditions. Include screening and treatment for common co-occurring concerns including hepatitis C virus (HCV) and sexually-transmitted diseases (STDs) including syphilis.
* **Offer medications for opioid use disorder treatment.** Buprenorphine can be successfully prescribed in a primary care setting and may be a good fit for many patients, if aligned with their treatment goals. Offering access to medications for opioid use disorder is considered standard of care for patients with opioid use disorder. Follow evidence-based guidelines for assessment of opioid withdrawal and MOUD initiation. (ASAM, PCSS).
  + See more resources on starting a program in primary care [here](https://www.learnabouttreatment.org/for-professionals/clinical-protocols/).
* **Prescribe dosages of MOUD and adjunct therapies that adequately address symptoms.** With the use of more potent substances like fentanyl, required doses needed to manage symptoms of withdrawal and cravings can be higher. Adjunct medications may be helpful to address symptoms of opioid withdrawal (e.g., autonomic arousal, anxiety/restlessness, insomnia, musculoskeletal pain, and gastrointestinal distress) during the MOUD stabilization period.
* **Prescribe MOUD for adequate duration.** There is no limit on how long an individual may use any MOUD, and shorter prescription lengths (e.g., 1-2 weeks) may introduce unnecessary barriers to MOUD access.
* **Assess possible medication interactions, especially with benzodiazepines**. Treatment of opioid use disorder with medications should not be discouraged or delayed, but the combined use of these drugs increases the risk of serious side effects; however, the harm caused by untreated opioid addiction can outweigh these risks.[[4]](#endnote-5)Follow ASAM National Practice Guidelines for Treatment for Opioid Use Disorder and guidelines of the [American Association for the Treatment of Opioid Dependence](https://www.aatod.org/advocacy/policy-statements/guidelines-for-addressing-benzodiazepine-use-in-opioid-treatment-programs-otps-april-6-2017/)
* **Write a prescription for and/or provide naloxone for use during an overdose.** For in-person visits, the ideal scenario is for patients to leave the appointment with naloxone in their possession. Providers can use the statewide standing order to dispense naloxone, and naloxone is free to request by mail in Washington state. Order free naloxone through Washington [Department of Health](https://doh.wa.gov/you-and-your-family/injury-and-violence-prevention/opioid-overdose-prevention).
  + Teach patients and families how and when to use naloxone. Washington State Department of Health’s video tutorial on how to respond to an opioid overdose and administer naloxone linked [here](https://vimeo.com/357020563).
* **In primary care, coordinate physical and behavioral healthcare.** Coordinate care across physical and behavioral health providers. See **Appendices** for information on care coordination compared to case management.
  + Consider referring to an Opioid Treatment Program for specialized care.
* **Regularly follow up with patients with opioid use disorder.** Document instances of recurrent substance use, reemergence of cravings or withdrawal symptoms and ongoing behavioral or physical health needs. Patients with opioid use disorder need care coordination of care as they are at increased risk of loss to follow up.
* **Use telehealth in care for patients with OUD.** MOUD can be safely provided over audio-visual and audio-only telehealth.
* **Understand the local epidemic in your community and be aware of populations most impacted by opioid use disorder and overdose.** With the rapid evolution of the opioid epidemic, providers should stay engaged with local community organizations that support people with substance use and stay up to date on local demographic trends and populations most impacted by opioid use, overdoses and deaths in their community and at the state level.

Checklists: The checklist translates the Bree guidelines into action steps for that sector (i.e., clinician, health delivery site, public health, etc.). The action items have been arranged into levels 1, 2, and 3 to correspond to the difficulty level of implementing the action into the sectors’ setting. Bree staff co-created the checklists with report workgroup members and topic experts.

## Level 1

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  + . Providers caring for pediatric patients should consider routinely screening for and have high clinical suspicion for substance use, and MOUD is recommended for adolescents with opioid use disorder.
  + **Ensure older adults are screened for unhealthy substance use.**
* ***If a patient screens positive, or independently brings up concerns about their opioid use, ask about frequency, amount, and route of opioid use,******perform comprehensive assessment, and discuss medications for opioid use disorder. Do not delay medication until a comprehensive assessment can be performed.***
* **Offer medications for opioid use disorder treatment.** Buprenorphine can be successfully prescribed in a primary care setting and may be a good fit for many patients, if aligned with their treatment goals. Offering access to medications for opioid use disorder is considered standard of care for patients with opioid use disorder. Follow evidence-based guidelines for assessment of opioid withdrawal and MOUD initiation. (ASAM, PCSS).
* **Assess possible medication interactions, especially with benzodiazepines**. Treatment of opioid use disorder with medications should not be discouraged or delayed, but the combined use of these drugs increases the risk of serious side effects; however, the harm caused by untreated opioid addiction can outweigh these risks.[[5]](#endnote-9)Follow ASAM National Practice Guidelines for Treatment for Opioid Use Disorder and guidelines of the [American Association for the Treatment of Opioid Dependence](https://www.aatod.org/advocacy/policy-statements/guidelines-for-addressing-benzodiazepine-use-in-opioid-treatment-programs-otps-april-6-2017/)
* **Write a prescription for and/or provide naloxone for use during an overdose.** For in-person visits, the ideal scenario is for patients to leave the appointment with naloxone in their possession. Providers can use the statewide standing order to dispense naloxone, and naloxone is free to request by mail in Washington state. Order free naloxone through Washington [Department of Health](https://doh.wa.gov/you-and-your-family/injury-and-violence-prevention/opioid-overdose-prevention).
* Teach patients and families how and when to use naloxone. Washington State Department of Health’s video tutorial on how to respond to an opioid overdose and administer naloxone linked [here](https://vimeo.com/357020563).
* **Regularly follow up with patients with opioid use disorder.** Document instances of recurrent substance use, reemergence of cravings or withdrawal symptoms and ongoing behavioral or physical health needs. Patients with opioid use disorder need care coordination of care as they are at increased risk of loss to follow up.
* **Understand the local epidemic in your community and be aware of populations most impacted by opioid use disorder and overdose.** With the rapid evolution of the opioid epidemic, providers should stay engaged with local community organizations that support people with substance use and stay up to date on local demographic trends and

## Level 2

* **Prescribe dosages of MOUD and adjunct therapies that adequately address symptoms.** With the use of more potent substances like fentanyl, required doses needed to manage symptoms of withdrawal and cravings can be higher. Adjunct medications may be helpful to address symptoms of opioid withdrawal (e.g., autonomic arousal, anxiety/restlessness, insomnia, musculoskeletal pain, and gastrointestinal distress) during the MOUD stabilization period.
* **Prescribe MOUD for adequate duration.** There is no limit on how long an individual may use any MOUD, and shorter prescription lengths (e.g., 1-2 weeks) may introduce unnecessary barriers to MOUD access.
* **In primary care, coordinate physical and behavioral healthcare.** Coordinate care across physical and behavioral health providers. See **Appendices** for information on care coordination compared to case management.
  + Consider referring to an Opioid Treatment Program for specialized care.

Use telehealth in care for patients with OUD. Providing MOUD through telehealth (audio-visual and audio-only) is now considered acceptable standard of care

## Level 3

* **Advocate for clinic process changes that improve timely access to MOUD**, such as same-day medication prescribing, rapid referral to behavioral healthcare, and educating support staff about stigma and chronic disease model of substance use disorders

1. Shoff, C., Yang, T. C., & Shaw, B. A. (2021). Trends in Opioid Use Disorder Among Older Adults: Analyzing Medicare Data, 2013 2018. American journal of preventive medicine, 60(6), 850–855. Doi: 10.1016/j.amepre.2021.01.010 [↑](#endnote-ref-2)
2. Substance Abuse and Mental Health Services Administration. (2020). *Treatment improvement protocol (TIP) series, no. 26: Substance use disorder treatment for people with co-occurring disorders*. <https://store.samhsa.gov/sites/default/files/tip-26-pep20-02-01-011.pdf> [↑](#endnote-ref-3)
3. Crystal, S., Nowels, M., Samples, H., Olfson, M., Williams, A. R., & Treitler, P. (2022). Opioid overdose survivors: Medications for opioid use disorder and risk of repeat overdose in Medicaid patients. *Drug and alcohol dependence*, *232*, 109269. https://doi.org/10.1016/j.drugalcdep.2022.109269 [↑](#endnote-ref-4)
4. U.S. Food and Drug Administration. (2024, September 17). FDA drug safety communication: FDA urges caution about withholding opioid addiction medications. U.S. Food and Drug Administration. <https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-urges-caution-about-withholding-opioid-addiction-medications> [↑](#endnote-ref-5)
5. U.S. Food and Drug Administration. (2024, September 17). FDA drug safety communication: FDA urges caution about withholding opioid addiction medications. U.S. Food and Drug Administration. <https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-urges-caution-about-withholding-opioid-addiction-medications> [↑](#endnote-ref-9)