ASAM COVID-19 TASK FORCE RECOMMENDATIONS

CARING FOR PATIENTS
DURING THE COVID-19 PANDEMIC

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

AMERICAN SOCIETY OF ADDICTION MEDICINE
FOUNDED 1954
ASAM

SUPPORTING ACCESS TO ALCOHOL USE DISORDER AND ALCOHOL WITHDRAWAL TREATMENT DURING THE COVID-19 PANDEMIC

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

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.

ASAM does not warrant the accuracy or completeness of the Guidance and assumes no responsibility for any injury or damage to persons or property arising out of or related to any use of this Guidance or for any errors or omissions.

SUPPORTING ACCESS TO ALCOHOL USE DISORDER AND ALCOHOL WITHDRAWAL TREATMENT DURING THE COVID-19 PANDEMIC

Purpose of the document

An increasing amount of data suggests that the COVID-19 pandemic is exacerbating symptoms of addiction and mental illness due to heightened levels of anxiety, stress, and social isolation. 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 clinicians to support continued access to care for alcohol use disorder (AUD) and alcohol withdrawal management (AWM) during the COVID-19 pandemic.

[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.

TOPICS

1. Remaining Open and Available for 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 clinicians 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 can be appropriately managed by telehealth, should have access to telehealth services. Those who are earlier in their treatment or requiring a higher level of care 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 telehealth contact. Examples that would warrant an 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.

- Place furniture and/or markings on the floor to manage patient flow and maintain 6+ feet of distance.
- In communities with low levels of COVID-19 positivity and control of spread, 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.

Current public health guidance is that patients, staff, and clinicians should all wear a mask. After the visit, both patient, staff, and clinicians should wash their hands and the room should be cleaned between uses.

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

- CDC calls on Americans to wear masks to prevent COVID-19 spread: https://www.cdc.gov/media/releas- es/2020/p0714-americans-to-wear-masks.html

- Updated definition of "close contact" by the CDC: https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/appendix.html#contact

2. Implementing Possesses for Managing and Responding to COVID-19

Given the complexity of challenges associated with the COVID-19 response throughout the 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 clinicians 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 and update 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 as they arise in real time.

3. 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 sustained treatment at increased risk of return to drinking. Further, access to treatment 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) may be limited to tele-groups. (See ASAM's COVID-19 Guidance on Support Group Access).

Recognizing that patients are likely to need increased support during this stressful time, clinicians are encouraged to use telehealth to increase the frequency of 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 telehealth 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. Efforts can be made to have this covered as durable medical equipment for some insurances). For those patients who consent, clinicians 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 three times daily.

- Disulfiram 125-500mg oral once daily.

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

Clinicians are encouraged to familiarize themselves with adjunct resources that can support patients during the pandemic. For example, NIAAA's Rethinking Drinking 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 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, wearing of face coverings, 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 clinicians 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.

4. Considerations for Alcohol Withdrawal Management during COVID-19

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 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.

Clinicians 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?

    - Is the patient 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 they age 65 or over?

- 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 may have diminished access to monitored environments where clinician-administered assessments of withdrawal are feasible. Whilethere 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.

- Consider advocating for and working with community leaders to 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 three times daily.
- Disulfiram 125-500mg oral once daily.

Resources

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

- ASAM's COVID-19 Guidance on Medication, Formulation and Dosages https://www.asam.org/Quality-Science/covid-19-coronavirus/medication-formulation-and-dosage-guidance

- APA's Practice Guideline for the Pharmacological treatment of Patients with Alcohol Use Disorder: https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9781615371969

5. Leveraging Telehealth

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

Telehealth 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, is 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 clinicians 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 provide care through telehealth.

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

Clinicians should assess whether an in-person visit would change management. 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. unhoused patients) may benefit from in-person visits. Clinicians 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. Clinicians and programs should work with patients to make sure they understand how to join a telehealth visit and should be prepared to adapt to technical issues that arise without abandoning care. 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 and the APA's Telepsychiatry Toolkit: https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit

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.

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 identity and 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 clinician at the time of the visit and the technology used for the connection. 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.

Resources

- AMA Quick Guide to Telemedicine in Practice: https://www.ama-assn.org/practice- man-agement/digital/ama-quick-guide-telemedicine-practice

- American Psychiatric Association: Telepsychiatry and COVID-19: https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-resources-on- telepsy-chiatry-and-covid-19

- CMS General Provider Toolkit: https://www.cms.gov/files/document/general-telemedicine- toolkit.pdf

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

- National Council Resources for COVID-19: https://www.thenationalcouncil.org/covid19/

6. 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 pre-scription 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. Clinicians can help their patients adhere to these guidelines by e-prescribing the longest possible safe duration of medications. In addition, clinicians should preferentially utilize pharmacies that offer home delivery or other contactless or minimal contact options like curbside or drive through pick up.

SAMHSA and the DEA have released guidance to facilitate e-prescribing of controlled substances, which would include any benzodiazepines, without an in-person medical evaluation during this public health emer-gency. The DEA also issued an Exception to Separate Registration Requirements Across State Lines. This exception applies to the prescription of controlled substances via telehealth. Subject to the conditions of the DEA letter's temporary exception (see Resources below), DEA-registered practitioners may prescribe con-trolled substances to patients via telehealth 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 telehealth prescribing of controlled substances. See ASAM's Telehealth Guidance for more information.

Resources

- Provision of Telemedicine While Providing MAT (May 2018): https://www.samhsa.gov/sites/de-fault/files/programs_campaigns/medication_assiste d/telemedicine-dea-guidance.pdf

- DEA Information on Telemedicine: https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_as sisted/dea-information-telemedicine.pdf

- DEA Policy: Exception to Separate Registration Requirements Across State Lines: https://www.deadiversion.usdoj.gov/GDP/(DEA-DC- 018)(DEA067)%20DEA%20state%20reciprocity%20(final)(Signed).pdf

7. 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
    - 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." See Treating Pregnant People with Opioid Use Disorder.

Clinicians and programs should continue to offer high risk patients appropriate care for alcohol use disorder, including alcohol withdrawal management, while minimizing their risk for exposure to COVID- 19.

Recommendation

High risk patients should continue to have access to appropriate addiction treatment, which should 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 appropriate (see Telehealth Guidance).

Policies or practices to consider

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

Resources

- https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/people-at-higher-risk.html
- https://www.samhsa.gov/sites/default/files/medicare-telemedicine-health-care-fact-sheet.pdf

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

- https://www.samhsa.gov/sites/default/files/medicare-telemedicine-health-care-fact-sheet.pdf

- AMA Quick Guide to Telemedicine in Practice: https://www.ama-assn.org/practice- management/digital/ama-quick-guide-telemedicine-practice

- American Psychiatric Association: Telepsychiatry and COVID-19: https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-resources-on- telepsychiatry-and-covid-19

- CMS General Provider Toolkit: https://www.cms.gov/files/document/general-telemedicine- toolkit.pdf

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

- National Council Resources for COVID-19: https://www.thenationalcouncil.org/covid19/

ASAM American Society *of* Addiction Medicine