ASAM American Society of Addiction Medicine

Caring for Patients During the COVID-19 Pandemic

ASAM COVID-19 Task Force Recommendations

A guide for addiction treatment providers and programs working to treat patients with substance use disorders safely and effectively during the COVID-19 pandemic.[1]

Treating Pregnant People with Addiction During the COVID Crisis

Purpose of the document

To provide guidance to addiction treatment providers and programs on the treatment of pregnant people with OUD during the COVID-19 pandemic. In March 2020, ASAM released a focused update to the National Practice Guideline for the Treatment of Opioid Use Disorder. The COVID-19 crisis is likely to require adjustments in care to balance the risks from both OUD and COVID-19. The purpose of this document is to provide guidance on adjusting that care in the current crisis.

Topics

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2. How does the Coronavirus Affect Pregnant People?
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4. Considerations for Breastfeeding
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Reopening Considerations

While many places across the country are starting to relax physical distancing restrictions, the COVID-19 pandemic is not over. Communities and treatment programs across the country remain at risk for increasing population prevalence over time. Providers and programs should continue to implement policies and procedures to reduce the risk for coronavirus transmission, based on national scientific guidance and informed by the available data and guidance in their state and local areas. In addition,

[1] 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.

clinicians and clinical programs should prepare for potential spikes in transmission in their community and program. Programs and providers should consider:

- Maintaining or implementing an incident command structure to prepare for and address any issues that arise due to COVID-19
- Reviewing current infection control processes, including the extent to which staff and patients are adhering to them.
- Assessing what worked well in your initial response and where there may be room for improvement, updating related policies and procedures as needed.
- Assessing your program or practices' potential needs related to:
    - Personal protective equipment and other supplies needed to control and mitigate the spread of the coronavirus.
    - Staff training
    - Staff support
    - Technology to support telehealth
- Addressing the evolving phases of the epidemic and how to prepare for the next stages in your community.

How does coronavirus affect pregnant people?

The CDC says "Pregnant people have changes in their bodies that may increase their risk of some infections. Pregnant people have had a higher risk of severe illness when infected with viruses from the same family as COVID-19 and other viral respiratory infections, such as influenza." https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/pregnancy-breastfeeding.html (accessed 4/24/2020)

A recent study of 38 cases of pregnant women with COVID-19 says "…unlike coronavirus infections of pregnant women caused by SARS and MERS, in these 38 pregnant women COVID-19 did not lead to maternal deaths."[2]

Are pregnant people at greater risk from COVID-19 than non-pregnant people?

CDC says "We do not currently know if pregnant people have a greater chance of getting sick from COVID-19 than the general public nor whether they are more likely to have serious illness as a result. Based on available information, **pregnant people seem to have the same risk as adults who are not pregnant**." https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/pregnancy-breastfeeding.html (accessed 4/24/2020)

Does having COVID-19 Harm the Fetus?

Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives says, "There are currently no data suggesting an increased risk of miscarriage or early pregnancy loss in relation to COVID-19. Case reports from early pregnancy studies with SARS and MERS do not demonstrate a convincing relationship between infection and increased risk of miscarriage or second trimester loss.

[2] Schwartz, D. A., & Graham, A. L. (2020). Potential Maternal and Infant Outcomes from (Wuhan) Coronavirus 2019-nCoV Infecting Pregnant Women: Lessons from SARS, MERS, and Other Human Coronavirus Infections. *Viruses*, *12*(2), 194. https://doi.org/10.3390/v12020194

There is no evidence currently that the virus is teratogenic. Very recent evidence has, however, suggested that it is probable that the virus can be vertically transmitted, although the proportion of pregnancies affected and the significance to the neonate has yet to be determined. There are case reports of preterm birth in women with COVID-19, but it is unclear whether this was iatrogenic in every case, or whether some were spontaneous. Iatrogenic birth was predominantly for maternal indications related to the viral infection, although there was evidence of fetal compromise and prelabour preterm rupture of the membranes in at least one report."
https://www.rcog.org.uk/globalassets/documents/guidelines/2020-04-17-coronavirus-covid-19-infection-in-pregnancy.pdf (accessed 4/23/2020)

Is there in utero mother-to-child transmission of COVID-19?

- The CDC says, "Mother-to-child transmission of coronavirus during pregnancy is unlikely, but after birth a newborn is susceptible to person-to-person spread.
- A very small number of babies have tested positive for the virus shortly after birth. However, it is unknown if these babies got the virus before or after birth.
- The virus has not been detected in amniotic fluid, breastmilk, or other maternal samples." https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/pregnancy-breastfeeding.html (accessed 4/24/2020)

Managing COVID-19 Illness During Pregnancy

According to the Society for Maternal and Fetal Medicine:

> During acute illness, fetal management should be similar to that provided to any critically ill pregnant woman. Continuous fetal monitoring in the setting of severe illness should be considered only after fetal viability, when delivery would not compromise maternal health or as another noninvasive measure of maternal status. Very little is known about the natural history of pregnancy after a patient recovers from COVID19. In the setting of a mild infection, management similar to that for a patient recovering from influenza is reasonable. It should be emphasized that patients can decompensate after several days of apparently mild illness, and women should be instructed to call or be seen for care if symptoms, particularly shortness of breath, worsen. Given how little is known about this infection, a detailed mid-trimester anatomy ultrasound examination may be considered following first-trimester maternal infection. For those experiencing illness later in pregnancy, it is reasonable to consider ultrasonographic assessment of fetal growth in the third trimester. Please see The Society for Maternal-Fetal Medicine COVID-19 Ultrasound Practice Suggestions for further information. Signs and symptoms of preterm labor should also be reviewed.
>
> https://s3.amazonaws.com/cdn.smfm.org/media/2322/COVID19-What_MFMs_need_to_know_revision_4-11-20_(final)_highlighted_changes._PDF.pdf

Transmission of Coronavirus Between Mothers and Babies

Should mothers and babies be separated?

There is very little research available on risks to newborns associated with COVID-19. However, the limited research that is available suggests that infants and children are at low risk of infection and,

according to the WHO, "The few confirmed cases of COVID-19 in young children to date have experienced only mild or asymptomatic illness." Further, there are clear harms associated with maternal infant separation. Separation can interfere with maternal infant bonding as well as with the establishment of breastfeeding. Breastfeeding supports the development of immunity in infants as mothers pass on antibodies through their milk. In addition, skin to skin contact has been shown to reduce infant mortality and improve long term health outcomes. ***Given the specific benefits of skin-to-skin and rooming in of mother and baby who may have opioid withdrawal, the risk of maternal infant separation must be carefully considered.***

Royal College of Obstetricians and Gynecologists and the Royal College of Midwives says, "Literature from China has advised separate isolation of the infected woman and her baby for 14 days. However, routine precautionary separation of a woman and a healthy baby should not be undertaken lightly, given the potential detrimental effects on feeding and bonding. Given the current limited evidence, we advise that women and healthy babies, not otherwise requiring neonatal care, are kept together in the immediate postpartum period. A risk and benefits discussion with neonatologists and families to individualize care in babies that may be more susceptible is recommended."
https://www.rcog.org.uk/globalassets/documents/guidelines/2020-04-17-coronavirus-covid-19-infection-in-pregnancy.pdf (accessed 4/23/2020)

The CDC guidance recommends that:

- "The determination of whether or not to separate a mother with known or suspected COVID-19 and her infant should be made on a case-by-case basis using shared decision-making between the mother and the clinical team."
- If mother and infant are not separated, steps should be taken to reduce the risk for transmission from mother to infant, including use of respiratory and hand hygiene practices.
  Infants born to mothers with known COVID-19 at the time of delivery should be considered to have suspected COVID-19 and should be tested and isolated from other healthy infants.
  https://www.cdc.gov/coronavirus/2019-ncov/hcp/inpatient-obstetric-healthcare-guidance.html).

Considerations for Breastfeeding

Can mothers breastfeed if infected with COVID-19 virus?

Both the World Health Organization and the CDC support breastfeeding by mothers with COVID-19.

> "WHO recommends that all mothers with confirmed or suspected COVID-19 continue to have skin-to-skin contact and to breastfeed. In all socio-economic settings, breastfeeding improves survival and provides lifelong health and development advantages to newborns and infants. Breastfeeding also reduces the risk of breast and ovarian cancer for the mother. Skin-to-skin contact, including kangaroo mother care, reduces neonatal mortality, especially for low birth weight newborns.
>
> While infants and children can contract COVID-19, they are at low risk of infection. The few confirmed cases of COVID-19 in young children to date have experienced only mild or asymptomatic illness." https://www.who.int/news-room/q-a-detail/q-a-on-covid-19-and-breastfeeding

The CDC says, **"**If you are sick and choose to directly breastfeed: Wear a facemask and wash your hands before each feeding. If you are sick and choose to express breast milk:

- Express breast milk to establish and maintain milk supply.
- A dedicated breast pump should be provided.
- Wash hands before touching any pump or bottle parts and before expressing breast milk.
- Follow recommendations for proper pump cleaning after each use, cleaning all parts that come into contact with breast milk.
- If possible, consider having someone who is well feed the expressed breast milk to the infant."
- https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/pregnancy-breastfeeding.html (accessed 4/24/2020).

Policies and Practices to Consider in Caring for Pregnant People with Addiction During COVID

- **Provide education and resources to pregnant patients regarding COVID-19.**
    - Educate pregnant and post-pregnant people and their family members about COVID-19 and steps to stay healthy. Education needs to be repeated frequently.
    - Have resources available to help pregnant and post-pregnant people obtain personal protective equipment
    - Provide resources to pregnant and post-pregnant people for dealing with anxiety and practicing self-care.
- **Use telemedicine, including telephonic visits, whenever possible and appropriate (See ASAM's COVID-19 Telehealth Guidance).**
    - If moving to "tele-treatment," discuss the risks and benefits of such a modality of care and document this discussion in the patient's chart. If possible, consider having patients sign a specific care consent that discuss risks and benefits of the new treatment modality. Such a process could be done via patient portals for electronic medical records or secure email (if available).
    - Discuss with each patient their ability to use tele-treatment platforms and continue to troubleshoot (data plans, connectivity, minutes are all issues). If an in-person meeting is needed, remember to use PPE and practice social distancing.
    - Complete staff training on" ethics and technology"
    - Develop new "ground rules for tele-treatment" to share with patients
    - Offer tele-counseling visits
    - Ensure clinical crisis plan response is updated to reflect new treatment modality
    - Explicit conversations with patients around confidentiality and guidelines for engagement – meaning they should not drive and be on the tele-treatment platform, they need to wear clothes, avoid eating, performing hygiene routines while on the tele-treatment platform
    - Encourage the patient to find a quiet, private space for telehealth visits, or to put on headphones if a child or other person is in the same room listening to the discussion.
- **Help patients to manage their stress and anxiety.**
    - Remember that all patients are under more stress during this time. COVID-19 and the isolation associated with sheltering in place may be triggering for many patients.
    - Make sure that pregnant patients and post-pregnant patients are having psychosocial assessments and there are responses in place for any issues that arise.

    - Social support is even more important during this crisis. Encourage virtual support group attendance.
        - But note that some patients are reporting fatigue with the online platform.
        - Help patients to develop a plan for obtaining social support that will work for them.
    - Be more understanding, flexible, and compassionate during this time.
    - Be flexible in re-scheduling sessions if the patient is having a rough day or transportation, childcare or other issues are preventing them from an in-person clinic visit.
- **Increase your efforts to maintain patient engagement in treatment.**
    - There is a risk that even fewer women will attend post-pregnancy visits. Thus, be more vigilant about ensuring they are completed.
- **Help women develop a COVID-19 birth plan.**
    - Can they virtually tour the hospital?
    - Can they refuse testing if they do not want it?
    - What if they cannot have visitors?
    - Can they FaceTime with a support person?
    - What can and can't they bring to the hospital?
    - What other changes to delivery and post-partum care has the hospital put in place?
    - What is the NAS care plan at the hospital?
    - Any special COVID-19 procedures in place?
    - Once the birth plan is developed, then share with all care providers.
    - What will happen if they have COVID at the time of delivery?
- **Increase communication with patients during this time.**
    - Avoid relying on written memos with patients for communication; now is the time to talk with patients and over-communicate to ensure they have the information they need.
- **Implement infection control and mitigation procedures**
    - See ASAM's COVID-19 Guidance on Infection Mitigation in Outpatient Settings and Infection Mitigation in Residential Settings
- **Continue to support comprehensive care.**
    - Counseling on contraception options
    - Postpartum depression screening
    - Nutrition
    - Smoking cessation
    - Pre-eclampsia education
    - Harm reduction (e.g. naloxone)
    - Be vigilant in providing support and resources to patients regarding domestic violence/ interpersonal violence and child abuse and neglect prevention or intervention.

Initiation of Medication for Opioid Use Disorder

ASAM's National Practice Guideline for the Treatment of Opioid Use Disorder recommends that hospitalization during initiation of treatment with buprenorphine or methadone may be advisable due to the potential for adverse events, especially in the third trimester. The decision of whether to

hospitalize a patient for initiation of medication should consider the experience of as well as comorbidities and other risk factors for the individual patient.

However, during the COVID-19 crisis, clinicians will need to weigh the individual patient's risks associated with hospitalization versus the risks for outpatient-based initiation of medication. Outpatient initiation of methadone and buprenorphine is generally safe and effective. Clinicians should consider:

- Is the patient at high risk for severe COVID-19 illness?
- Which option is associated with higher risk of COVID-19 transmission?
    - Are there high levels of community transmission?
    - What is the situation at the hospital where initiation would occur?
    - What is the situation at the outpatient clinic?
        - Are they providing services through telehealth?
        - Do they have adequate PPE?
        - Are there sufficient infection control procedures in place?
    - How many in-person visits are anticipated?
        - Would the patient need to take mass transit or ride with another person to the visit?
- After discussing the risks, what does the patient prefer?
- Is the patient experiencing any symptoms consistent with COVID or have they had any potential exposures?
- Is the patient living in a high-risk environment for COVID-19 transmission?
- Is the patient at high risk of adverse events related to their OUD (e.g. overdose, suicide) or co-occurring conditions?
- Can and will the patient engage in telemedicine visits?
- Is the patient more likely to disengage from treatment?
- Can the patient appropriately and safely manage take home medications?
    - Is the patient likely to divert or misuse their medication?

Drug Testing

ASAM's National Practice Guideline for the Treatment of Opioid Use Disorder notes that, for pregnant people:

> Drug testing may be used to detect or confirm suspected opioid and other drug use but should be performed only with the patient's consent and in compliance with state laws (See ASAM's *Appropriate Use of Drug Testing in Clinical Addiction Medicine* guidance document). State laws differ in terms of clinicians' reporting requirements of identified drug use (through either drug testing or self-report) to child welfare services and/or health authorities. Laws that penalize pregnant women for substance use disorders serve to prevent women from obtaining prenatal care and treatment for opioid use disorder, which may worsen outcomes for mother and child. […] Even with patient consent, urine testing should not be relied upon as the sole or valid indication of drug use. […] Positive urine screens should be followed with a definitive drug assay.

The same considerations discussed in ASAM's COVID-19 Drug Testing Guidance apply to pregnant and postpartum women.

Take Home Doses of Opioid Agonist Medication

The same considerations discussed in ASAM's COVID-19 Guidance for Opioid Treatment Program and COVID-19 Guidance on Access to Buprenorphine apply to pregnant and postpartum women. However, dose adjustments may be needed more often during pregnancy and postpartum, which should be considered in the determination of the appropriate number of take-home doses.

Supporting Parents in the Child Welfare System

During the COIV-19 crisis, there has been increased stress on the child welfare system. Treatment providers need to know about both the challenges that face the system and families as well as the information as to how the system has been instructed to respond.

Challenges that parents have encountered include:

- Delays in family court hearings
- Denial of visitation for parents
- Over-reliance on tele-visits for all children including newborns (which is developmentally inappropriate)
- Increase in reporting of parents for certain substances used and removals of children due to parental substance use.

The Children's Bureau issued important guidance that:

- Urged avoiding making wide orders to stop, suspend or delay hearings
- Stressed a case by case approach
- Recommended attorneys file written motions raising issues of immediate concern
- Advised use of technology to facilitate remote proceedings where possible and appropriate
- Recommended ensuring parents and children have access to the necessary technology and internet connection to be able to participate in connection with the family and in hearings or other meetings/proceedings
- Advised engaging attorneys to resolve issues that have already been agreed upon using virtual meetings to prevent unnecessary delays to reunification.

Resources:

CDC's Considerations for Inpatient Obstetric Healthcare Settings:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/inpatient-obstetric-healthcare-guidance.html

Society for Maternal Fetal Medicine COVID-19 Resources: https://www.smfm.org/covidclinical

SMFM Coronavirus (COVID-19) and Pregnancy: What Maternal-Fetal Medicine Subspecialists Need to Know: https://s3.amazonaws.com/cdn.smfm.org/media/2322/COVID19-What_MFMs_need_to_know_revision_4-11-20_(final)_highlighted_changes._PDF.pdf

World Health Organization Guidance on Breastfeeding and COVID-19: https://www.who.int/news-room/q-a-detail/q-a-on-covid-19-and-breastfeeding

Administration for Children and Families, Children's Bureau COVID-19 Guidance:
https://www.acf.hhs.gov/cb/resource/covid-19-resources

A Joint Statement on Child Welfare Courts During a Public Health Crisis: Access to Justice and Advocacy are Critical Anchors During Uncertain Times:
https://www.acf.hhs.gov/sites/default/files/cb/statement_child_welfare_crisis.pdf