In Reply

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In Reply We thank Christian et al for raising concerns that (1) chronic diseases, rather than substance use disorder (SUD), may be more directly responsible for adverse outcomes of COVID-19 infection and (2) SUD itself can cause chronic somatic and mental health disorders. Both concerns are valid and important. These suggest new directions for research to describe the relative impact of chronic diseases and SUD on outcomes of COVID-19 infection. We agree that a better understanding of how medications prescribed for opioid use disorder (eg, metha-done or buprenorphine) alterCOVID-19riskamongpersonswith this SUD would be an important scientific contribution.

We also agree that a finer distinction of a person's drug exposure for SUD is warranted. The 2021 National Survey on Drug Use and Health found that nearly 1 in 6 people (16.5%; 46.3 million) reported having an SUD, yet most (94%) received no SUD treatment.[1] Some likely denied having a drug problem and, therefore, were not treated for SUD for fear of stigmatization.[2] Even in our analysis of 1.2 million US adults, only 4.6% were noted to have an SUD in the hospital discharge record. However, we found that an unrecognized SUD may underestimate—by as much as 31 percentage points—the likelihood of hospitalization for patients in the emergency department with a COVID-19 infection and a known psychiatric disorder.[3] This highlights the importance of improving identification of all people with drug use and/or SUD in the medical records and in population-based studies so that treatment may begin and chronic diseases potentially averted. As Christian and colleagues also point out, such identification could be improved with greater use of drug testing at the point of care, such as emergency departments and hospitals.

Further, we think that a typology of drug use patterns is generally lacking and deserves development. An SUD typology—with definitions indicating whether use is continuous, episodic, current, or recurrent in each person—could improve data quality and help guide

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treatment. For example, data analysis of the current typology of people who use tobacco as current, former, passive, and never smokers, has led to a spectrum of personal and environmental treatments and policies.[4] Concerning patients with SUD, the *International Classification of Diseases, 11th Revision* (*ICD-11*) has specified different harmful patterns of substance use as single episode, continuous, episodic, or recurrent.[5] However, its implementation in the US, though anticipated, had not begun before the publication of our article.[3] Widespread use of these codes in hospital discharge and electronic health records may help policy makers and health care professionals better understand and track patient needs. Once use of these new *ICD-11* codes for SUD is in common practice, the codes could be considered as a meaningful way to track indicators of drug use and SUD in a future revision of Healthy People.[6] Thus, an improved typology could improve the quality of population trend data and inform prevention and response effects, such as harm reduction and link-age to care. Its use would help health care professionals treat their patients better without increasing stigmatization.[2]

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