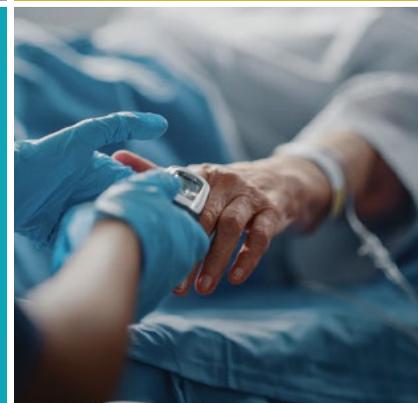
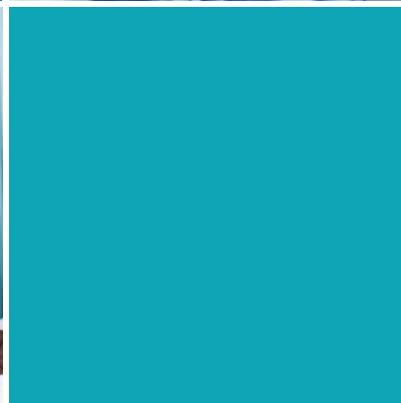




Society of Hospital Medicine

Improving Care for Hospitalized Patients

Opioid Use Disorder



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Introduction

In 2021, opioid overdose deaths surpassed 100,000.¹ Hospitalizations for infections related to opioid use disorder (OUD) are at an all-time high, placing a significant burden on patients, clinicians, and other hospital workers.² Hospitalists have an opportunity to reduce the burden of OUD among hospitalized patients by offering patients evidence-based OUD care. This primer is intended to guide hospitalists in the best practices to diagnose and treat OUD. The information presented in this primer is based upon the Consensus Statement from the Society of Hospital Medicine for the management of OUD and associated conditions among hospitalized adults.³

Scope of the Problem

Drug overdose deaths are rising at an unprecedented rate. Opioids, including illicitly manufactured fentanyl, were involved in three-quarters of drug overdose deaths in 2019 to 2020.⁴ Highly effective medications for OUD, including methadone and buprenorphine, have the potential to reduce overdose deaths by approximately 40% over a 12-month period,^{4,5} yet many people with OUD are unable to access this life-saving treatment.⁶⁻¹⁰

Despite their effectiveness, there remains a significant treatment gap for hospitalized patients with OUD. A recent study estimated that 87% of Americans with OUD do not receive methadone or buprenorphine.¹¹ Common barriers cited by physicians to prescribe medications for OUD include a lack of training or experience, availability of outpatient follow-up, a lack of institutional support, competing needs for clinician time, inadequate or burdensome reimbursement or regulatory procedures, and stigma related to prescribing medications for OUD.¹²⁻¹⁵ Despite these challenges, clinicians with a buprenorphine waiver increased 175% between 2016 to 2018 and

office-based visits involving a buprenorphine prescription increased more than two-fold over the past decade.¹⁶ Hospitalization offers an opportunity to provide treatment to hospitalized patients with OUD and hospitalists are uniquely positioned to provide this life-saving care.^{3,17,18}

Non-Stigmatizing Medical Communication and Language

Stigma toward people with substance use disorders is pervasive within health care and is a barrier to treatment engagement.¹⁹ Negative attitudes held by the public and health care professionals can deter people from seeking treatment for substance use disorder, leave treatment prematurely, and contribute to worse outcomes.²⁰⁻²² Language can propagate stigma which is harmful, distressing, and marginalizing to the people who bear it.^{23,24} Person-first language puts the individual before the word describing their behavior or condition to highlight that the condition is not their defining characteristic (e.g., person with OUD).^{25,26} When referring to hospitalized patients with OUD, do not use stigmatizing language such as ‘addict’, ‘opioid abuse’, or ‘IV drug user’.^{27,28} Instead, use person-first language such as ‘person who uses drugs,’ ‘person who injects drugs,’ or ‘person with OUD’ in written and verbal communication with patients and the medical team (Table 1).

Screening for Unhealthy Opioid Use in the Hospital Setting

Screening for unhealthy opioid use can help identify patients who may be at risk for OUD and who may benefit from evidence-based treatment. Screening assessments can be done by clinical assistants, nursing staff, social workers, or clinicians. In 2020, the United States Preventative Service Task Force (USPSTF) recommended “screening adults for unhealthy drug use in the primary care setting when services for accurate

diagnosis, effective treatment, and appropriate care can be offered or referred.”²⁹ Similar recommendations have not been made in the hospital setting. Reported barriers to completing universal screening in the hospital includes limited reimbursement for services, time constraints, and lack of clarity for treatment initiation and referral.^{30,31} Unhealthy opioid use includes the nonmedical use of prescription opioids, or the use of heroin, fentanyl, or other opioid analogues obtained through illegal drug markets. Patients with unhealthy opioid use may be hospitalized for overdose, skin and soft tissue infections, osteomyelitis, and endocarditis. More subtle behaviors associated with unhealthy opioid use includes the use of opioids in hazardous situations, an inability to cut down opioid use, cravings to use opioids, or opioid use leading to social, legal, or financial problems.³² Validated tools to screen for unhealthy opioid use are available (e.g., [NIDA Quick Screen](#), the [NIDA 8-item ASSIST](#), [TAPS Tool](#), [DAST-10](#)).^{30,33-36} When a person screens positive for unhealthy opioid usage, the hospitalist should determine if the patient meets criteria for OUD.

Diagnostic and Statistical Manual of Mental Disorders, 5th Edition Criteria to Diagnose OUD

A patient who reports unhealthy opioid use may develop signs and symptoms of opioid withdrawal which includes tachycardia, diaphoresis, mydriasis, gooseflesh, restlessness, rhinorrhea, patient reported myalgias, anxiety or irritability, nausea, diarrhea, and tremor. If a patient has signs and symptoms of opioid withdrawal, they should be assessed for OUD.³⁷ A diagnosis of OUD is made by using the criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM–5).³⁸ OUD is diagnosed when a person meets two or more of the 11 criteria outlined in the DSM–5 for OUD in a 12-month period. OUD severity is defined by the number of DSM–5 criteria met

(mild 2-3; moderate 4-5; and severe ≥ 6 criteria).³⁹ Opioid tolerance and opioid withdrawal alone, in the absence of other DSM–5 criteria, are insufficient to diagnose OUD for patients who are prescribed opioids and take the opioids as prescribed. To gather this information, hospitalists should take a history, including a review of symptoms, conduct a physical examination to assess for signs of opioid withdrawal, intoxication, injection marks (subcutaneous, intramuscular, and intravenous), and review the prescription drug monitoring program (PDMP) for scheduled medication data. To help determine the severity of patient’s substance

use history, inquire about age at first use, routes of ingestion, history of tolerance and withdrawal, co-use of opioids and other substances, including alcohol, stimulants, benzodiazepines, and tobacco, and inquire about past overdose events. It is useful to understand patient’s past treatment history to inform future treatment options and goals. Importantly, hospitalists should address patients nonjudgmentally and respectfully, exploring patients’ ambivalence about their opioid use, while taking care to conduct a trauma-informed examination (Table 2).⁴⁰

Table 1. DSM – 5 Criteria for OUD as published by the American Psychiatric Association⁴¹

A problematic pattern of opioid use leading to clinically significant impairment or distress in the past 12 months.

1. Opioids are taken in larger amounts or over a longer period of time than intended
2. Persistent desire or unsuccessful effort to cut down or control opioid use
3. A great deal of time is spent obtaining, using, or recovering from opioid use
4. Cravings for opioids
5. Opioid use leads to an inability to fulfill work, school, or home obligations
6. Continued opioid use despite negative consequences
7. Given up or reduced social, work, or recreational activities due to opioid use
8. Recurrent opioid use in physically hazardous situations
9. Continued opioid use despite persistent physical or psychological problems related to opioid use
10. **Tolerance:** increased amounts of opioids are needed to achieve desired effects, diminished effect with continued use of the same amount*
11. **Withdrawal:** characteristic withdrawal symptoms for opioids, opioids relieve withdrawal symptoms*

Severity: Mild: 2 to 3 symptoms | Moderate: 4 to 5 symptoms | Severe: ≥ 6 symptoms

*This criterion is not considered to be met for patients taking opioids solely under medical supervision.



Laboratory Testing

For patients who meet DSM-5 criteria for OUD, recommended laboratory tests includes a pregnancy test, liver function tests, HIV, hepatitis A, B, and C serologies, syphilis, and urine analysis. Hospitalization offers an opportunity to identify pregnancy, infectious diseases, and link patients to ongoing care.⁴²⁻⁴⁵ Pregnancy status should be confirmed and, if pregnant, patients should be offered buprenorphine or methadone and referred to prenatal care. Liver function tests are recommended prior to starting buprenorphine or intramuscular (IM) naltrexone as significant liver disease may be a contraindication for use. The Centers for Disease Control and Prevention (CDC) recommends at least annual HIV screening for people who inject drugs, with informed consent, although the optimal frequency for HIV testing is unknown for this patient population.⁴⁶ Among high risk adults including people who inject drugs or engage in transactional sex, the CDC recommends routine periodic testing for hepatitis A, B, C, and syphilis, with administration of the hepatitis A and B vaccination for nonimmune people.⁴⁷⁻⁵⁰ Urine drug analysis may provide data not obtained during the history and physical exam to help inform medical management.

Confirmatory testing, when available, should be performed when results are not consistent with information provided by the patient. Though explicit informed consent is not required for clinical drug testing,⁵¹ hospitalists should explain the reason for the test and the intended use of the results prior to sample collection and patients should be allowed to opt-out.^{52,53} Hospital policies should outline procedures for protecting the confidentiality of drug testing and results, especially for pregnant people.⁵²⁻⁵⁴

Summary Statements:

- Use patient centered language to screen for, and diagnose, OUD.
- A diagnosis of moderate OUD can be made during a history and physical examination when a person meets at least two criteria for OUD (Table 1).
- Laboratory data should be used to augment clinical decision making and treatment decisions.

Medications for OUD

Buprenorphine, methadone, and intramuscular naltrexone are the three medications approved by the Food and Drug Administration (FDA) to treat OUD (Table 3). High quality evidence demonstrates that routine use of buprenorphine and methadone reduce opioid-related mortality and all-cause mortality.^{6,56} The use of IM naltrexone is non-inferior to buprenorphine for select patients who complete a period of opioid abstinence and successfully initiate IM naltrexone.^{57,58} Regardless of the medication used to treat OUD, medication effectiveness is dependent upon patient preference and medication access, including the availability of local Opioid Treatment Programs [required for methadone], office based opioid treatment programs or primary care practices that offer buprenorphine or IM naltrexone, and cost.⁵⁹ This information should be shared with patients so they can make an informed, active decision about medication initiation for OUD. The Substance Abuse and Mental Health Services Administration provides [treatment locator resources](#) for treatment referral.

In Hospital Use of Medications for OUD

There are no legal or regulatory restrictions regarding inpatient ordering and titration of methadone or buprenorphine for opioid withdrawal management among patients hospitalized for medical or surgical reasons.^{59,60} The 42 Code of Federal Regulations (CFR), Title 21, Section 1306.07 “Administering or dispensing of narcotic drugs” describes federal regulations in detail.⁵⁹ Consider partnering with a clinical pharmacist or developing staff expertise to educate colleagues about these medications and to limit delays in medication administration.

Buprenorphine

Buprenorphine binds to the opioid receptor to prevent symptoms of opioid withdrawal and opioid cravings. Compared to placebo, buprenorphine reduces illicit opioid use and retains people in OUD treatment.^{62,63} Buprenorphine is a partial opioid agonist and exhibits a ceiling effect on opioid activity and respiratory depression due to its partial agonism at the opioid receptor. Buprenorphine is less likely than methadone or other full opioid agonists (i.e., oxycodone, heroin, hydromorphone, fentanyl) to cause respiratory depression.⁶⁴ When adequately dosed, buprenorphine should suppress opioid withdrawal symptoms and cravings for 24 to 36 hours, however, its analgesic effect lasts between 6 to 8 hours. If used to treat OUD and pain, hospitalists should consider dosing 2-4 times daily.

Initiating Buprenorphine in the Hospital

Initiation of buprenorphine in the hospital can facilitate management of other medical issues by relieving symptoms associated with withdrawal,⁶⁴ reducing “against medical advice” discharges,⁶⁵⁻⁶⁷ and improving outpatient addiction treatment linkage.^{68,69} Hospitalists should initiate buprenorphine when the patient demonstrates obvious signs of opioid withdrawal. Validated opioid withdrawal assessment scales such as the [Clinical Opiate Withdrawal Scale](#) (COWS)⁷⁰ can quantify opioid withdrawal symptoms and direct buprenorphine initiation. Prior to initiating buprenorphine, hospitalists should order a COWS score to assess the patient’s severity of opioid withdrawal. Nursing staff should document the COWS score in the health record every 4-6 hours. Hospitalists can safely initiate buprenorphine once a patient has a documented COWS score of 8 to 10, an indicator of mild opioid withdrawal.

Patients typically experience mild opioid withdrawal symptoms between 6 to 12 hours after the last heroin or short acting-opioid use.⁷¹ Buprenorphine initiation during mild to moderate opioid withdrawal (score 8-12) is less likely to precipitate further opioid withdrawal. One common approach for buprenorphine initiation includes dose increases by 2 to 4 milligrams every 2 hours until opioid withdrawal symptoms and cravings resolve, or a COWS score of ≤ 5 , for a total dose of 12 to 16 milligrams on day 1. Hospitalists should continue dose titration on day 2 to assess for ongoing cravings and withdrawal symptoms. Evidence supports increased treatment retention with buprenorphine doses of 16 to 24 milligrams per day.^{72, 73} Data are evolving about best practices to initiate buprenorphine with high⁷⁴ and low-dose protocols.^{75, 76} In the setting of synthetic opioids (e.g., fentanyl) that behave like long-acting opioids, patients may experience precipitated withdrawal with traditional buprenorphine starts and may benefit from low-dose [buprenorphine initiation](#) protocols. How and when to start buprenorphine should be a decision between the patient and clinician. Various resources guide buprenorphine initiation, management of [precipitated opioid withdrawal](#), and 24/7 access to a [substance treatment warmline](#).

Buprenorphine Prescribing at Hospital Discharge

Any hospitalist with a DEA license can prescribe buprenorphine. Free training for buprenorphine is widely accessible.⁷⁸ Every patient prescribed buprenorphine for OUD at discharge should also receive naloxone for overdose reversal.

Methadone

Methadone, a full opioid agonist, is the most studied pharmacotherapy for OUD and has been used to treat OUD for over 50 years.^{62, 79, 80} Numerous clinical trials and meta-analyses have demonstrated that methadone is associated with significant rates of treatment retention and lower rates of illicit opioid use compared with placebo.^{81, 82} Methadone has no ceiling effect and so increased doses will produce an equivalent physiological response, including respiratory depression and overdose. Care must be taken when initiating and titrating methadone due to dose stacking. Be aware that peak methadone dose occurs approximately 2 to 4 hours after administration. Patients with an inadequate methadone dose will experience their most intense opioid withdrawal symptoms between 12 to 24 hours after their last methadone dose.

Initiating Methadone in the Hospital

The hospitalist should initiate methadone when patients report opioid cravings or withdrawal symptoms. A starting methadone dose between 20 to 30 milligrams (mg) is supported by most guidelines. The dose should be increased by 5 to 10 mg every 2 to 3 hours to no more than 40 mg on day 1 for reported withdrawal symptoms. In some cases, e.g., older age, liver disease, poor respiratory reserve, lower opioid tolerance, consider beginning with 10 mg of methadone.⁸³ During methadone initiation, patients should be instructed to judge their dose by how they feel during the peak blood concentration period, approximately 2 to 4 hours after their dose.⁸³ On day 2, if the patient reports ongoing withdrawal symptoms, increase the methadone dose to 50 mg. On day 3, if the patient reports ongoing withdrawal symptoms, increase the methadone dose to 60 mg. On day 4 and beyond, consider increasing the methadone

dose by 10 mg every 3 to 5 days for going withdrawal symptoms. Plasma levels of methadone reach a steady state in about 5 days, i.e., five half-lives. Patients reach a stable methadone dose when they are not overly sedated and when they do not experience opioid withdrawal symptoms or cravings for approximately 24 hours following their dose. Doses of at least 60 mg are associated with greater treatment retention.⁸¹ Typical methadone doses range between 80 to 120 mg, however some patients benefit from higher doses.⁸⁰⁻⁸² Resources are available to guide [methadone initiation](#) in the hospital.

The Role of the Electrocardiogram in Methadone Treatment

Whether to check an EKG in patients starting on methadone is controversial.^{58, 84, 85} Most guidelines recommend checking an EKG when a patient has risk factors for QTc interval prolongation, including electrolyte abnormalities, impaired liver function, structural heart disease, genetic predisposition such as congenital prolonged QT syndrome or familial history of prolonged QT syndrome, and use of drugs with QTc-prolonging properties.⁸⁶⁻⁹⁰ Because most hospitalized patients will have an EKG performed, hospitalists should review the results to assess for QTc prolongation. If a patient has a QTc of ≥ 500 milliseconds, assess for reversible causes, (e.g., correcting electrolyte abnormalities or discontinuing other non-essential QTc prolonging medications). If the QTc remains ≥ 500 milliseconds, hospitalists should discuss the risks versus benefits of methadone with the patient and consider buprenorphine.

Methadone at Hospital Discharge

In the United States, methadone for the treatment of OUD cannot be legally dispensed from an outpatient pharmacy and may only be dispensed from an [Opioid Treatment Program](#). If patients request methadone after hospital discharge, they must be referred to an Opioid Treatment Program. Hospitalists cannot prescribe methadone for OUD at hospital discharge.

IM Naltrexone

IM naltrexone tightly binds to, and blocks, the opioid receptor.⁹¹ It does not activate the opioid receptor and exerts no opioid effects.^{62, 91} IM naltrexone provides opioid blockage by delivering steady naltrexone concentrations for approximately one month.⁹² Patients do not develop physical dependence to naltrexone. IM naltrexone is non-inferior to buprenorphine for select patients who complete a period of opioid abstinence and successfully initiate IM naltrexone.^{56, 57} Oral naltrexone is not recommended for OUD treatment because it is equivalent to placebo for OUD treatment retention or illicit opioid use reduction.⁹³

Initiating IM Naltrexone in the Hospital

Patients with OUD or opioid dependence must wait between 7 to 10 days after their last use of short-acting opioids, i.e., heroin, oxycodone, or 10 to 14 days after their last use of long-acting opioids, i.e., methadone to avoid precipitated opioid withdrawal. Prior to starting IM naltrexone, ensure the patient has not had recent opioid exposure and obtain a urine analysis to assess for the absence of opioids. You can also consider a naloxone challenge test to ensure no recent opioid use. Also, consider offering a one-time dose of oral naltrexone to rule out any drug allergy prior to administration of IM naltrexone.

IM Naltrexone at Hospital Discharge

Typically, IM naltrexone is administered in the outpatient setting every 4 weeks for ongoing opioid blockade.⁹² To provide a safe transition, hospitalists should ensure patients have a scheduled follow-up appointment with a clinic that offers IM naltrexone following hospital discharge. Hospitalists should counsel patients on the risk of overdose with return to opioid use when IM naltrexone wears off, as opioid tolerance will be reduced.

Adjunctive Medications for Opioid Withdrawal

Commonly reported opioid withdrawal symptoms includes anxiety, diarrhea, nausea, and myalgias.³⁷ In addition to buprenorphine or methadone, hospitalists should prescribe clonidine, loperamide, non-steroidal anti-inflammatory medications (NSAIDs), acetaminophen, ondansetron, or hydroxyzine in the early stages of opioid withdrawal when initiating and therapeutically titrating medications for OUD.^{70, 94-97}

Summary Statements:

- OUD medications are safe and effective to reduce morbidity and mortality related to opioid use.
- Shared decision making between the patient and hospitalist should direct which medication is best suited for the patient. For example, inquire if the patient has a preference between buprenorphine, methadone, or IM naltrexone, location and ease of access to medications, past experiences with medications, and cost.
- Adjunctive comfort medications can be used, in conjunction with buprenorphine or methadone, to resolve opioid withdrawal symptoms.
- There are no legal restrictions to prescribe buprenorphine or methadone in the hospital.
- Methadone for OUD treatment can only be dispensed at an Opioid Treatment Program and cannot be prescribed at hospital discharge.
- Patients with OUD should always receive naloxone at hospital discharge for overdose reversal.



Acute Pain and Perioperative Pain Management in the Setting of OUD

Patients with OUD on buprenorphine or methadone may be hospitalized with acute pain or have scheduled elective surgeries. Elective surgeries in patients with OUD require careful planning and interdisciplinary involvement to coordinate care and OUD treatment management.⁹⁸ Discontinuation of buprenorphine or methadone is not recommended during acute pain or in the perioperative setting and will result in an opioid debt which may worsen acute pain, making treatment more difficult, and may increase risk of return to opioid use and opioid overdose. Ensuring adequate pain control using a multimodal approach is paramount for patient and hospitalist satisfaction. Resources are available to guide [acute pain management](#) for hospitalized people who use opioids.

Continue Buprenorphine or Methadone

When a patient is admitted to the hospital with acute pain, or for a planned surgery, hospitalists should begin by confirming the patient's current buprenorphine or methadone dose through the Prescription Drug Monitoring Program (PDMP) or with the patient's Opioid Treatment Program, with the last date of dosing. Hospitalists should continue the patient's usual dose throughout hospitalization unless there is an acute medical contraindication. In the setting of pain,

experts recommend splitting the total daily buprenorphine dose into three times a day to optimize the analgesic activity of buprenorphine.^{99,100} Similar dose splitting can be done with methadone to maximize its analgesic effect, which is approximately 6 to 8 hours. In both cases, dose splitting should be discussed with the patient prior to making any changes. There are no legal restrictions on buprenorphine or methadone dose splitting during hospitalization. If methadone doses are split, they should be consolidated to once daily dosing prior to hospital discharge.

Non-Opioid Analgesia

Multimodal analgesics are recommended and should be targeted to the etiology of the pain (e.g., neuropathic medications, NSAIDs, acetaminophen, or local/regional anesthesia).¹⁰¹

Short-Acting Opioids

If additional opioid analgesia is needed for acute pain control, patients with OUD may require higher doses of short-acting opioids, even when receiving buprenorphine or methadone. Hospitalists should dose short-acting opioids at more frequent intervals, i.e., every 4 hours instead of every 6 hours, and approximately 1.5 to 2 times the usual dose of opioids typically prescribed for opioid-intolerant patients. There is no evidence that exposure to opioid analgesia for acute pain control among patients on medications for OUD increases the risk of return to opioid use.^{100,102,103}

Pain Management at Hospital Discharge

Whenever possible, patients should remain hospitalized until their acute pain is well managed with non-opioid analgesics in conjunction with buprenorphine or their daily methadone dose. After discharge, and especially if patients with OUD require full agonist opioids at discharge, hospitalists should ensure close follow-up with their buprenorphine prescriber or Opioid Treatment Program.

Summary Statements:

- Buprenorphine and methadone used for OUD treatment should not be stopped during an acute pain episode or during the perioperative period.
- Buprenorphine and methadone dose splitting can maximize their analgesic properties; this should be discussed with the patient before changes are made.
- Use multimodal analgesia for acute pain and post-operative pain control. Short-acting opioids should be prescribed at higher doses and shorter frequencies for people with OUD who have acute pain or post-operative pain uncontrolled by non-opioid analgesia.

Care Transitions for Patients with OUD

People with OUD are at high risk of returning to opioid use when buprenorphine or methadone are discontinued. Facilitating OUD treatment linkage to continue these medications is beneficial when patients with OUD request treatment continuation after hospital discharge.

Naloxone at Hospital Discharge

Fentanyl contamination of the drug supply is common and every patient who uses an unprescribed substance should be provided naloxone for overdose reversal at hospital

discharge. High-quality evidence supports the use of naloxone to reverse opioid-related overdose and death.¹⁰⁴⁻¹⁰⁷ The legal risk with prescribing naloxone is no higher than that associated with any other medication.^{108,109}

Linkage to Medications for OUD

Health systems should designate a team member, i.e., a social worker, a clinical nurse specialist, a pharmacist, or a hospitalist, to develop and update a resource sheet with local buprenorphine prescribers and Opioid Treatment Programs for treatment linkage. Many websites provide resources for addiction treatment services across the United States.¹¹⁰⁻¹¹² Telehealth follow-up is an option for people prescribed buprenorphine.¹¹³⁻¹¹⁷ Hospital teams should identify [treatment linkage](#); however, lack of follow-up should not preclude use of buprenorphine or methadone during hospitalization or provision of buprenorphine at discharge.¹¹⁸

Linkage to Psychosocial Treatment and Community-Based Support following Hospital Discharge

Referrals to [psychosocial treatment](#) interventions and community-based supports, including peer support groups and harm reduction agencies, should be offered to patients, in addition to medications for OUD and naloxone for overdose reversal. Examples of psychosocial addiction treatment includes individual or group therapy, intensive outpatient treatment, residential treatment, structured counseling, and dedicated mental health treatment.^{110,112,119} Peer-based support groups are free and are a source of additional guidance and support for people with OUD.^{120,121} [Harm reduction](#) agencies and local recovery community organizations provide naloxone and sterile syringes, partner with people who use drugs to teach naloxone administration and wound care techniques, and advocate for policy reform to increase access to evidence-based harm reduction strategies.^{112,122-124}

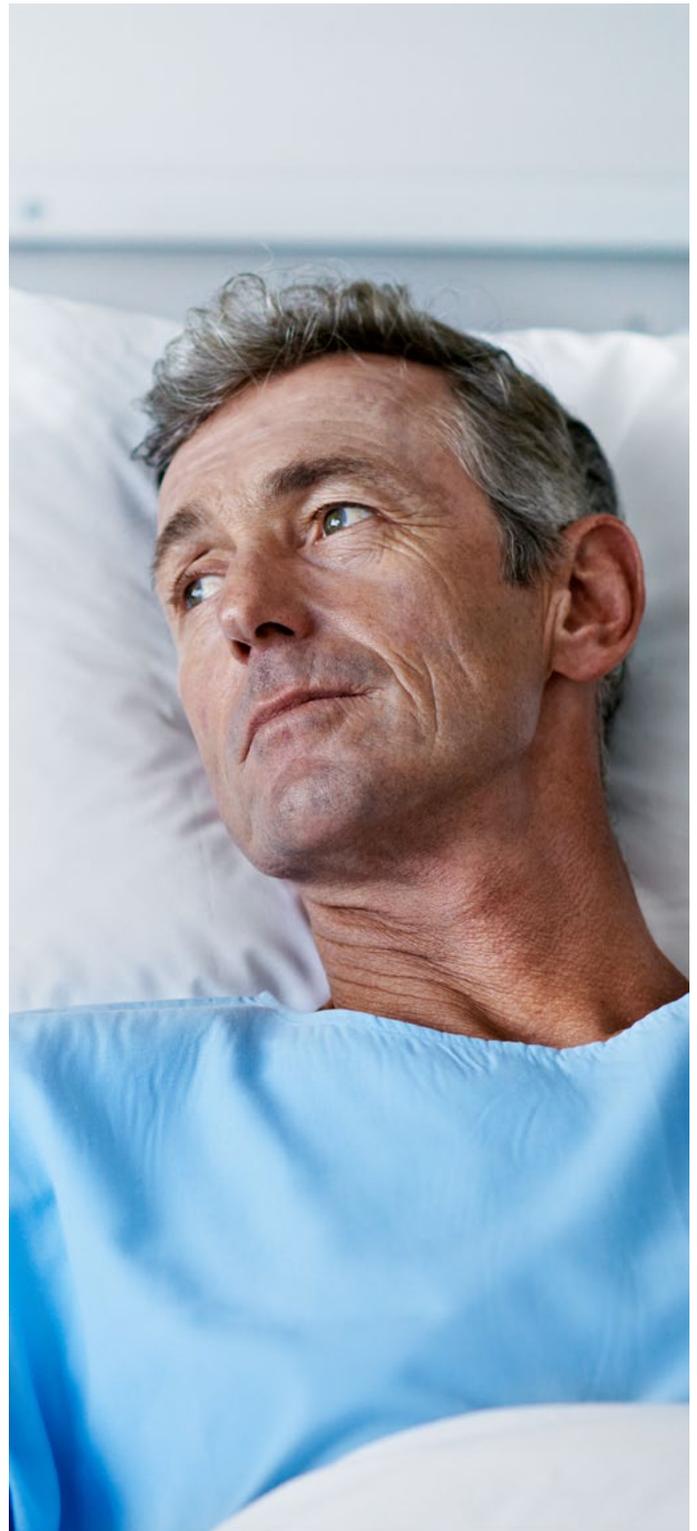
Post-Acute Care Facilities and Medications for OUD

Continuation of medications for OUD at hospital discharge to post-acute care facilities is paramount for ongoing treatment of OUD. Care facilities such as skilled nursing facilities that prohibit continuation of medications for OUD are in violation of the Title III of the Americans with Disabilities Act.^{125, 126}

Summary Statement:

Continuation of buprenorphine or methadone following hospital discharge reduces opioid-related and all-cause mortality. All patients with OUD should be prescribed naloxone at discharge. Health systems should identify a staff member to develop, and regularly update, referral networks for buprenorphine prescribers, local Opioid Treatment Programs, psychosocial treatment, peer support, and harm reduction agencies, to ensure patients are linked to ongoing addiction treatment and recovery resources following hospital discharge.

Hospitalizations related to the consequences of opioid use are rising.¹²⁷ Many people with OUD are unable to access life-saving treatment because medications for OUD are vastly underutilized.^{6-10, 128-131} Hospitalists are well positioned to close the treatment gap for people with OUD, which will save lives.^{3, 18}



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Table 1. Words Matter – Terms to Avoid and Use in Written and Verbal Communication about Addiction ¹³²

Terms to Avoid	Terms to Use	Why To Avoid?
Addict User Substance or drug abuser Junkie	<ul style="list-style-type: none"> Person with substance use disorder Person who uses drugs 	<ul style="list-style-type: none"> Person first language The change shows that a person “has” the problem rather than “is” the problem
Alcoholic	<ul style="list-style-type: none"> Person with alcohol use disorder 	<ul style="list-style-type: none"> The terms avoid eliciting negative associates, punitive attitudes, and individual blame
Drunk	<ul style="list-style-type: none"> Person who misuses alcohol Person who engages in unhealthy or hazardous alcohol use 	
Former addict Reformed addict	<ul style="list-style-type: none"> Person in sustained remission from a substance use disorder Person in (long-term) recovery 	
Habit	<ul style="list-style-type: none"> Substance use disorder Drug addiction 	<ul style="list-style-type: none"> Inaccurately implies that a person is choosing to use substances or can choose to stop Habit may undermine the seriousness of the disease
Abuse	<p>For illicit drugs:</p> <ul style="list-style-type: none"> Use <p>For prescription medications:</p> <ul style="list-style-type: none"> Misuse Used other than prescribed 	<ul style="list-style-type: none"> The term “abuse” was found to have a high association with negative judgments and punishment Legitimate use of prescription medications is limited to their use as prescribed by the person to whom they are prescribed Consumption outside these parameters is misuse
Opioid substitution or replacement therapy Medication assisted treatment	<ul style="list-style-type: none"> Opioid agonist therapy Pharmacotherapy Addiction medication Medication for a substance use disorder Medication for opioid use disorder (MOUD) 	<ul style="list-style-type: none"> It is a misconception that medications merely “substitute” one drug or “one addiction” for another The term MAT implies that medication should have a supplemental or temporary role in treatment Using “MOUD” aligns with the way other psychiatric medications are understood (e.g., antidepressants, antipsychotics), as critical tools that are central to a patient’s treatment plan

*Chart continues on next page

Terms to Avoid	Terms to Use	Why To Avoid?
Clean	<p>For toxicology screen results:</p> <ul style="list-style-type: none"> • Testing negative <p>For non-toxicology purposes:</p> <ul style="list-style-type: none"> • Being in remission or recovery • Abstinent from drugs • Not drinking or taking drugs • Not currently or actively using drugs 	<ul style="list-style-type: none"> • Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions • Set an example with your own language when treating patients who might use stigmatizing slang • Use of such terms may evoke negative and punitive implicit cognitions
Dirty	<p>For toxicology screen results:</p> <ul style="list-style-type: none"> • Testing positive <p>For non-toxicology purposes:</p> <ul style="list-style-type: none"> • Person who uses drugs 	<ul style="list-style-type: none"> • Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions • May decrease patients' sense of hope and self-efficacy for change
Addicted baby	<ul style="list-style-type: none"> • Baby born to mother who used drugs while pregnant • Baby with signs of withdrawal from prenatal drug exposure • Baby with neonatal opioid withdrawal/neonatal abstinence syndrome • Newborn exposed to substances 	<ul style="list-style-type: none"> • Babies cannot be born with addiction because addiction is a behavioral disorder—they are simply born manifesting a withdrawal syndrome • Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions • Using person-first language can reduce stigma

Table 2. Recommendations to Practice Trauma-Informed Care ⁴⁰

Patient Centered Communication and Care

- Ask every patient what can be done to make them more comfortable during the exam
- Share that they don't have to answer questions or share history that is hurtful or retraumatizing and will not move their care forward
- Prior to physical examination, present a summary of what parts of the body will be involved, allow the patient to ask questions, and let the patient know there will also be time available to ask questions afterward
- Give the option of shifting an item of clothing out of the way rather than putting on a gown when an entire area does not need to be visualized
- Offer the option of a mirror to see procedures or examinations that are out of the patient's visual field
- If patient nonverbal behavior indicates a moderate to high level of anxiety, conduct further anxiety assessment and offer patient ways to "signal" distress either verbally or via by raising their hand

Understanding the Health Effects of Trauma

- Understand that maladaptive coping (e.g., smoking, substance use and high-risk sexual behavior) may be related to trauma history
- Understand that the maladaptive coping behaviors have adverse health effects
- Engage with patients in a collaborative, non-judgmental fashion when discussing health behavior change

Table 3. FDA Approved Medications for Opioid Use Disorder and their Mechanism of Action

Medication	Mechanism of Action	Formulation	Location of Outpatient Treatment
Methadone	Full opioid agonist at the μ -opioid receptor	<ul style="list-style-type: none">• Liquid formulation used for OUD treatment (Qday dosing)• Tablet formulation used for pain (BID to TID dosing) and may also be used OUD treatment in hospitals	<ul style="list-style-type: none">• For OUD treatment, can only be dispensed at an opioid treatment program in the outpatient setting• For pain control, can be prescribed by any clinician with a DEA and can be dispensed at any pharmacy
Buprenorphine	Partial agonist at the μ -opioid receptor	<ul style="list-style-type: none">• Sublingual tab or film; subcutaneous injection used for OUD (mg dosing)• Patch, buccal film, or IV formulation used for pain (μg to mg dosing). These are sometimes used in hospitals for low-dose buprenorphine initiations	<ul style="list-style-type: none">• Can be dispensed at a pharmacy• Can be prescribed by a clinician with a DEA license
IM naltrexone	Full antagonist at the μ -opioid receptor	<ul style="list-style-type: none">• IM naltrexone Qmonth 380 mg	<ul style="list-style-type: none">• IM naltrexone must be administered in the gluteal muscle by a clinician trained in the procedure