

ASAM COVID-19 TASK FORCE RECOMMENDATIONS

# CARING FOR PATIENTS DURING THE COVID-19 PANDEMIC

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Addiction Treatment in the Acute Hospital  
Setting During the COVID-19 Pandemic



# ADDICTION TREATMENT IN THE ACUTE HOSPITAL SETTINGS DURING THE COVID-19 PANDEMIC

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A guide for addiction treatment clinicians and programs working to treat patients with substance use disorders safely and effectively during the COVID-19 pandemic<sup>1</sup>.

For additional recommendations for the Ongoing Management of the Continuum of Addiction Care during COVID-19, [please click here](#).

## CONTENT DISCLAIMER

This Clinical Guidance ("Guidance") is provided for informational and educational purposes only. It is intended to provide practical clinical guidance to addiction medicine physicians and others caring for individuals with substance use disorders during the COVID-19 pandemic as it unfolds. Adherence to any recommendations included in this Guidance will not ensure successful treatment in every situation. Furthermore, the recommendations contained in this Guidance should not be interpreted as setting a standard of care or be deemed inclusive of all proper methods of care nor exclusive of other methods of care reasonably directed to obtaining the same results.

The ultimate judgment regarding the propriety of any specific therapy must be made by the physician and the patient in light of all the circumstances presented by the individual patient, and the known variability and biological behavior of the medical condition.

This Guidance and its conclusions and recommendations reflect the best available information at the time the Guidance was prepared. The results of future studies may require revisions to the recommendations in this Guidance to reflect new data.

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## ADDICTION TREATMENT IN THE ACUTE HOSPITAL SETTING DURING THE COVID-19 PANDEMIC

### Purpose of the document

To provide guidance related to the delivery of addiction treatment in hospital settings during the COVID-19 pandemic.

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<sup>1</sup>This resource was developed by a Task Force appointed by ASAM's Executive Council. To enable more rapid development and dissemination it was not developed through ASAM's normal process for clinical guidance development that is overseen by the ASAM Quality Improvement Council.

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### 1. Maintaining Access to Care

The COVID-19 crisis has not diminished, and evidence is emerging that it is exacerbating the addiction crisis in America. While most patients with substance use disorders can be effectively treated in outpatient or residential treatment programs, some patients have acute medical needs that require inpatient treatment. For example, patients with severe or complicated alcohol withdrawal, drug overdoses, or infectious complications from injection drug use may need admission to acute general medical settings. It is critical that these patients continue to have access to life saving care and that clinicians treating these patients address the underlying substance use disorder. In the era of COVID-19, this is especially important for reducing the chances of hospital readmission which pose additional risks for both the patient and public health.

Many hospitals have expanded the availability of inpatient substance use disorder services over the last several years as a response to the ongoing opioid crisis. However, the COVID-19 pandemic has stretched acute medical settings in ways that may impact access to these services:

- While some hospitals are moving to resume “non-essential” services, some continue to reduce these types of care as a result of the COVID-19 pandemic. If addiction medicine services are included in the “non-essential” category, these changes may impact their availability.
- To conserve PPE and reduce viral exposure, hospitals have converted consultative activities, including those for addiction medicine, to telehealth platforms. This may help restore access to addiction treatment.
- Some hospitals have needed to shift their focus to addressing acute medical problems rather than chronic vulnerabilities; addressing substance use disorders from a chronic disease perspective may not be a priority in these situations.

As described in *The ASAM Criteria*, hospital inpatient treatment is appropriate for patients with acute medical or psychiatric problems who require 24 hour medically managed care. Hospital policies and clinicians working in hospitals should consider:

- Whether the patient can safely be treated in a less intensive level of care, balancing the risks to the individual patient posed by exposure to the novel coronavirus and the risks posed by their addiction and co-occurring conditions.
- What other treatment options are accessible to the patient during this time.

## 2. COVID-19 Risks Associated with SUDs

While it is not known whether the medical sequelae of substance use disorders directly increase risk for COVID-19, alcohol and drug behaviors may increase the probability of contracting and exacerbating the course of COVID-19 by the following mechanisms:

- Inhalation of drugs may increase exposure to and generation of aerosolized respiratory fluids due to coughing.
- Drugs that suppress respiratory drive may interact with adverse respiratory effects of COVID-19, contributing to increased risk of severe illness as well as overdose.
- Alcohol and many illicit drugs have direct and indirect immunosuppressing effects, particularly when used heavily and chronically.
- Smoking any substance, including tobacco and vaping damage the lungs and increase vulnerability to coronavirus infection and developing COVID-19 symptoms.
- Drugs that constrict blood flow may interact with hematological effects of coronavirus to increase risk of coagulopathies and/or ischemic disease.
- Communal living, incarceration, homelessness, and poor hygiene increase exposure to the coronavirus.

- People who have substance use disorders are driven by the disease to take risks that others might not. As a result, they may be less likely to maintain physical distancing than others, and the novel coronavirus may be more likely to spread in this population.
- Patients with substance use disorders, at least partially due to the effects of prejudice and stigma, are less likely to seek acute medical services for serious symptoms.

In addition, patients who are admitted to hospitals with substance use disorders often have underlying medical conditions that increase risk from COVID-19, and thus may have amplified risk of poor outcomes from:

- Respiratory disorders
- Cardiac disorders
- Chronic infections
  - Bacterial (e.g. infective endocarditis)
  - Viral (e.g.: HIV, HCV).

### **3. Clinical Considerations for Hospitalized Patients with SUD during the COVID-19 Pandemic**

#### **Balancing the Risks of COVID-19 with the Risks Associated with SUD**

The risks associated with COVID-19 may shift decision-making for some patients regarding whether they should be treated in an acute general hospital setting. However, for other patients the risks of untreated complications of substance use disorder may be greater than the risks posed to them by potential coronavirus transmission. For example, a patient with infective endocarditis may need acute hospital care to address this life-threatening infection. While they are receiving medical care, it is also imperative that the patient be engaged in treatment for the underlying addictive disease. Inadequate treatment of the SUD, especially the treatment of opioid withdrawal and opioid use disorder, is associated with non-completion of antibiotic treatment, against-medical-advice discharges, and eventual return to the hospital in more severe distress.

By definition, addiction involves continued use of substances despite the harms they cause to a patient's health. Simply knowing that endocarditis may recur and may even cost one's life does not, in general, change patient behavior. It is critical that the patient receive evidence-based treatment for their underlying addiction to optimize chances for recovery and remission. Despite this fact, some hospitals will attempt to treat endocarditis without initiating addiction treatment and even deny care if the endocarditis recurs, with potentially fatal consequences. This practice poses significant ethical issues if healthcare systems hold patients accountable for treatment failure when effective treatment was not offered in the first place.

When treating patients with SUDs, clinicians should conduct a thorough assessment to determine the severity of the patient's SUD and co-occurring conditions to understand the risks posed by inpatient treatment versus treatment in a less intensive level of care that the patient is able to access. While it is an incomplete substitution, consultations can be continued by remote chart review and telehealth (provided the hospital and patient have adequate technology). This practice can work so long as the medical teams caring for the patient is willing to prescribe the medications recommended by the consultant. **Any clinician with prescribing authority can provide either methadone or buprenorphine in a hospital inpatient setting in the following circumstances:**

- for withdrawal management or the treatment of opioid use disorder in patients admitted to the hospital for another medical condition (other than primary opioid use disorder or opioid withdrawal).
- to patients who have already been prescribed one of these medications and are admitted to the hospital or treated in the emergency department.

## **The Symptoms of Alcohol or Drug Withdrawal may Mimic Symptoms of COVID-19**

Alcohol and sedative hypnotic withdrawal signs and manifestations can include nausea, vomiting, sweating, psychomotor agitation, tremors, seizures, and tachycardia. Opioid withdrawal symptoms can include myalgias, arthralgias, diarrhea, vomiting, nausea, sweating, abdominal cramps, tachycardia, and psychomotor agitation. Some of these symptoms can mimic COVID-19 illness or worsen presenting symptoms. Clinicians should ask patients about recent changes in use of alcohol, illicit drugs, and controlled prescription medications. The high levels of stress and anxiety caused by the COVID-19 pandemic is becoming a well-recognized trigger for increased substance use and recurrence of addictive disease among many patients, even those previously in remission and recovery.

## **Withdrawal Management**

Alcohol and sedative hypnotic withdrawal can be life threatening and may require acute hospital care.

### *Alcohol Withdrawal*

Patients who should be evaluated for inpatient alcohol withdrawal management include those with moderate to severe withdrawal signs and risk factors that can complicate treatment:

- history of delirium tremens
- history of alcohol-related seizures
- age greater than 65
- medical co-morbidities such as advanced pulmonary, liver, or renal disease

Patient with unstable housing or homelessness generally require inpatient alcohol withdrawal management. See [ASAM's Clinical Practice Guideline on Alcohol Withdrawal Management](#) for guidance on the diagnosis, risk assessment, symptom assessment, level of care determinations, and management of alcohol withdrawal in both ambulatory and inpatient settings. In determining the appropriate level of care for a given patient during the COVID-19 pandemic, clinicians should also consider the COVID-19 risks for a given patient versus the risks associated with treating alcohol withdrawal in a less intensive care setting. Considerations should include:

- Rates of community transmission of COVID-19 virus
- Available resources, both within the hospital and within the community
- What other care options are currently accessible to the patient (particularly given reduced access as a result of COVID-19)
- Which care options the patient is willing to engage in
- The individual patient's risk for severe COVID-19 illness
- The individual's risk for exposure to the coronavirus in the different available care settings

As discussed in the Guideline, a validated scale such as the Clinical Instrument Withdrawal Assessment for Alcohol, Revised (CIWA-Ar) should be used to assess alcohol withdrawal severity and guide treatment. This scale should not be used as a diagnostic tool because scores can be influenced by conditions other than alcohol withdrawal.

### ***Sedative Hypnotic Withdrawal***

Similar to alcohol withdrawal, patients at risk for severe or complicated benzodiazepine withdrawal should be monitored closely. Abrupt cessation of benzodiazepines is dangerous and should be assiduously avoided. Longer acting benzodiazepines should be used in a tapering fashion to treat or prevent benzodiazepine withdrawal.

See [SAMHSA's TIP 45: TIP 45: Detoxification and Substance Abuse Treatment](#)

### ***Opioid Withdrawal***

The most effective medications for the treatment of opioid withdrawal are methadone and buprenorphine, although other medications are also commonly used (e.g., clonidine, lofexidine). With respect to methadone and buprenorphine, any clinician with prescribing authority can provide either of these medications in a hospital inpatient setting in the following circumstances:

- for withdrawal management or the treatment of opioid use disorder in patients admitted to the hospital for another medical condition (other than primarily for opioid use disorder or opioid withdrawal).
- to patients who have already been prescribed one of these medications and are admitted to the hospital or treated in the emergency department.

Patients who are initiated on methadone or buprenorphine should be engaged in ongoing treatment in the community since withdrawal management without ongoing treatment puts the patient at increased risk of overdose and overdose death. Consultation with an addiction specialist clinician is recommended. This consultation can be done remotely via telehealth. This practice requires that the treating team be more active in the SUD care than they may be when the consultant is able to meet with the patient face-to-face. Initiation of methadone or buprenorphine for long-term opioid use disorder treatment can start during hospitalizations for acute medical or psychiatric conditions. For patients admitted primarily for opioid withdrawal or opioid use disorder, hospital clinicians can start opioid agonist therapies as long as an appropriately licensed clinician has agreed to manage the patient in follow-up. In such cases, continued treatment with these medications should continue post-hospital discharge and be coordinated as part of the patient's discharge plan. If this is not the case, the opioid agonist medication needs to be tapered off prior to hospital discharge. Long-term treatment with medications is the first-line standard of care for opioid use disorder, resulting in better outcomes for most patients than short-term opioid withdrawal management or detoxification.

See [ASAM's National Practice Guideline for the Treatment of Opioid Use Disorder](#) for recommendations for treating opioid use disorder, including opioid withdrawal.

## Importance of Continued Screening for SUD

Screening for alcohol, nicotine, and other substance use and use disorders is critical and should **not** be suspended during the COVID-19 crisis. Remember, many emergency department visits are alcohol related.<sup>1</sup> In addition, alcohol and other drug use or withdrawal can complicate other diagnoses and treatment. Untreated withdrawal can also lead the patient to leave prior to receiving needed medical care. During the COVID-19 crisis, patients may have increased alcohol intake while sheltering in place. Patients may find themselves experiencing more severe withdrawal than at other times in the past. As states move through relaxation of COVID-19 related restrictions, it is likely clinicians will see an increase in the number of patients experiencing withdrawal.

Recommendations:

- Continue to screen for nicotine use, alcohol use, and other substance use using validated screening tools. See [NIDA's list of validated screening tools](#).
  - Ensure that positive screening cases result in a clinical assessment.
- Assess patient risk for alcohol or drug withdrawal and ensure that withdrawal is proactively addressed
  - See [ASAM's Clinical Practice Guideline on Alcohol Withdrawal Management](#)
  - See [ASAM's National Practice Guideline for the Treatment of Opioid Use Disorder](#) for recommendations for treating opioid withdrawal
  - See [SAMHSA's TIP 45: TIP 45: Detoxification and Substance Abuse Treatment](#)
- Counsel all patients against tobacco use
  - Smoking and vaping may increase risks associated with both transmission and severity of COVID-19 illness.
  - Smoking restrictions may cause the patient to leave against medical advice. Nicotine replacement therapy (NRT) should be offered while the patient is in the hospital.
  - Prescriptions for NRT or other evidence-based cessation treatments should be provided prior to discharge.
- Ensure that patients with opioid use disorder have naloxone or a prescription for naloxone before they are discharged.

## Supporting Access to Medications

Clinicians should ensure that patients who are currently taking medications for addiction or psychiatric disorders have their medications continued. The dose of any controlled medication should be verified in parallel to initiation. While verifying dose is critical, there may be delays in verification processes during this crisis. Patients should not be denied access to medication if there are credible indications that the patient was taking a reasonable dosage as an outpatient. In the absence of credible evidence, or when there are concerns about appropriate decision-making regarding initiation or continuation of medication, seek consultation with an addiction specialist physician.

<sup>1</sup> <https://pubmed.ncbi.nlm.nih.gov/22081821/>

## *Medications for Opioid Use Disorder*

Medication, in combination with psychosocial services targeted to the patient's needs, is the standard of care for treating opioid use disorder. Disruption of medications for OUD can lead to relapse, overdose, and overdose death. During the COVID-19 crisis, access to addiction treatment, including OUD medications, may be disrupted.

Some patients may lose access to medications and need interim medication. Methadone and buprenorphine can be administered by non-waivered clinicians (clinicians without a DATA 2000 waiver to prescribe buprenorphine) in emergency department and hospital settings under limited circumstances.

In hospital settings, if the primary reason for admission is for opioid withdrawal, buprenorphine or methadone can be ordered and administered by non-waivered clinicians for no more than 3 days to treat acute withdrawal symptoms. Simultaneously, hospital clinicians should arrange for referral to ongoing treatment post-discharge. Not more than one day's medication is administered or given to a patient at one time in this scenario.

Clinicians treating patients with opioid use disorder admitted to acute medical settings for anything other than withdrawal are not bound by the 3-day rule. In these situations, patients can start or continue methadone or buprenorphine throughout the entire course of the admission. <https://www.samhsa.gov/medication-assisted-treatment/legislation-regulations-guidelines/special>

Naltrexone can be prescribed in any setting by any clinician with the authority to prescribe medications. However, naltrexone cannot be initiated until the patient has been fully withdrawn from opioids. This typically requires a 7 to 10-day period of being opioid-free.

Initiation of medication for OUD in hospitals and emergency departments can save lives and reduce the risk for readmission. Consideration should be given to the choice of medication and formulation in the context of the COVID-19 crisis. See [ASAM's COVID Guidance on Medications, Formulations, and Dosages](#).

Recommendations:

- Ensure that patients who are currently taking medication for opioid use disorder have their medication continued.
- Do not discontinue a medication for opioid use disorder if a patient has an unexpected or concerning urine drug test result upon admission. Such a result should prompt a discussion with the patient, and coordination with outpatient care providers.
- Patients with COVID-19 who are taking methadone should be monitored for QT interval prolongation because, like methadone, some treatments for COVID-19 may increase the QT interval. Clinicians should weigh the risks of destabilizing a patient's opioid use disorder by reducing methadone doses or switching to a different medication with the risk of a Torsade de Pointes before making drastic changes to a patient's methadone regimen.
- Consider increased duration of discharge medications to ensure that the patient has sufficient medications to prevent relapse prior to engaging in continuing care.
- Coordinate with community treatment providers to ensure that patients have continued access to medications after discharge.

- If initiating methadone, coordinate with local opioid treatment programs (OTPs).
  - Initiation of methadone requires an in person medical exam for new patients. However, if the patient is in the hospital for another medical issue the hospital can complete the medical exam and initiate the medication. When the patient is discharged, the OTP can provide continued care via telehealth as appropriate.

## 4. Intravenous Medications

Hospitalized patients with a history of intravenous (IV) drug use have no direct contraindication to placement of an indwelling catheter (e.g., PICC line). Many patients with active addiction are admitted to acute care settings for infectious complications of their IV drug use and require PICC line placement for 6-8 weeks of intravenous antibiotics. Once stabilized, many of these patients can be discharged from the hospital to a monitored setting for completion of their antibiotics. When possible, patients should be discharged to a subacute nursing facility or other medically monitored residential setting where appropriate nursing care is provided and available on a 24-hour basis and readmission to the hospital is easily arranged if needed. However, during COVID-19, skilled nursing facilities or residential treatment facilities may have decreased access, and guidance is provided below on considerations for when patients with a history of IV drug use can be discharged home with a PICC line.

### **Considerations for Discharging Patients with a History of IV Drug Use with a PICC Line**

Discharging patients to home with an active addiction and a PICC line is generally contraindicated.

Discharging patients to home when they have a history of IV drug use and a PICC line can be considered on a case-by-case basis, particularly as subacute nursing facilities may be less accessible to patients during the COVID-19 crisis. For home IV antibiotics with a PICC line, visiting nursing and home infusion services are needed for PICC line dressing changes, lab draws for antibiotic monitoring, and antibiotic delivery. These services may be less available during COVID-19. In addition, these home-based services are not always available to persons with SUD. It may be possible to have the patient come to the clinic setting for PICC line dressing changes and lab draws. The risk of use of the PICC line for drug use should be taken into account.

If discharging to home, the clinician should ensure that visiting nursing and infusion services are available and that the patient:

- Is currently taking medication for the treatment of OUD.
- Has a safe and stable home environment with clean water and heat.
- Has sufficient support at home and is able to provide informed consent and participate in PICC-line care education and teach-back. Optimally another person is identified who receives PICC care and IV antibiotic administration instructions and can assist the patient at home.

Clinicians should also consider the patient's risk for relapse, particularly given the factors that may increase this risk during the COVID-19 crisis. Consultation with an addiction specialist is recommended.

If the patient has COVID-19 or is suspected of having COVID-19, transfer to an alternative care site may be

appropriate. The clinician should coordinate with the alternative care site to determine whether they have the capacity to manage the needs of the given patient, including those related to addiction and provision of necessary medications (increased coordination may be needed to ensure continuation of methadone or buprenorphine.)

## **Discharge Against Medical Advice**

Some patients may leave “against medical advice” prior to completion of a course of IV antibiotics. Consultation with an infectious disease specialist is recommended. All clinicians should work together when exploring options for switching from IV antibiotics to oral antibiotics.

If there are no oral alternatives that would provide adequate infectious disease outcomes, the clinicians should consider:

- Whether there are IV dose alternatives, including once daily formulations or long-acting injectable formulations like dalbavancin that can be delivered via an alternative route.
  - Daily dosing may be provided by infusion centers, home health agencies or an alternative care site, depending on their capabilities.
- Whether the patient is willing to be transferred to a skilled nursing facility or residential treatment setting with the capacity to manage IV antibiotics, such as an ASAM Level 3.7 or 4.0 treatment program.
  - Some skilled nursing facilities and residential addiction treatment programs have reduced admissions during the COVID-19 crisis.
- Whether patients can safely continue IV antibiotics in their homes. Clinicians should assess the risks and benefits for the individual patient and consider:
  - The stability of the patient’s substance use disorder.
  - The safety and stability of the patient’s home environment.
  - Availability of home support.
  - The substance use disorder treatment services the patient is receiving, whether the patient can continue to access those services during their antibiotic treatment, and ability to coordinate with addiction treatment clinicians.

## **5. Engagement in Addiction Treatment**

Addiction is a chronic medical illness that requires ongoing care. Delays or disruptions in care can be life threatening for some patients. While acute medical problems are addressed in the emergency department or hospital, steps should be taken to engage the patient in ongoing care for any substance use disorder. Staff responsible for coordinating ongoing patient care should keep abreast of local challenges in addiction treatment access. Some addiction treatment and withdrawal management programs have either closed, stopped taking new patients, or significantly reduced their capacity during the COVID-19 crisis. Other community programs have converted to telehealth.

## Recommendations

- Consider how telehealth can be used to provide addiction treatment concurrent with acute medical care during the hospitalization.
  - This can include telehealth encounters by addiction treatment clinicians, peer recovery coaches, health behavior specialists, case managers and other team members involved in coordinating the patient's treatment plan. See [ASAM's COVID-19 Telehealth Guidance](#).
  - Virtual support groups may also be helpful. See [ASAM's COVID-19 Guidance on Support Groups](#).
- Engage and work with community addiction treatment clinicians and programs to learn what services the patient will have access to after discharge.
- Determine whether the community treatment program can complete a tele-health intake while the patient is still in the hospital.
  - Interaction between the patient and the aftercare provider may yield a scheduled follow up appointment and increase likelihood of follow up.
  - Help walk the patient through use of telehealth technology while they are inpatient.
- Determine whether the patient can reliably access telehealth services after discharge.
  - As many community treatment clinicians and programs have converted to telehealth, persons without access to digital devices or safe settings from which to use those devices may experience even further reductions in access to services.
  - Coordinate with community treatment clinicians and programs regarding options for patients without access.
- Consider increased duration of addiction treatment medications on discharge to ensure that the patient has enough medications to prevent relapse prior to linking to aftercare (e.g. 2-4-week supply of buprenorphine depending on follow-up setting). Understand that this carries some risk of overdose and diversion, and that the net benefit is yet unknown.
- Coordinate with local clinics, including bridge clinics or bridge programs, if available to manage patient transitions from inpatient to outpatient care.

## 6. Discharge of Patients with COVID-19 and Addiction

### Transitioning Patients with COVID-19 and Addiction to Less Intensive Care Settings

Patients who are COVID-19 positive (or presumptively infected), including those with addiction, can be discharged from the hospital whenever it is clinically indicated. These patients should be engaged in appropriate aftercare (See [Engagement in Addiction Treatment Section](#)). Clinicians will need to consider where the patient can be safely discharged based on the ongoing care they require for both COVID-19 and addiction.

## Recommendations

- Perform an evaluation for the appropriate treatment level of care using a structured approach such as *The ASAM Criteria*. Match the patient's care needs with programs available to provide this care. Specific challenges to access to SUD treatment due to COVID-19 may be present in your local community.
- Consider the patient's ability to obtain addiction treatment services via telehealth.
  - Consider available treatment options via telehealth.
  - Consider whether the patient has access to safe and stable housing.
  - Consider whether the patient has access to the necessary technology or resources to engage in telehealth.
- Consider use of alternative care sites.
  - Do available sites have the capacity to continue SUD treatment with adequately trained and credentialed staff?
  - If patients are going to acute care or alternative care sites that do not have primary addiction care available, consider incorporating telehealth addiction treatment services at these sites.
- Consider residential addiction treatment facilities.
  - Is there an appropriate residential addiction treatment program to which the patient has access?

## Discharging to Home

The CDC's COVID-19 guidance states that:

Patients can be discharged from the healthcare facility whenever clinically indicated. If discharged to home:

- Isolation should be maintained at home if the patient returns home before discontinuation of Transmission-Based Precautions. The decision to send the patient home should be made in consultation with the patient's clinical care team and local or state public health departments. It should include considerations of the home's suitability for and patient's ability to adhere to home isolation recommendations. Guidance on [implementing home care of persons who do not require hospitalization](#) and the [discontinuation of home isolation for persons with COVID-19](#) is available.

The guidance also discusses discharge to long-term care or assisted living facility with recommendations which are applicable to residential addiction treatment programs and other alternative care sites. The guidance addresses two different patient scenarios::

- Scenarios in which transmission-Based Precautions *are still required*. Patients should go to a facility with an ability to adhere to infection prevention and control recommendations for the care of COVID-19 patients. Preferably, the patient would be placed in a location designated to care for COVID-19 residents.
- Scenarios in which transmission-Based Precautions *have been discontinued*, but the patient has persistent symptoms from COVID-19 (e.g., persistent cough). Patients should be placed in a single room, be restricted to their room, and wear a facemask during care activities until all symptoms are completely resolved or until 10-20 days after illness onset, with the longer duration required for immunocompromised patients with more severe COVID illness..

- Transmission-Based Precautions **have been discontinued and the patient's symptoms have resolved**. The patient does not require further restrictions, based upon the history of their COVID-19.

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>

## 7. Harm Reduction

Patients may have reduced access to harm reduction services during COVID-19. Hospitals can play a role in ensuring that their patients have access to the necessary supplies that can prevent acute harms related to substance use and reduce hospital readmissions.

### Recommendations

- Continue giving naloxone kits, or prescribing naloxone, to patients at risk for opioid overdose prior to discharge from the hospital.
  - Prescription costs can be a barrier for some patients. As such, direct distribution is preferred if possible.
- Consider providing antiseptic swabs or alcohol pads if appropriate.
- Coordinate with local harm reduction service providers to explore options for naloxone distribution and syringe service programs or provide naloxone or a prescription if able.
- Consider Pre-Exposure Prophylaxis (PrEP) prior to discharge and connecting to outpatient continuity depending on the resources in the community for follow up and the patient's likelihood of adherence to the medication and follow-up services.

## 8. General Resources

- NIAAA's COVID-19 resources: <https://www.niaaa.nih.gov/alcohol-and-covid-19>
- NIAAA Alcohol Treatment Navigator Telehealth and Mutual Support Options: <https://alcoholtreatment.niaaa.nih.gov/FAQs-searching-alcohol-treatment#topic-how-can-i-access-quality-alcohol-treatment-during-the-covid-19-emergency-through-telehealth-or-online-programs>
- [ASAM's Clinical Practice Guideline on Alcohol Withdrawal Management](#)
- [SAMHSA's TIP 45: TIP 45: Detoxification and Substance Abuse Treatment](#)
- [NIDA's list of validated screening tools.](#)
- [ASAM's National Practice Guideline for the Treatment of Opioid Use Disorder](#)
- CDC's Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance) <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>



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