| Appendix Table | | |
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| **Recommendation** | **Description, including possible COVID-19-considerations** | **Key Resources** |
| 1. Identify and treat acute withdrawal | **Opioids:** Untreated acute opioid withdrawal is miserable, and commonly leads to against medical advice (AMA) discharge. Providers have a duty to treat acute withdrawal with medications such as methadone and buprenorphine. We recommend hospitalists initiate medications in the hospital and refer to continued treatment after discharge. Despite common misconceptions, starting methadone or buprenorphine in the hospital is legal, safe, and requires no additional training or certification in the hospital.<br><br>Symptoms of acute opioid withdrawal may mimic COVID-19. In such instances, treating acute opioid withdrawal has potential to be both diagnostic and therapeutic.<br><br>**Alcohol:** COVID-19 may drive increased need to manage acute alcohol withdrawal in ambulatory settings, especially if there are COVID-19-related changes to capacity in detoxification centers and hospitals. Hospital providers should consider ambulatory withdrawal management in low-risk patients, and weigh risks of undertreated withdrawal with benefits of less restrictive withdrawal management care settings.<br><br>**Other SUD:** withdrawal from other substances (e.g. nicotine, methamphetamines, benzodiazepines) can trigger cravings, anxiety, and other side effects. Identifying and managing acute withdrawal can improve patient experience and may prevent AMA discharge. | Evidence-based recommendations regarding SUD assessment, withdrawal management and post-withdrawal management [14]<br><br>ASAM Guideline on Alcohol Withdrawal Management[15]<br><br>2020 National Practice Guideline For the Treatment of Opioid Use Disorder – Focused Update[15] |
| 2. Manage acute pain, including high dose opioids if needed | Patients with opioid use disorder (OUD) and other substance use disorders (SUD) commonly experience untreated or undertreated acute pain during hospitalization. This can cause for patient-provider conflict and increase risk for substance use and leaving AMA.[7] | 2020 National Practice Guideline For the Treatment of Opioid Use Disorder – Focused Update[15] |
| 3. Support patients to tolerate hospitalization | Cumulative patient stresses of acute illness, fear of death, no-visitor policies, mistrust of healthcare providers and establishments, and experiences of stigma; and, heightened provider anxiety may all amplify distress and increase patients' risk for leaving AMA. Providers can mitigate this by acknowledging these stresses, communicating empathy, and practicing trauma-informed care. | Free Virtual recovery meetings and online peer support[17] |

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| | Hospitals should consider providing patients with tablets or other means to communicate with family, friends, and recovery supports via videolink, and making referrals to virtual peer support and recovery meetings during hospitalization. | |
| 4. Initiate and refer to addiction treatment | Opioids: Hospital providers can and should offer medication for opioid use disorder (MOUD) as part of hospital care.[13] Providers must have a federal waiver to prescribe buprenorphine at discharge, and should consider longer prescriptions during COVID-19. COVID-19-related regulatory changes permit buprenorphine initiation and maintenance via telephone, and may ease historical barriers to MOUD transitions. Hospital providers can partner with buprenorphine providers statewide. Generally, methadone clinics remain open for new intakes, and many may have less stringent in-person requirements for daily dosing during COVID-19.<br><br>Alcohol, tobacco: Providers can initiate and prescribe medications for alcohol (e.g. naltrexone, acamprosate) and tobacco (e.g. varenicline, bupropion) use disorder like any other discharge medication. | Evidence-based recommendations regarding medication for SUD[14]<br><br>Hospitalists SUD treatment resources[13] |
| 5. Assess mental health and suicide risk | Hospital teams can ask patients about symptoms of anxiety and depression, offer evidence-based medications, and refer to mental health and peer support resources after discharge.<br><br>Generally, addiction medicine providers recommend against use of benzodiazepines given the increased risks for unintentional overdose and long term dependence or addiction.[14] | Point-of-care suicide assessment[18] |
| 6. Discuss relapse prevention for people in recovery | Hospital providers can ask about triggers to return to use and discuss mitigation of risks with patients. Additionally, staff can offer virtual recovery supports and initiate these while patients are still in the hospital. Particularly for patients who have lower technology literacy, this may offer an opportunity to test-run how engagement may go after discharge. | Free Virtual recovery meetings and online peer support[17] |
| 7. Promote harm reduction and overdose prevention | There are many ways in which providers can support people to use drugs more safely. This may include counseling patients to avoid sharing supplies such as pipes, straws, and syringes; reviewing safer injection practices; sanitizing surfaces; and hand hygiene. If people are using substances alone, safer use might involve using a smaller amount of substance(s) and going more slowly to avoid overdose; avoiding mixing substances such as opioids and alcohol or benzodiazepines; and calling a nearby friend before and after use to allow for someone to activate 911 or other emergency medical response if needed.<br><br>Providers should prescribe naloxone for all patients with opioid use disorder; prescribed opioids; or stimulant use disorder, given concerns for fentanyl contamination of stimulants. | Harm reduction resources[20, 21]<br><br>Naloxone information[19] |

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| 8. Consider high-risk transitions that may be exacerbated by COVID-19. | **Explore safe housing options:** Safe discharge plans among people experiencing homelessness may remain very challenging in some communities. Some communities are rapidly repurposing existing spaces or building new ones to care for people without a safe place to recover after acute hospitalization; yet many communities have no such resources. In settings that do, hospital teams can support transitions across settings through partnership and communication.<br><br>**Acknowledge community resources may change**: Community supportive and SUD treatment services may change rapidly. For example, shelters and addiction treatment centers may temporarily close due to COVID-19 outbreaks. Providers can give patients information about how to stay up to date about changes in their community. | Maintain updated list of shelter, hotel, and housing resources. Consider reaching out to local or state health departments for information. |