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Major Gaps in the Cascade of Care for Opioid Use Disorder: Implications for Clinical Practice

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In 2022, drug overdose was the leading cause of death for US residents aged 23 to 46 years, and among the leading causes of death for older US residents.[1] That year, 81 806 opioid-involved overdose deaths were reported in the US, more than in any previous year and more than 6 times as many as in 2002.[1]

Many people who die of an opioid-involved overdose have untreated or undertreated opioid use disorder (OUD) and most were not prescribed 1 of the 3 US Food and Drug Administration–approved medications for treating OUD: methadone, buprenorphine, or extended-release naltrexone.[2] These medications—and particularly the opioid agonists methadone and buprenorphine for moderate to severe OUD—are highly effective, life-saving, first-line treatments.[3] All practitioners with a current Drug Enforcement Administration registration that includes Schedule III authority can prescribe buprenorphine, with the 2023 removal of the federally required Drug Addiction Treatment Act of 2000 waiver (X-waiver) that may have previously limited prescribing. Given the high burden, morbidity, and mortality of OUD, it is important that all clinicians become familiar with the medications to treat OUD and that these medications become a routine part of medical practice.[4]

This week, a new *Morbidity and Mortality Weekly Report* applied data from the 2022 National Survey on Drug Use and Health to estimate the opioid *cascade of care*, which is a framework to characterize the adult US populations who needed OUD treatment, received any OUD treatment, and received medication as part of OUD treatment.[2] One of every 27 US adults (3.7%) aged 18 years or older needed treatment. However, just 55.2% of these

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individuals received any treatment, and only one-quarter (25.1%) who needed treatment received medication. Most adults who needed treatment either did not perceive that need (42.7%) or received treatment that did not include medications to treat OUD (30.0%).

The care cascade—widespread screening regardless of the point of care; ensuring diagnosed patients receive treatment, including medications; and retaining patients in care—has been part of medical care for many years and most clinicians, regardless of medical specialty or practice setting, have understood its importance. The care cascade has been most notably applied to HIV care, where its importance is widely recognized.[5] The concept of the care cascade is equally applicable to OUD, but US clinicians have been slower to embrace the concept broadly. More than 5 times as many people in the US now live with OUD (estimated 6.1 million[6]) compared with HIV (estimated 1.2 million[7]). With 1 in 27 adults needing OUD treatment, most US clinicians are likely to have patients who need treatment in their practices, whether they are aware of it or not.

Clinicians may be hesitant to prescribe OUD medications to patients who perceive a need for treatment for a range of reasons. They may not know the strong efficacy data for these medications; feel unprepared to prescribe because of lack of training; worry about the impact on their practice flow or inadequate reimbursement; lack local specialist backup, especially for more complex patients with polysubstance use; or have unconscious stigma related to caring for patients with OUD, among other reasons. Clinicians may also struggle to connect patients to needed mental health and recovery supports.

Unfortunately, in this context, when patients seek care for OUD, some clinicians may continue to encourage detoxification alone,[8] without a connection to Food and Drug Administration–approved medications for OUD. This approach has a higher rate of treatment failure and is associated with an increased risk of mortality (eg, fatal overdose) compared with receiving medications for OUD.[3,4]

Many health systems, harm reduction programs, and public health departments have developed innovative approaches to help connect people with OUD to medications. The COVID-19 pandemic allowed more telehealth prescribing, which in turn helped build the evidence base for at-home buprenorphine induction.[9] Often, peer recovery and navigation programs may be available. More prescribers could help to meet needs and particularly address the persistent disparities in access. For example, in 2022, among adults who needed OUD treatment, non-Hispanic Black and Hispanic or Latino adults were less likely to receive any OUD treatment than non-Hispanic White adults.[2]

Primary care and obstetrics/gynecology clinicians can make treating OUD with medications a part of routine practice. Clinicians practicing in emergency departments and inpatient settings can provide buprenorphine induction and a warm handoff to ongoing treatment for patients with OUD. Clinicians in specialized settings (eg, mental health or infectious disease clinics, jails and prisons, mobile and shelter settings for people experiencing homelessness) that may care for patients with OUD who may not access other sources of care can routinely prescribe medications for OUD or ensure patients are provided access to medications. Care transitions may be especially important, including when people are released from

in carceration; discharged from hospitalization, emergency departments, or substance use treatment programs; or become pregnant, give birth, or progress through the postpartum period.

To achieve the care cascade, clinicians can do the following:

1. Routinely screen for OUD, diagnose OUD, and educate patients about OUD.

A diagnosis of OUD is based on *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition, Text Revision) criteria, such as unsuccessful efforts to cut down or control use or use resulting in a failure to fulfill obligations at work, school, or home.[4] More than 2 in 5 people who met the criteria for OUD did not perceive they needed treatment,[2] highlighting major gaps in screening and education.

2. Routinely discuss medication options (methadone, buprenorphine, or naltrexone) with patients with OUD while connecting patients to available recovery support services.

Clinicians can learn more about the medications and which may be most appropriate for different patients,[10] along with existing options for specialized treatment and recovery in their community. Methadone, for example, can only be dispensed from certified opioid treatment programs. It is important that all clinicians are familiar with any opioid treatment programs in their communities and able to directly connect their patients who may benefit most from methadone.

3. Prescribe buprenorphine themselves.[4,10]

Primary care and specialty care physicians, physician assistants, nurse practitioners, and certified nurse-midwives, among other clinicians with current Drug Enforcement Administration registration that includes Schedule III authority, can all prescribe buprenorphine, if permitted by state law. Eligible prescribers may offer buprenorphine induction in their practice setting or provide a short-term buprenorphine prescription and instruct patients on home induction. Clinicians can start small, with 1 or 2 patients, to build confidence and experience. A wide range of free training and mentoring opportunities is available.[10]

4. Continue shared decision-making practices with patients around treatment initiation and retention.

For example, clinicians may ask questions about patients' beliefs and worries about treatment along with questions about substance use patterns. Knowing the policies in their state can help advise patients about specific concerns, including initiating OUD treatment during pregnancy. Clinicians can ask patients what will help them stay in care and offer to connect them to peer-recovery supports, where available.

5. Share and reinforce harm reduction strategies with all patients with OUD,[4] regardless of whether the patient is ready for treatment or not.

For example, clinicians can provide education on the risks of using drugs alone. When possible, it is helpful to provide take-home naloxone, not just a prescription, with an in-clinic demonstration.

Over the past decade, many clinicians have adopted safer opioid prescribing practices to help reduce the risk of patients developing OUD after receiving prescribed opioids. Given the dramatic rise of illegally made fentanyl and fentanyl analogs, and increases in deaths involving more than 1 substance,[1] all prescribers, not just those in addiction-centric specialties, can play a more active role in treating individuals with OUD. It is important for all clinicians to embrace the care cascade for OUD and their role in it. We can work to ensure that all patients with OUD know their diagnosis, are connected to harm reduction approaches including naloxone, and can access evidence-based treatments that include medications for OUD and recovery support.

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REFERENCES

1. Centers for Disease Control and Prevention. Wide-ranging Online Data for Epidemiologic Research (WONDER). Accessed May 15, 2024. https://wonder.cdc.gov
2. Dowell D, Brown S, Gyawali MS, et al. Treatment for opioid use disorder: population estimates—United States, 2022. MMWR. June 27, 2024. doi:10.15585/mmwr.mm7325a1
3. Santo T Jr, Clark B, Hickman M, et al. Association of opioid agonist treatment with all-cause mortality and specific causes of death among people with opioid dependence: a systematic review and meta-analysis. JAMA Psychiatry. 2021;78(9):979–993. doi:10.1001/jamapsychiatry.2021.0976 [PubMed: 34076676]
4. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC clinical practice guideline for prescribing opioids for pain—United States, 2022. MMWR Recomm Rep. 2022;71(3):1–95. doi:10.15585/mmwr.rr7103a1
5. Haber N, Pillay D, Porter K, Bärnighausen T. Constructing the cascade of HIV care: methods for measurement. Curr Opin HIV AIDS. 2016;11(1):102–108. doi:10.1097/COH.0000000000000212 [PubMed: 26545266]
6. Substance Abuse and Mental Health Services Administration. Key Substance Use and Mental Health Indicators in the United States: Results From the 2022 National Survey on Drug Use and Health. Publication No. PEP23–07-01–006. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration; 2023.
7. Centers for Disease Control and Prevention. HV surveillance supplemental report: estimated HIV incidence and prevalence in the United States, 2018–2022. May 21, 2024. Accessed May 21, 2024. https://stacks.cdc.gov/view/cdc/156513
8. Beetham T, Saloner B, Gaye M, Wakeman SE, Frank RG, Barnett ML. Therapies offered at residential addiction treatment programs in the United States. JAMA. 2020;324(8):804–806. doi:10.1001/jama.2020.8969 [PubMed: 32840587]
9. Jones CM, Shoff C, Hodges K, et al. Receipt of telehealth services, receipt and retention of medications for opioid use disorder, and medically treated overdose among Medicare beneficiaries

before and during the COVID-19 pandemic. JAMA Psychiatry. 2022;79(10):981–992. doi:10.1001/jamapsychiatry.2022.2284 [PubMed: 36044198]

10. Providers Clinical Support System—Medications for Opioid Use Disorders. Accessed May 15, 2024. https://pcssnow.org/medications-for-opioid-use-disorder