Caring for Patients During the COVID-19 Pandemic

ASAM COVID-19 Task Force Recommendations

Supporting Access to Alcohol Use Disorder and Alcohol Withdrawal Treatment During the COVID-19 Pandemic

Purpose of the document
The anxiety, stress, and social isolation associated with the COVID-19 pandemic may exacerbate symptoms of addiction and mental illness. Every effort should be made to ensure that patients with addiction can initiate and maintain treatment in a timely manner. These materials seek to provide guidance to addiction treatment providers to support continued access to care for alcohol use disorder (AUD) and alcohol withdrawal management (AWM) during the COVID-19 pandemic.

Topics
1. Remaining Open and Available to Patients
2. Implementing Processes for Managing and Responding to COVID-19
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Remaining Open and Available to Patients
Each patient should be reassured that quality treatment programs will remain open and that every effort will be made to continue their medication, peer support, case management, and counseling throughout this crisis, even if not in the traditional manner.

Addiction treatment providers and programs should actively develop protocols to safeguard their patients, staff, and community from spread of Covid-19. See ASAM's guidance on Infection Mitigation in Outpatient Settings and Infection Mitigation in Residential Settings.
Considerations for In-Person Visits
Patients who are relatively stable can be managed by telemedicine. Those who are unstable may be better served by a face-to-face visit, again balancing the risk of COVID-19 exposure with the benefit of in-person compared to telemedicine contact. Examples of instability that would warrant an urgent in-person visit might include new or exacerbated medical issues, suicidal thoughts, new homelessness, interpersonal violence, difficulty dealing with the pandemic, or involvement of child protective services. For stable patients, the risk of in-person visits is likely to outweigh the benefits of such visits. Clinicians must use their clinical judgment in determining when an in-person visit may be beneficial.

Managing Clinic Visits
Measures should be taken to help patients maintain 6+ foot physical distancing when coming to the clinic:

- As discussed in ASAM’s COVID guidance on Infection Mitigation in Outpatient Settings, patients should be screened for symptoms of COVID-19 and exposure to the coronavirus prior to their appointments and upon arrival.
- Patients should be advised to wear a mask; those who do not have one should be provided one.
- Limit the number of patients who can enter the waiting room at a given time (see Waiting Room Precautions section of the guidance for Infection Mitigation in Outpatient Settings).
- Consider using larger rooms to facilitate physical distancing as available.
- Place furniture and/or markings on the floor to manage patient flow and maintain 6+ feet of distance.
- Consider scheduling appointments to minimize interactions between patients at high risk for COVID infection and those with lower risk. For example, patients at high risk of infection may be seen on different days, or at alternate times, than patients at lower risk. If such strategies are used, thoroughly cleaning patient areas and clinic facilities often and between patient days or time blocks is critical.

For in-person encounters within 6 feet, current public health guidance is that patients and clinicians should both wear a mask. After the visit, both patient and clinician should wash their hands and the room should be cleaned between uses.

Resources

NIAAA Alcohol Treatment Navigator Telehealth and Mutual Support Options: https://alcohtreatment.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

Implementing Processes for Managing and Responding to COVID-19
Given the complexity of challenges associated with the COVID-19 response across the anticipated phases of this pandemic, all treatment programs should appoint a dedicated management team with clearly defined roles and responsibilities to manage the planning and implementation of the program’s preparations and response.
Policies and Procedures to consider:
For example, treatment programs could consider implementing an incident command system to manage and coordinate their response. Whether a formalized incident command system is used or not, any dedicated management team should include a hierarchy with clearly defined roles and responsibilities within specific areas including overall leadership, safety, communications, operations, and any other key function needed by the organization to effectively manage the response. For example, coordination with recovery/transitional housing providers may need a point person.

Dedicated staff should be tasked with monitoring and managing supplies. The management team should define what supplies are essential to program functioning and implement processes for tracking and managing these supplies.

The management team should also work to rapidly develop updated policies and procedures needed to adapt to the COVID-19 crisis. For example:

- Infection control and mitigation procedures (outpatient, residential)
- Transitioning to telehealth whenever possible
- Updated clinical procedures related to medications and drug testing
- Managing patients and staff with COVID-19 or suspected of having COVID-19.
- Process for reviewing staffing daily and modifying schedules if needed to effectively provide care
- Communication with staff, patients, and caregivers
- Tracking patient hospitalizations and adjusting care as needed
  - Programs should be able to track patient emergency department visits and hospitalizations in their state or local health information exchange (HIE)
  - Programs should have processes in place to keep patients who have been hospitalized separate from other patients as hospitalization may pose a risk for COVID-19 exposure.

Unanticipated and unplanned for issues will arise as the crisis evolves. The dedicated management team should provide efficient ways for identifying and rapidly addressing challenges that arise in real time.

Considerations for Alcohol Use Disorder Treatment during COVID-19
Stress is consistently associated with increased drinking. The COVID-19 pandemic puts those with current AUD at increased risk of worsening drinking but also puts those in remission at increased risk of return to drinking. Further, access to many of the recovery supports which many patients use to manage their stress and alcohol use (e.g. group counseling, mutual-help groups such as AA or Smart Recovery, and religious services and meetings) is limited, at least with respect to in-person meetings. (See ASAM’s COVID-19 Guidance on Support Group Access).

Recognizing that patients are likely to need increased support during this stressful time, providers are encouraged to use telehealth to increase the frequency of their contact with their patients. (See ASAM’s COVID-19 Telehealth Guidance). The COVID-19 public health emergency and the associated relaxation of many of the regulatory and payer requirements for telemedicine offers an opportunity for widespread expansion of telehealth to ensure access to treatment for patients with alcohol use disorder. Phone calls, video visits, and video groups are all ways to connect with patients.
Patients should be monitored for adherence to pharmacotherapy, alcohol consumption, and/or development of alcohol withdrawal symptoms. Breathalyzers can be used in conjunction with audio/video telehealth sessions to assess recent alcohol use (they can be purchased at pharmacies for about $50). For those patients who consent, providers should consider enlisting family members, significant others, and/or close friends to assist in providing support and monitoring. When possible and available, patients should also be connected to peer support, which may provide another level of support and monitoring.

**FDA-approved Medications for Alcohol Use Disorder**

- Naltrexone 50-100mg oral once daily (must ensure opioid abstinence for at least 7 to 10 days)
  - Liver function tests should be considered when 100mg doses are prescribed.
- Naltrexone ER 380mg IM once every 28 days intramuscular (gluteal) injection (must ensure opioid abstinence for at least 7 to 10 days)
- Acamprosate 333-666mg oral TID
- Disulfiram 125-500mg oral once daily.

Medication adherence can be monitored by audio visual telehealth if available.

Providers are encouraged to familiarize themselves with adjunct resources that can support patients during the pandemic. For example, [NIAAA’s Rethinking Drinking](https://www.niaaa.nih.gov) website is a great resource for patients, families, and clinicians. The website provides a variety of tools to help patients evaluate their own drinking patterns, determine strategies they can employ to cut down on drinking, and resources for supporting individuals looking to stop drinking.

Chronic alcohol use impairs the pulmonary (lung) immune responses. Thus, those with chronic heavy alcohol use may be at increased risk for infection with the novel coronavirus, if exposed, and may be at increased risk for COVID-19 related morbidity and mortality. Patients with AUD should be advised of their potential for increased risks associated with coronavirus infection and should be educated on mitigation of risk as advised by the Centers for Disease Control and their respective state and local health departments (e.g. physical distancing, appropriate hand washing, frequent disinfection of high-touch surfaces, etc.). Additionally, patients should be educated on recognition of Covid-19 symptoms and who to call if they develop potential COVID-related symptoms.

In summary, treatment providers should:

- Continue to accept new patients.
- Increase the frequency of contact with existing patients.
- Explore telehealth-based strategies for monitoring adherence to pharmacotherapy, alcohol consumption, and/or development of alcohol withdrawal symptoms.
- Encourage patients to use online and smartphone recovery support resources.
- Connect patients with peer support.
- Partner with family members and close friends to extend support and monitoring.
- Educate patients about their risks for COVID-19, how to mitigate risk, how to recognize signs and symptoms, and what to do if they develop.
Considerations for Alcohol Withdrawal Management

During the COVID-19 pandemic access to alcohol may be reduced in some areas, which may increase the risk for alcohol withdrawal. At its most severe, alcohol withdrawal can cause seizures, delirium, and even death. ASAM recently released Clinical Practice Guidelines for Alcohol Withdrawal Management. These guidelines provide recommendations for determining the appropriate level of care for a given patient. However, the risks associated with COVID-19 may influence this determination.

Providers should consider:

- Can the patient be safely monitored in an ambulatory care setting, or at home?
  - Does the patient have safe housing?
  - Does the patient have support at home?
  - Can the patient maintain the necessary telephone-based contact?
  - Can the patient follow the necessary medication instructions?
- Does the patient need inpatient care?
  - Are they at risk of severe or complicated withdrawal?
  - Does the patient have a history of seizures or delirium tremens?
  - Does the patient have medical comorbidities likely to complicate their withdrawal treatment?
- Is the patient experiencing any symptoms consistent with COVID-19 or have they had any potential exposures?
  - How severe are their symptoms? How is this likely to impact their alcohol withdrawal symptoms?
  - Does your facility have the capacity to provide remote monitoring and services for patients with alcohol withdrawal syndrome?
  - If providing residential or inpatient services, does your facility have the capacity to manage patients with, or suspected of having, COVID-19?
- What is the risk to the specific patient associated with inpatient care?
  - Are they at high risk for severe COVID-19 illness?
  - Are they living with or caring for someone at high risk of severe illness?
  - What is the patient's level of anxiety around inpatient care?

When treating in an outpatient setting with home monitoring, consider a dosing protocol that includes higher doses of alcohol withdrawal medications. In the context of COVID-19, the community has diminished access to monitored environments where clinician-administered assessments of withdrawal are feasible. While there is an elevated risk of adverse effects (typically related to sedation) from withdrawal medications, these are often outweighed by the risk of under-treated alcohol withdrawal syndrome.

- Consider using the short alcohol withdrawal scale (SAWS) which can be self-administered.
- Communities should consider launching an “on-call” line for urgent SUD and withdrawal management services where patients can be triaged to determine if they need inpatient care.
- Consider developing standard protocols for specific settings where alcohol withdrawal management may be needed. For example:
Protocols for management of low acuity alcohol withdrawal in emergency shelters for people experiencing homelessness

Protocols for COVID-19 quarantine sites staffed by nurses which may be able to handle more moderate acuity patients.

See sample protocols, courtesy of Dr. Brian Hurley MD, MBA, DFASAM (see the content disclaimer):

- Management of OUD, AUD, and withdrawal in Low Acuity Settings
- Management of OUD, AUD, and withdrawal in quarantine sites

When patients are treated for alcohol withdrawal, the provider should work to engage the patient in treatment for alcohol use disorder.

- Naltrexone 50-100mg oral once daily (must ensure opioid abstinence for at least 7 to 10 days)
  - Liver function tests should be considered when 100mg doses are prescribed.
- Naltrexone ER 380mg IM once every 28 days intramuscular (gluteal) injection (must ensure opioid abstinence for at least 7 to 10 days)
- Acamprosate 333-666mg oral TID
- Disulfiram 125-500mg oral once daily.

See ASAM’s COVID-19 Guidance on Medications, Formulations, and Dosages.

See APA’s Practice Guideline for the Pharmacological treatment of Patients with Alcohol Use Disorder.

Resources:

ASAM’s Clinical Practice Guideline for Alcohol Withdrawal Management:
https://www.asam.org/Quality-Science/quality/guideline-on-alcohol-withdrawal-management

APA’s Practice Guideline for the Pharmacological treatment of Patients with Alcohol Use Disorder:
Leveraging Telehealth

Providers and programs should take steps to minimize in-person interactions throughout the COVID-19 crisis. Telehealth is an important tool for maintaining access to treatment while minimizing the risk of transmission of the coronavirus. See also ASAM’s Access to Telehealth Guidance, which provides an overview of recent federal and state policy changes to enable telehealth during the COVID-19 crisis.

*Telemedicine or virtual visits should be used whenever possible and appropriate to provide addiction treatment to patients.* It is very important to maintain close contact with patients during this time of stress, anxiety, and social isolation. Telehealth, including both telephone based and audio-visual based check-ins and visits, are an important way of staying connected with and managing patients. Federal regulations have been relaxed during the COVID-19 pandemic to facilitate the use of telehealth, including allowing providers to use non-HIPAA compliant technologies which at the time of this writing include Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, and Skype. These changes should make it easier to rapidly transition to telehealth.

Telemedicine communication conducted using an audio-visual, real-time, two-way interactive communication system is preferred but some audio-only visits may also be considered. For example, some patients may not have the technical capabilities available for video visits.

Providers should carefully assess whether an in-person visit would change the management of a given patient. For stable patients, the risk of in-person visits is likely to outweigh the benefits. Patients who are unstable, or patients that do not have reliable access to a telephone (e.g. homeless patients) may still benefit from in-person visits. Providers and programs should consider infection mitigation strategies for in person visits. See Infection Mitigation: Outpatient guidance.

Communication with patients is key during any transition to telehealth services. Programs should work with patients to make sure they understand how to join a telehealth visit and should be prepared to adapt to any technical issues that arise. See guidance from the National Council on Best Practices for Telehealth During COVID-19 Public Health Emergency: [https://www.thenationalcouncil.org/wp-content/uploads/2020/03/Telehealth_Best_Practices.pdf?daf=375ateTbd56](https://www.thenationalcouncil.org/wp-content/uploads/2020/03/Telehealth_Best_Practices.pdf?daf=375ateTbd56) and the APA’s Telepsychiatry Toolkit: [https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit](https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit)

During a telemedicine encounter, face masks should be discouraged unless there is a specific need. This can facilitate a more satisfactory connection between the patient and provider, even though they are not in the same location and are connected via video rather than in person.

In addition to the typical assessments and treatment modalities, during this crisis telehealth counseling sessions should address how the patient is responding to the COVID-19 crisis, and should focus on reinforcing social distancing and hygiene practices. Counselors should help patients to problem solve around these issues. Counselors should also talk to patients about what they should do if they develop symptoms.

Patients should also be encouraged to participate in virtual support groups if appropriate for the individual. See ASAM’s COVID-19 guidance for Support Group Access.
Providing services through telehealth does require clinicians to adapt their practices. Programs should encourage staff to participate in virtual trainings on how to effectively provide services through telehealth.

Resources

- National Consortium of Telehealth Resource Centers: https://www.telehealthresourcecenter.org/

Considerations for Telehealth Documentation

Verbal or written consent should be obtained from the patient before each telehealth visit. If the clinician is not using a HIPAA compliant telehealth platform, the patient should be informed about this and about the potential security limitation, and their verbal or written consent to continue should be obtained.

All documentation should note the patient’s consent for treatment via telehealth (acknowledging the potential HIPAA violation if appropriate). It should also document the date and time of the call, the location of the patient and the provider at the time of the visit, and the technology used for the connection. It is important to verify the patient’s identity, especially for phone contacts. Each note should describe how the patient’s identity was verified. As with all services the note should document the discussion during the call, including information regarding assessment of the patient’s mental status, mood, quality of speech, etc.; outline the plan for the next contact; and contain any other information consistent with coding requirements. The note should also indicate that the encounter is in the context of the COVID-19 crisis, and describe how this was addressed during the visit (e.g. reinforcing the importance of physical distancing, assessing how the patient is coping with the stress, anxiety and social isolation during this crisis, etc.).

Prescriptions and Refills

Providing refills without requiring in-person visits is another strategy for reducing risk of exposure to COVID-19. The Centers for Disease Control recommends that individuals maintain a 2-week supply of prescription medications as part of a “household plan of action in case of illness in the household or disruption of daily activities” due to COVID-19. Physical distancing, including avoiding all non-essential interactions, is key to reducing the spread of COVID-19. Providers can help their patients adhere to these guidelines by e-prescribing the longest possible safe duration of medications. In addition, providers should preferentially utilize pharmacies that offer home delivery.
SAMHSA and the DEA have released guidance to facilitate e-prescribing of controlled substances without an in-person medical evaluation during this public health emergency. The DEA also issued an Exception to Separate Registration Requirements Across State Lines. This exception applies to the prescription of controlled substances via telemedicine. Subject to the conditions of the DEA letter’s temporary exception (see Resources below), DEA-registered practitioners may prescribe controlled substances to patients via telemedicine in states in which they are not registered with DEA. However, individual states may have additional registration requirements, and these should be consulted prior to the clinician engaging in telemedicine prescribing of controlled substances. See ASAM’s Telehealth Guidance for more information.

Resources

Considerations for High Risk Patients
According to the CDC individuals who are at higher risk for severe illness from COVID-19 include:

- People aged 65 and older
- People with chronic health conditions including
  - Serious heart conditions
  - Lung disease or moderate to severe asthma
  - People who are immunocompromised or on immune suppressing drugs
  - Severe obesity (BMI ≥40).

The CDC also notes that, “people who are pregnant should be monitored since they are known to be at risk with severe viral illness, however, to date data on COVID-19 has not shown increased risk”.

This guidance is focused on helping providers and programs to establish recommendations for continuing to offer high risk patients appropriate care while minimizing their risk for exposure to COVID-19.

Recommendation
High risk patients should continue to have access to appropriate addiction treatment, which may need to include some capacity for face-to-face treatment. However, every effort should be made to minimize in-person interactions. Telehealth services should be used whenever possible (see Telehealth Guidance).
Policies or practices to consider

- Consider risk stratifying patients further based on level of individual risk, stage of disease, ability to access telehealth services and recent history of non-prescribed substance use.
- Consider extending prescriptions beyond usual practice to allow for fewer in-person healthcare touches including at pharmacies where additional exposure may occur.

Resources

Resources
- NIAAA Alcohol Treatment Navigator Telehealth and Mutual Support Options: https://alcohotreatment.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
- National Consortium of Telehealth Resource Centers: https://www.telehealthresourcecenter.org/