Pregnant and Postpartum Care for People with Substance Use Disorder During the COVID-19 Pandemic

Mishka Terplan MD MPH FACOG DFASAM
Addiction Medicine Specialist, DMAS
Senior Physician Research Scientist, Friends Research Institute
Substance Use Warm Line Clinician, UCSF
@do_less_harm
Brief History of SARS-CoV-2/COVID-19

• Novel corona virus identified December 2019 as cause of pneumonia cluster in Wuhan – led to rapid outbreak in China

• Designated severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) – February 2020 WHO designated the disease COVID-19 (coronavirus disease 2019)

• WHO Pandemic early March

• Route of transmission: respiratory droplets (direct or indirect – from infected surfaces)

• Incubation Period - 14 days from exposure to symptoms

• Symptoms – Cough, Fever, SOB, Chills, Muscle Pain, Sore Throat, New Loss of Taste or Smell

• Illness Spectrum
  – 81% Mild (mild or no pneumonia)
  – 14% Severe (dyspnea, hypoxia, or >50% lung involvement)
  – 5% Critical (respiratory failure, shock)
  – Death Rate – 3.4% globally (range 0.6 South Korea - 12% Wuhan time delay analysis)

• Risk Factors: Age and underlying medical comorbidities (pulmonary)
  – However 20% of hospitalizations are adults 20-44 yo
What makes this virus so dangerous

- Novel – Information still evolving
- Virus is stable in aerosols for hours
- Highly transmissible – average infection > 2 people
- Resource intensive (for serious illness 2-3 week ICU admission)
- Limited prevention and no treatment (aside from supportive care)

- Therefore: Social Distancing, Face Masks, and Hand washing
Key Summary Points

The likelihood that approximately 40% to 45% of those infected with SARS-CoV-2 will remain asymptomatic suggests that the virus might have greater potential than previously estimated to spread silently and deeply through human populations.

Asymptomatic persons can transmit SARS-CoV-2 to others for an extended period, perhaps longer than 14 days.

The absence of COVID-19 symptoms in persons infected with SARS-CoV-2 might not necessarily imply an absence of harm. More research is needed to determine the significance of subclinical lung changes visible on computed tomography scans.

The focus of testing programs for SARS-CoV-2 should be substantially broadened to include persons who do not have symptoms of COVID-19.

---

Table: Summary of SARS-CoV-2 Testing Studies

<table>
<thead>
<tr>
<th>Cohort</th>
<th>Tested, n</th>
<th>SARS-CoV-2 Positive, n (%)</th>
<th>Positive but Asymptomatic, n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iceland residents (6)</td>
<td>13,080</td>
<td>100 (0.8)</td>
<td>43 (43.0)</td>
</tr>
<tr>
<td>Vo', Italy, residents (7)</td>
<td>5,155</td>
<td>102 (2.0)</td>
<td>43 (82.2)</td>
</tr>
<tr>
<td>Diamond Princess cruise ship passengers and crew (8)</td>
<td>3,711</td>
<td>712 (19.2)</td>
<td>331 (45.6)</td>
</tr>
<tr>
<td>Boston homeless shelter occupants (9)</td>
<td>408</td>
<td>147 (36.0)</td>
<td>129 (87.6)</td>
</tr>
<tr>
<td>New York City obstetric patients (11)</td>
<td>214</td>
<td>33 (15.4)</td>
<td>29 (87.9)</td>
</tr>
<tr>
<td>U.S.S. Theodore Roosevelt aircraft carrier crew (12)</td>
<td>4,954</td>
<td>856 (17.3)</td>
<td>~500 (58.4)</td>
</tr>
<tr>
<td>Japanese citizens evacuated from Wuhan, China (2)</td>
<td>565</td>
<td>13 (2.3)</td>
<td>4 (30.8)</td>
</tr>
<tr>
<td>Greek citizens evacuated from the United Kingdom, Spain, and Turkey (14)</td>
<td>783</td>
<td>40 (5.1)</td>
<td>35 (87.5)</td>
</tr>
<tr>
<td>Charles de Gaulle aircraft carrier crew (13)</td>
<td>1,760</td>
<td>1,046 (59.4)</td>
<td>~500 (47.8)</td>
</tr>
<tr>
<td>Los Angeles homeless shelter occupants (10)</td>
<td>178</td>
<td>43 (24.2)</td>
<td>27 (62.8)</td>
</tr>
<tr>
<td>King County, Washington, nursing facility residents (15)</td>
<td>76</td>
<td>48 (63.2)</td>
<td>3 (6.3)</td>
</tr>
<tr>
<td>Arkansas, North Carolina, Ohio, and Virginia inmates (16)</td>
<td>4,693</td>
<td>3,277 (69.8)</td>
<td>3,146 (96.0)</td>
</tr>
<tr>
<td>New Jersey university and hospital employees (17)</td>
<td>829</td>
<td>41 (4.9)</td>
<td>27 (65.9)</td>
</tr>
<tr>
<td>Indiana residents (18)</td>
<td>4,611</td>
<td>781 (17.1)</td>
<td>35 (44.8)</td>
</tr>
<tr>
<td>Argentine cruise ship passengers and crew (19)</td>
<td>217</td>
<td>128 (59.0)</td>
<td>104 (81.3)</td>
</tr>
<tr>
<td>San Francisco residents (29)</td>
<td>4,160</td>
<td>74 (1.8)</td>
<td>39 (92.7)</td>
</tr>
</tbody>
</table>
COVID-19 Virginia

Retrieved 6/10/20
Association of Stay-at-Home Orders With COVID-19 Hospitalizations in 4 States

In analyses of the effectiveness of response measures to the outbreak of coronavirus disease 2019 (COVID-19), most studies have used the number of confirmed cases or deaths. However, case count is a conservative estimate of the actual number of infections and hospitalizations in the absence of community-wide serologic testing. Death count is a lagging metric and insufficient for proactive public health capacity planning. A more valuable metric for assessing the effects of public health interventions on the health care infrastructure is hospitalizations. As of April 18, 2020, governors in 42 states had issued statewide executive “stay-at-home” orders to help mitigate the risk that COVID-19 hospitalizations would overwhelm state’s health care infrastructure. This study assessed the association between these orders and hospitalization trends.

Methods | In March 2020, we began collecting data on cumulative confirmed COVID-19 hospitalizations from each state’s department of health website on a daily basis. Among states issuing a statewide stay-at-home order, we identified states with at least 7 consecutive days of cumulative hospitalization data for COVID-19 (including patients currently hospitalized and those discharged) before the stay-at-home order date and at least 17 days following the order date. Because the median incubation period of COVID-19 was reported to be 4 to 5 days, we hypothesized that any association between stay-at-home orders and hospitalization rates would become evident after 12 days (median effective date). States included in this sample were Colorado, Minnesota, Ohio, and Virginia. Of the 4 states meeting the inclusion criteria, the earliest date with data on hospitalizations was March 10. All states were observed through April 28. We fit the best exponential growth function to cumulative hospitalization data in each state for days up to and including the median effective date of that state’s stay-at-home order. We computed 95% prediction bands on the exponential fit line to determine if the observed number of hospitalizations fell within the interval. We then examined whether the observed cumulative hospitalizations for dates after the median effective date deviated from the projected exponential growth in cumulative hospitalizations. In an additional analysis, a linear growth function was fit to cumulative hospitalizations up to and including the median effective date, and goodness of fit was assessed with an R² comparison. All analyses were performed using Microsoft Excel version 14.1.

Results | In all 4 states, cumulative hospitalizations up to and including the median effective date of a stay-at-home order closely fit and favored an exponential function over a linear fit ($R^2 = 0.973$ vs 0.695 in Colorado; 0.965 vs 0.865 in Minnesota; 0.98 vs 0.803 in Ohio; 0.994 vs 0.775 in Virginia) (Table). However, after the median effective date, observed hospitalization growth rates deviated from projected exponential growth rates with slower growth in all 4 states. Observed hospitalizations consistently fell outside of the 95% prediction bands of the projected exponential growth curve (Figures).

For example, Minnesota’s residents were mandated to stay at home starting March 28. On April 13, 5 days after the median effective date, the cumulative projected hospitalizations were 988 and the actual hospitalizations were 361. In Virginia, projected hospitalizations 5 days after the median effective date were 2335 and actual hospitalizations were 1048.

Discussion | In 4 states with stay-at-home orders, cumulative hospitalizations for COVID-19 deviated from projected best fit exponential growth rates after these orders became effective. The deviation started 2 to 4 days sooner than the median effective date of each state’s order and may reflect the use of a median incubation period for symptom onset and time to hospitalization to establish this date. Other factors that potentially decreased the rate of virus spread and subsequent hospitalizations include school closures, social distancing guidelines, and general pandemic awareness. In addition, economic insecurity and loss of health insurance during the pandemic may have also decreased hospital utilization. Limitations of the study include that these other factors could not be modeled in the analysis and that data on only 4 states were available.

Table. Cumulative hospitalizations due to COVID-19 in Colorado, Minnesota, Ohio, and Virginia, March 10 through April 28, 2020

<table>
<thead>
<tr>
<th>State</th>
<th>Start date</th>
<th>Median effective date</th>
<th>Onset of reporting</th>
<th>Onset 95% CI</th>
<th>Onset 95% CI mean</th>
<th>Onset 95% CI median</th>
<th>Onset 95% CI R²</th>
<th>Exponent index</th>
<th>95% CI</th>
<th>Exponent index 95% CI mean</th>
<th>Exponent index 95% CI median</th>
<th>Exponent index 95% CI R²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado</td>
<td>March 10</td>
<td>April 28</td>
<td>2677</td>
<td>1.28 (1.02-1.54)</td>
<td>0.24 (0.09-0.45)</td>
<td>0.972 (0.83-1.13)</td>
<td>0.95 (0.21-0.23)</td>
<td>0.98 (0.84-1.13)</td>
<td>0.95 (0.22-0.21)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td>March 10</td>
<td>April 28</td>
<td>912</td>
<td>2.02 (1.84-2.21)</td>
<td>1.07 (0.80-1.34)</td>
<td>0.965 (0.88-1.05)</td>
<td>0.95 (0.21-0.23)</td>
<td>0.95 (0.21-0.23)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ohio</td>
<td>March 10</td>
<td>April 28</td>
<td>3340</td>
<td>2.02 (1.84-2.21)</td>
<td>1.07 (0.80-1.34)</td>
<td>0.965 (0.88-1.05)</td>
<td>0.95 (0.21-0.23)</td>
<td>0.95 (0.21-0.23)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Virginia</td>
<td>March 10</td>
<td>April 28</td>
<td>2165</td>
<td>2.02 (1.84-2.21)</td>
<td>1.07 (0.80-1.34)</td>
<td>0.965 (0.88-1.05)</td>
<td>0.95 (0.21-0.23)</td>
<td>0.95 (0.21-0.23)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Soumya Sen, MD
Phoebe Kanter-Karakus, PhD
Archele Georgiou, MD

Author Affiliations: Department of Information and Decision Sciences, University of Minnesota Carlson School of Management, Minneapolis (Sen, Karakerkus); Department of Finance, University of Minnesota Carlson School of Management, Minneapolis (Karakus); Stanek Hearing Technologies, Eden Prairie, Minnesota (Georgiou)

Accepted for Publication: May 11, 2020.

Published Online: May 27, 2020. doi:10.1001/jama.2020.3996

Author Contributions: Dr Sen and Karakerkus had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. Concept and design: All authors. Acquisition, analysis, or interpretation of data: All authors. Drafting of the manuscript: All authors. Critical revision of the manuscript for important intellectual content: All authors. Administrative and editorial support: Georgiou. Other: Georgiou had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.
COVID-19 Considerations for People with SUD

• High risk of co-morbidities that may increase severity of COVID-19
  – COPD, Cirrhosis, HIV
  – Smoking

• Overlap between symptoms of opioid withdrawal and COVID-19 infection

• Risk of drug overdose due to social distancing/isolation, drug supply disruption, reduced access to community-based naloxone distribution

• Increase in other substance use including alcohol

• Barriers to accessing treatment due to illness, quarantine, and financial resources for both patients and providers
What Impact Has COVID-19 Had on Outpatient Visits?

April 23, 2020
| Ateev Mehrota, Michael Chernew, David Linetsky, Hilary Hatch, and David Cutler

As the number of in-person visits dropped, telehealth visits increased. But the increase in telehealth visits only partially offset the drop in in-person visits.

The decline in visits was generally larger among surgical and procedural specialties and smaller in other specialties such as adult primary care, obstetrics/gynecology, oncology, and behavioral health.
Changes in federal regulations

  
  “The Office for Civil Rights will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency.”

  
  “We emphasize that, under the medical emergency exception, providers make their own determinations whether a bona fide medical emergency exists for purposes of providing needed treatment to patients.”

  
  “Accordingly, as of March 16, 2020, and continuing for as long as the Secretary’s designation of a public health emergency remains in effect, DEA-registered practitioners in all areas of the United States may issue prescriptions for all schedule II–V controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:
  
  - The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice;
  - The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and

  **March 31, 2020 guidance:** DEA will allow waivered physicians to initiate buprenorphine using telephonic (audio-only) communication. The practitioner is acting in accordance with applicable Federal and State laws.”
Alcohol use in times of the COVID-19: Implications for monitoring and policy

JURGEN REHM1,2,3,4,5,6, CAROLIN KILIAN7, CARINA FERREIRA-BORGES7, DAVID JERNIGAN7, MARISTELA MONTEIRO7, CHARLES D. H. PARRY2,7,8, ZILA M. SANCHEZ12 and JAKOB M. THONEY12

1Institute of Clinical Psychology and Psychotherapy, TU Dresden, Dresden, Germany, 2Institute for Mental Health Policy Research, Centre for Addictions and Mental Health, Toronto, Canada, 3Campbell Family Mental Health Research Institute, Centre for Addiction and Mental Health, Toronto, Canada, 4Dalhia Law School of Public Health, University of Toronto, Toronto, Canada, 5IM. Scheckel First Moscow State Medical University (Sechenov University), Moscow, Russia, 6WHO European Office for Prevention and Control of Noncommunicable Diseases, Moscow, Russia, 7Department of Health Law, Policy and Management, Boston University School of Public Health, Boston, USA, 8Pan American Health Organization, Washington, USA, 9Alcohol, Tobacco and Other Drug Research Unit, South African Medical Research Council, Cape Town, South Africa, 10Department of Psychiatry, University of Cape Town, South Africa, 11Departamento de Medicina Preventiva e Saude Publica, Universidade Federal de Sao Paulo, Sao Paulo, Brazil, and 12Centre for Interdisciplinary Addiction Research, UKE Hamburg-Eppendorf, Germany

Abstract

Based on a literature search undertaken to determine the impacts of past public health crises, and a systematic review of the effects of past economic crises on alcohol consumption, two main scenarios—with opposite predictions regarding the impact of the current COVID-19 pandemic on the level and patterns of alcohol consumption—are introduced. The first scenario predicts an increase in consumption for some populations, particularly men, due to distress experienced as a result of the pandemic. A second scenario predicts the opposite outcome, a lowered level of consumption, based on the decreased physical and financial availability of alcohol. With the current restrictions on alcohol availability, it is postulated that, for the immediate future, the predominant scenario will likely be the second, while the distress experienced in the first may become more relevant in the medium- and longer-term future. Monitoring consumption levels both during and after the COVID-19 pandemic will be necessary to better understand the effects of COVID-19 on different groups, as well as its implications from those arising from existing alcohol control policies. [Rehm J, Kilian C, Ferreira-Borges C, Jernigan D, Monteiro M, Parry CDH, Sanchez ZM, Manthey J. Alcohol use in times of the COVID-19: Implications for monitoring and policy. Drug Alcohol Rev 2020;39:301–304]
Issue brief: Reports of increases in opioid-related overdose and other concerns during COVID pandemic

*Updated May 25, 2020*

As the COVID-19 global pandemic continues, so does the nation’s opioid epidemic. The AMA is greatly concerned by an increasing number of reports from national, state and local media suggesting increases in opioid-related mortality—particularly from illicitly manufactured fentanyl and fentanyl analogs. More than 20 states have reported increases in opioid-related mortality as well as ongoing concerns for those with a mental illness or substance use disorder in counties and other areas within the state. See below for select national and state examples.

The AMA is pleased that the U.S. Substance Abuse and Mental Health Services Administration and U.S. Drug Enforcement Administration (DEA) have provided increased flexibility for providing buprenorphine and methadone to patients with opioid use disorder. The AMA is further pleased at increased flexibility provided by the DEA to help patients with pain obtain necessary medications.

There are four actions that must occur, however, to put these new policies into action and help reduce opioid-related harms:

- Governors must adopt the revised SAMHSA and DEA rules and guidance in-full for the duration of the national emergency—this includes flexibility for evaluation and prescribing requirements using telemedicine;
- States must enact as part of their own Emergency Orders and other actions a complete removal of prior authorization, step therapy and other administrative barriers for medications used to treat opioid use disorder;
- States must remove existing barriers for patients with pain to obtain necessary medications. This includes removing arbitrary dose, quantity and refill restrictions on controlled substances; and
- States must enact, implement and support harm reduction strategies, including removing barriers to sterile needle and syringe services programs.

Read the full range of AMA recommendations for states to help patients with opioid use disorder and pain as well as how to further harm reduction efforts.

For more information, please contact Daniel Blaney-Koen, JD, Senior Legislative Attorney, AMA Advocacy Resource Center, at Daniel.Blaney-Koen@ama-assn.org or (312) 464-4954.

National reports

- The pandemic may fuel the next wave of the opioid crisis.
  

© 2020 American Medical Association. All rights reserved.
Psychological Distress and Loneliness Reported by US Adults in 2018 and April 2020

Coronavirus disease 2019 (COVID-19) introduced stressors to mental health, including loneliness stemming from social isolation, fear of contracting the disease, economic strain, and uncertainty about the future. We fielded a national survey measuring symptoms of psychological distress and loneliness among US adults in April 2020 and compared results with national data from 2018.

Methods | We fielded the Johns Hopkins COVID-19 Civic Life and Public Health Survey from April 7 to April 13, 2020, using NORC’s AmeriSpeak panel. AmeriSpeak is a probability-based panel designed to be representative of the US adult population. The panel is sourced from NORC’s area probability sample and from a US Postal Service address-based sample covering 9% of US households. The panel has a recruitment rate of 50% and includes approximately 35,000 members. The sample for the Johns Hopkins survey was drawn from this panel and the survey was administered online. NORC obtains informed consent prior to enrolling individuals in the panel. The Johns Hopkins Bloomberg School of Public Health institutional review board deemed this study not human participants research and waived informed consent.

We measured the prevalence of symptoms of serious psychological distress in the overall sample and among demographic subgroups using the Kessler 6 Psychological Distress Scale, with the validated measure of serious distress defined as a score of 15 or higher on the 0 to 24-point scale. We also measured the proportion of respondents who reported that they or others often felt lonely in response to the item “How often do you feel lonely?” with response options always, often, sometimes, rarely, and never.

We compared the prevalence of serious psychological distress in April 2020 with an identical measure from the 2018 National Health Interview Survey (NHIS), which used the Kessler 6 scale among 25,417 adults aged 18 years or older in household interviews. The 2018 NHIS response rate was 64.8%.

For estimates, we calculated proportions and 95% CIs using Stata version 15 (StataCorp). The Johns Hopkins and NHIS survey data were analyzed separately. Analyses of both data sets incorporated survey weights to generate nationally representative estimates.

Results | The survey response rate was 20.4%, with a final sample of 1648 adults aged 18 years or older. In April 2020, 13.6% (95% CI, 11.2%-16.0%) of US adults reported symptoms of serious psychological distress, relative to 3.9% (95% CI, 3.4%-4.2%) in 2018 (Figure). Among the subgroups examined, in April 2020, symptoms of psychological distress
## Letters

**Prescription Fill Patterns for Commonly Used Drugs During the COVID-19 Pandemic in the United States**

Conflicting information regarding the benefits of hydroxychloroquine/chloroquine and azithromycin in coronavirus disease 2019 (COVID-19) treatment and the substantial concerns for drugs, such as angiotensin-converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs), have challenged care during the pandemic. However, limited data are available about how prescription of these therapies has changed. The objective of this exploratory analysis was to evaluate prescription patterns of these therapies, along with other commonly used drugs for reference, in the United States during the COVID-19 pandemic. We hypothesized that the prescription of hydroxychloroquine/chloroquine and azithromycin would exceed historical estimates while ACE inhibitor/ARB use would be reduced.

### Methods

1. Trends in mean weekly prescriptions dispensed between February 16 and April 25, 2020, of hydroxychloroquine/chloroquine, azithromycin, and the top 10 drugs based on total claims in 2019, which included the most common ACE inhibitors (lisinopril) and ARBs (losartan), were compared with mean weekly prescriptions dispensed from February 17 to April 27, 2020. (Table). We used all-payer US pharmacy data from 58332 chain-independent pharmacies across 14241 zip codes in 50 states, reflecting approximately 17 million de-identified claims. Prescriptions of hydroxychloroquine/chloroquine were also examined based on fill quantity (<28 tablets, 28-60 tablets, or >60 tablets). Pharmacy claims were assigned weights to match prescription data from the Medical

### Table: Estimates of Total Weekly Fills and Relative Percentage Change From 2019 Estimates of Commonly Prescribed Drugs, Azithromycin, and Hydroxychloroquine/Chloroquine

<table>
<thead>
<tr>
<th>Drug</th>
<th>February 16-22</th>
<th>February 23-29</th>
<th>March 1-7</th>
<th>March 8-14</th>
<th>March 15-21</th>
<th>March 22-28</th>
<th>March 29-April 4</th>
<th>April 5-11</th>
<th>April 12-18</th>
<th>April 19-25</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amitriptyline</strong></td>
<td>3.921 (4.04)</td>
<td>3.919 (4.00)</td>
<td>3.919 (4.00)</td>
<td>3.919 (4.00)</td>
<td>3.919 (4.00)</td>
<td>3.919 (4.00)</td>
<td>3.919 (4.00)</td>
<td>3.919 (4.00)</td>
<td>3.919 (4.00)</td>
<td>3.919 (4.00)</td>
</tr>
<tr>
<td><strong>Lisinopril</strong></td>
<td>1.199 (1.20)</td>
<td>2.175 (2.18)</td>
<td>2.175 (2.18)</td>
<td>2.175 (2.18)</td>
<td>2.175 (2.18)</td>
<td>2.175 (2.18)</td>
<td>2.175 (2.18)</td>
<td>2.175 (2.18)</td>
<td>2.175 (2.18)</td>
<td>2.175 (2.18)</td>
</tr>
<tr>
<td><strong>Carvedilol</strong></td>
<td>1.400 (2.04)</td>
<td>1.400 (2.04)</td>
<td>1.400 (2.04)</td>
<td>1.400 (2.04)</td>
<td>1.400 (2.04)</td>
<td>1.400 (2.04)</td>
<td>1.400 (2.04)</td>
<td>1.400 (2.04)</td>
<td>1.400 (2.04)</td>
<td>1.400 (2.04)</td>
</tr>
<tr>
<td><strong>Verapamil</strong></td>
<td>1.450 (2.04)</td>
<td>1.450 (2.04)</td>
<td>1.450 (2.04)</td>
<td>1.450 (2.04)</td>
<td>1.450 (2.04)</td>
<td>1.450 (2.04)</td>
<td>1.450 (2.04)</td>
<td>1.450 (2.04)</td>
<td>1.450 (2.04)</td>
<td>1.450 (2.04)</td>
</tr>
<tr>
<td><strong>Lamivudine</strong></td>
<td>3.150 (3.24)</td>
<td>3.150 (3.24)</td>
<td>3.150 (3.24)</td>
<td>3.150 (3.24)</td>
<td>3.150 (3.24)</td>
<td>3.150 (3.24)</td>
<td>3.150 (3.24)</td>
<td>3.150 (3.24)</td>
<td>3.150 (3.24)</td>
<td>3.150 (3.24)</td>
</tr>
<tr>
<td><strong>Elogarid</strong></td>
<td>1.110 (1.07)</td>
<td>1.110 (1.07)</td>
<td>1.110 (1.07)</td>
<td>1.110 (1.07)</td>
<td>1.110 (1.07)</td>
<td>1.110 (1.07)</td>
<td>1.110 (1.07)</td>
<td>1.110 (1.07)</td>
<td>1.110 (1.07)</td>
<td>1.110 (1.07)</td>
</tr>
<tr>
<td><strong>Tenofovir</strong></td>
<td>4.230 (2.30)</td>
<td>4.230 (2.30)</td>
<td>4.230 (2.30)</td>
<td>4.230 (2.30)</td>
<td>4.230 (2.30)</td>
<td>4.230 (2.30)</td>
<td>4.230 (2.30)</td>
<td>4.230 (2.30)</td>
<td>4.230 (2.30)</td>
<td>4.230 (2.30)</td>
</tr>
</tbody>
</table>

*Table: Estimates of Total Weekly Fills and Relative Percentage Change From 2019 Estimates of Commonly Prescribed Drugs.*

*Weekly fill volume is the median fill volume of each drug group.

---

Muthiah Vaduganathan, MD, MPH  
Jeroen van Meijgaard, PhD  
Mandep R. Mehra, MD, MSc  
Jacob Joseph, MD  
Christopher J. O’Donnell, MD, MPH  
Haidar J. Warraich, MD
Universal Screening for SARS-CoV-2 in Women Admitted for Delivery

TO THE EDITOR: In recent weeks, Covid-19 has rapidly spread throughout New York City. The obstetrical population presents a unique challenge during this pandemic, since these patients arevailable on admission. Nasopharyngeal swabs were obtained from 210 of the 211 women (99.5%) who did not have symptoms of Covid-19; of these women, 29 (13.7%) were positive for SARS-CoV-2.

The prevalence of asymptomatic infection has limited generalizability to geographic regions with lower rates of infection, it underscores the risk of Covid-19 among asymptomatic obstetrical patients. Moreover, the true prevalence of infection may be underestimated because of false negative results of tests to detect SARS-CoV-2.

The potential benefits of a universal testing approach include the ability to use Covid-19 status to determine hospital isolation practices and bed assignments, inform neonatal care, and guide the use of personal protective equipment. Access to such clinical data provides an important opportunity to protect mothers, babies, and health care teams during these challenging times.

Desmond Sutton, M.D.
Karim Fuchs, M.D., M.H.A.
Mary D’Alton, M.D.
Dena Goffman, M.D.
Columbia University Irving Medical Center
New York, NY
Dg2020@cumc.columbia.edu

Figure 1. Symptom Status and SARS-CoV-2 Test Results among 215 Obstetrical Patients Presenting for Delivery.

Testing of Patients and Support Persons for Coronavirus Disease 2019 (COVID-19) Infection Before Scheduled Deliveries

Angela Bianco, MD, Ayisha B. Buckley, MD, Jessica Overby, DNP, Scott Smilen, MD, Brian Wagner, MD, Cheryl Dinglas, MD, Holly Loudon, MD, Alan Garely, MD, Michael Brodman, MD, and Joanna Stone, MD

OBJECTIVE: To evaluate the rate of coronavirus disease 2019 (COVID-19) infection with the use of universal testing in our obstetric population presenting for scheduled deliveries, as well as the concordance or discordance rate among their support persons during the initial 2-week period of testing. Additionally, we assessed the utility of a screening tool in predicting severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) testing results in our cohort.

METHODS: This was an observational study in which all women who were scheduled for a planned delivery within the Mount Sinai Health system from April 4 to April 15, 2020, were contacted and provided with an appointment for themselves as well as their support persons to undergo COVID-19 testing 1 day before their scheduled delivery. Both the patients and the support persons were administered a standardized screen specific for COVID-19 infection by telephone interview. Those support persons who screened positive were not permitted to attend the birth. All patients and screen-negative support persons underwent SARS-CoV-2 testing.

RESULTS: During the study period, 135 patients and 146 support persons underwent SARS-CoV-2 testing. The prevalence of asymptomatic COVID-19 infection was 15.5% (CI 9.8–21.2%) and 9.6% (CI 4.8–14.4%) among patients and support persons, respectively. The rate of discordance among tested pairs was 7.5%. Among patients with COVID-19 infection, 58% of their support persons also had infection; in patients without infection, lower than 38% of their support persons had infection.

CONCLUSION: We found that more than 15% of asymptomatic maternity patients tested positive for SARS-CoV-2 infection despite having screened negative with the use of a telephone screening tool. Additionally, 58% of their asymptomatic, screen-negative support persons also tested positive for SARS-CoV-2 infection. Alternatively, testing of the support persons of women who had tested negative for COVID-19 infection had a low yield for positive results. This has important implications for obstetric and newborn care practices as well as for health care professionals.

DOI: 10.1056/NEJMe2030815

The coronavirus disease 2019 (COVID-19), caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus, has been declared a pandemic by the World Health Organization as of March

Box 1. Telephone Screening Tool

All patients must answer these questions.
1. Do you have a fever or feel hot?
2. Do you have a cough, shortness of breath, or a sore throat?
3. Are you vomiting, or do you have diarrhea?
4. Do you have a rash?
Research Letters

Prevalence of SARS-CoV-2 Among Patients Admitted for Childbirth in Southern Connecticut

Developing an approach to care for pregnant and childbirth during the coronavirus disease 2019 (COVID-2019) crisis is a priority to (1) provide safe care to pregnant women and newborns, and (2) protect health care workers from infection. A study conducted in New York City reported a 13.5% prevalence of asymptomatic infection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in women presenting for childbirth. On March 30, 2020, an initially asymptomatic woman admitted to the Yale New Haven Health System developed cough and fever soon after childbirth, testing confirmed SARS-CoV-2 infection. This event prompted the development of a SARS-CoV-2 screening and testing program of patients presenting for childbirth; we report the prevalence detected in the first weeks of the program.

Methods | From April 2, 2020, to April 29, 2020, screening and testing of patients admitted for childbirth was initiated at Yale New Haven Health hospitals in southern Connecticut. Screening consisted of questions related to travel, contacts, and symptoms of COVID-19. All patients without a prior diagnosis of COVID-19 underwent SARS-CoV-2 polymerase chain reaction (PCR) testing of nasopharyngeal swabs, with rapid testing available. Patients scheduled for cesarean birth were screened and tested at preparative visits.

Hospital policies recommended universal mask use on clinical units by clinicians, patients, and support persons and limited each patient to 1 support person visitor for childbirth. For patients with symptoms of COVID-19, clinicians wore N95 respirators and a personal protective equipment (PPE) until results returned, continuing use for patients with positive test results. For patients without symptoms of COVID-19, clinicians wore cloth masks and appropriate personal protective equipment (PPE) until results returned, continuing use for patients with positive test results. Excluded patients diagnosed with COVID-19 prior to admission, or those who presented after delivery.

Table 1. Demographics and Characteristics of Patients Tested for SARS-CoV-2 Admission for Childbirth

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>SARS-CoV-2 PCR result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (y)</td>
<td>Positive (n = 30)</td>
</tr>
<tr>
<td>&lt; 35</td>
<td>14 (46.7)</td>
</tr>
<tr>
<td>35-44</td>
<td>10 (33.3)</td>
</tr>
<tr>
<td>45-54</td>
<td>6 (20.0)</td>
</tr>
<tr>
<td>&gt; 54</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Nulliparity</td>
<td>16 (53.3)</td>
</tr>
<tr>
<td>Cesarean delivery</td>
<td>5 (16.7)</td>
</tr>
<tr>
<td>APAR score</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>&gt; 24 hours</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Maternal body mass index</td>
<td>1330 (41.2)</td>
</tr>
<tr>
<td>&lt; 18.5</td>
<td>47 (15.3)</td>
</tr>
<tr>
<td>18.5-24.9</td>
<td>144 (48.0)</td>
</tr>
<tr>
<td>&gt; 24.9</td>
<td>39 (13.0)</td>
</tr>
<tr>
<td>Maternal height, cm</td>
<td>163 (53.3)</td>
</tr>
<tr>
<td>Maternal weight, kg</td>
<td>1330 (41.2)</td>
</tr>
<tr>
<td>Maternal height/weight</td>
<td>1 (0.0)</td>
</tr>
<tr>
<td>&gt; 24 hours</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Maternal body mass index</td>
<td>1330 (41.2)</td>
</tr>
<tr>
<td>&lt; 18.5</td>
<td>47 (15.3)</td>
</tr>
<tr>
<td>18.5-24.9</td>
<td>144 (48.0)</td>
</tr>
<tr>
<td>&gt; 24.9</td>
<td>39 (13.0)</td>
</tr>
</tbody>
</table>

Abbreviations: COVID-19, coronavirus disease 2019; PCR, polymerase chain reaction; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

The overall prevalence of positive test results among asymptomatic women was 2.9% (22/756). Prevalence of positive test results among asymptomatic patients increased from 0.6% (2/346) to 5% (17/346) from the first 2 weeks (April 2-9, 2020) to the second 2 weeks (April 16-26, 2020), though the prevalence of symptomatic patients who tested positive in the total population with positive for childbirth decreased from 1.4% (4/303) to 0.7% (3/405) (Table 2). Fifty-seven percent (51/86) of patients with symptoms tested positive. No asymptomatic patients who tested negative developed symptoms or required further testing. The positive test results were from women admitted with fever, headache, rhinorrhea, sore throat, myalgias, congestion, cough, anosmia/ageusia. One patient had severe symptoms, including fever, myalgias, malaise, congestion and shortness of breath. No mild symptoms patients developed COVID-19-related complications. The severely symptomatic patient recovered from respiratory insufficiency with critical care and oxygen support via noninvasive mask.

and among US states, Connecticut had the 3rd highest death rate per capita from COVID-19, indicating a substantially affected region. The increasing prevalence of positive SARS-CoV-2 test results in the asymptomatic population, while the prevalence of symptomatic infections decreased, may indicate that universal testing identifies patients in a convalescent period, in addition to those with subclinical active infection. Although performed in mixed community and academic hospital settings, limitations of the findings include a short duration and a single geographic region.

Approaches to care that balance screening and testing of patients combined with a rationalized use of PPE should be considered for obstetric units.

Katherine H. Campbell, MD, MPH
Jean M. Tornatore, MD
Kirsten E. Lawrence, MD
Jessica L. Illuzzi, MD
L. Scott Sussman, MD
Heather S. Lipkind, MD
Christian M. Petitt, MD

Author Affiliations: Department of Obstetrics, Gynecology, and Reproductive Sciences, Yale School of Medicine, New Haven, Connecticut; Lawrence, Illuzzi, Lipkind, Petitt)
Department of Obstetrics and Gynecology, Bridgeport Hospital, Bridgeport, Connecticut (Tornatore); Clinical Redesign, Yale-New Haven Health, New Haven, Connecticut (Sussman).
Corresponding Author: Katherine H. Campbell, MD, MPH, Department of Obstetrics, Gynecology, and Reproductive Sciences, Yale School of Medicine, 330 Cedar St, FMB 302, New Haven, CT 06520-8063 (katherin.campbell@yale.edu).
Accepted for Publication: May 11, 2020.
Published Online: May 26, 2020. doi:10.1001/jama.2020.8604
Author Contributions: Dr Campbell had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.
Concept and design: Campbell, Illuzzi, Sussman, Lipkind, Petitt
Acquisition, analysis, or interpretation of data: Campbell, Tornatore, Lawrence, Illuzzi, Lipkind, Petitt
Drafting of the manuscript: Campbell, Illuzzi, Lipkind, Petitt
Critical review of the manuscript for important intellectual content: All authors.
Statistical analysis: Illuzzi, Lipkind, Petitt
Administrative, technical, or material support: Tornatore, Lipkind, Petitt
Supervision: Lawrence, Illuzzi, Lipkind, Petitt
Conflict of Interest Disclosures: None reported.

Table 2. SARS-CoV-2 Test Results for Patients Tested at Admission for Childbirth, Stratified by Symptoms

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Asymptomatic</th>
<th>Symptomatic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>2 (6.7)</td>
<td>3 (6.7)</td>
</tr>
<tr>
<td>Negative</td>
<td>553 (97.7)</td>
<td>51 (93.3)</td>
</tr>
</tbody>
</table>

Abbreviations: COVID-19, coronavirus disease 2019; PCR, polymerase chain reaction; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

Signs and symptoms of COVID-19 in patients with positive SARS-CoV-2 test results were mild in 7 patients, including fever, headache, rhinorrhea, sore throat, myalgias, congestion, cough, anosmia/ageusia. One patient had severe symptoms, including fever, myalgias, malaise, congestion and shortness of breath. No mild symptoms patients developed COVID-19-related complications. The severely symptomatic patient recovered from respiratory insufficiency with critical care and oxygen support via noninvasive mask.
"Real Housewives" star Kara Keough Bosworth opens up about the heartbreaking loss of her newborn son

Over the past month, "Real Housewives of Orange County" star Kara Keough Bosworth has been speaking out about the loss of her son, who she and her husband, Nick, welcomed on April 12. But even as she has shared her grief, she has also spoken about the hope and love that has come from the experience.

Bosworth lost her son, who she and Nick named Nick Jr., after he was born prematurely on April 12. They had been expecting a healthy baby, but things went wrong when he was born. The baby was born with a rare condition that left him with Down syndrome, and he passed away just a few days later.

Bosworth and her husband have been open about their grief and have shared their story on social media. They have posted about the love and support they have received from their friends and family, and they have spoken about the importance of being open about their experience.

Bosworth has also shared her story with other parents who have experienced similar losses. She has been advocating for research into Down syndrome and has been speaking out about the importance of early intervention and support for families who are dealing with the loss of a child.

Bosworth and her husband have been working to honor their son's memory. They have started a foundation called "The Nick Jr. Foundation," which is dedicated to raising awareness about Down syndrome and providing support for families who are dealing with the loss of a child.

Bosworth and her husband have also been working to raise money for research into Down syndrome. They have been hosting events and raising money through their foundation, and they have also been working with other organizations to raise awareness about the condition.

Bosworth and her husband have also been working to raise awareness about the importance of early intervention and support for families who are dealing with the loss of a child. They have been speaking out about the importance of being open about their experience and have been encouraging other parents to share their stories.

In an interview with PEOPLE, Bosworth said, "I know that Nick Jr. would want us to keep going. He would want us to keep moving forward. He would want us to keep living our lives. And I know that's what he would want."

Bosworth and her husband are working to honor their son's memory and to raise awareness about Down syndrome. They are a true inspiration to others who are dealing with the loss of a child.
COVID-19 Considerations for Pregnant People

• There appears to be nothing pregnancy specific for COVID19
  – Maternal risk does not seem greater than general population (this is not H1N1)
  – Fetal/newborn risk does not seem greater (this is not Zika)
  – Not transmitted in breast milk

• Health Care Provider Safety – limited PPE and staffing
  – Limited to know other people in delivery room – lack of support for people in labor
    – People with OUD may need more support

• The biggest risk is the unknown
  – Maternal/newborn separation following delivery
  – Limited “rooming in” in NICUs with restrictions on number of transits per day
    – People with OUD may feel less autonomy in resisting – and may suffer sequelae of separation more
COVID-19 General Response(s)

• Primary Response:
  – Provision of continuing care via (primarily) remote/tele services

• Under-emphasized:
  – Considerations for people with untreated addiction
  – Providers need to see new patients (either virtually or in-person)

• Lacking attention to “Special Populations”:
  – Pregnant people – for whom some in-person visits are essential (ie for prenatal care)
  – People with SUD – how they are experiencing the pandemic, social isolation, the in-person clinic experience

• Public Health/Public Policy: Balance staff safety and support of remote services with person-centered care
Caring for Women Who Are Planning a Pregnancy, Pregnant, or Postpartum During the COVID-19 Pandemic

Soraya A. Ramnussen, MD, MS, Denise J. Jamieson, MD, MPH

Since its recognition in China in December 2019, coronavirus disease 2019 (COVID-19), caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), has rapidly spread throughout the world and become a pandemic. Although considerable data on COVID-19 are available, much remains to be learned about its effects on pregnancy.

No data are currently available to assess whether pregnant women are more susceptible to COVID-19. Pregnant women are at risk for severe respiratory illnesses (eg, 2009 H1N1 influenza),1 but this, for pregnant women with COVID-19 is not apparent or at increased risk for severe disease compared with the general population. Data from China showed that among 147 pregnant women, 8% had severe disease and 1% had critical illness, which are lower rates than observed in the nonpregnant population (94% for severe disease and 6% with critical illness).2 Case series from China consisting primarily of women with third trimester infection have shown that clinical findings in pregnant women are similar to those seen in the general population.3 Conversely, a small Swedish study reported that pregnant and postpartum women with COVID-19 were 3 times more likely to be admitted to an intensive care unit compared with nonpregnant women of similar age.4

Data on pregnant women with COVID-19 in the US are beginning to accumulate. For example, a recent report included 43 pregnant women with COVID-19 who presented for care at 2 hospitals in New York City.5 Although this case series did not include a nonpregnant control group, the proportion of pregnant women with severe disease was similar to that described in nonpregnant adults with COVID-19.6 More information is needed about the effect of pregnancy and comorbidities to understand how they affect clinical outcomes of COVID-19. The US experience might differ from other countries because of the high frequency of comorbidities among pregnant women in the US.

The effects of COVID-19 during pregnancy are not well understood. Nearly all infections reported from China were during the third or late second trimester, so whether first trimester SARS-CoV-2 infection might cause birth defects or pregnancy loss is unknown. Some newborns born to mothers with COVID-19 during pregnancy were born preterm or of low birth weight, but whether these outcomes were COVID-19 related is unclear. SARS-CoV-2 transmission from a mother to her newborn could occur perinatally, postnatally or postnatally in 3 newborns tested after birth, results have been negative for SARS-CoV-2.7 However, symptomatic newborns born to mothers with COVID-19 have been reported to have SARS-CoV-2 infection at a few days of life; whether this was due to perinatal, neonatal or postnatal transmission is unknown. Recently, a probable case of congenital infection was reported in a newborn born to a woman with familial neutropenia who was diagnosed with COVID-19 before delivery. A neonatal sepsis workup was collected on the day of birth prior to skin-to-skin maternal contact was possible.8 The presence of IgM and IgG antibodies in 3 infants born to mothers with COVID-19 during pregnancy was recently reported.9 IgG antibodies freely cross the placenta; however, IgM antibodies do not typically cross the placenta, suggesting the possibility of prenatal transmission of SARS-CoV-2. However, these studies do not provide definitive evidence for intrauterine transmission because cross-reactivity and false-positive IgM test results can occur.10 Whether transmission occurs in utero through breastfeeding on pregnant women with COVID-19 who have been detected in breastmilk samples from a single woman with COVID-19, and her infant tested positive for SARS-CoV-2, but whether the mother is less severe for severe disease has been described.11 Given the benefits of breast milk, when feasible, breast milk should be offered to infants regardless of maternal COVID-19 status. Based on experimental evidence with other infections (eg, influenza), adverse effects on the fetus or newborn related to prenatal infection might occur even without intrauterine transmission. For example, severe maternal illness with severe disease and high risk of requiring intensive care admission was associated with increased risks for preterm birth, low birth weight, and low Apgar scores.12 Whether an increased risk for adverse outcomes among newborns born to women with COVID-19 will be seen is unknown. Given the limited data, recommendations for caring for women who are planning a pregnancy, pregnant, or have given birth during the COVID-19 pandemic are based on expert opinion. Women planning a pregnancy in the time of COVID-19 might ask whether they should delay pregnancy until after the pandemic. Based on limited data, there does not seem to be a compelling reason to recommend delaying pregnancy. For women who are pregnant, the primary recommendation is to avoid becoming infected with SARS-CoV-2 through hygiene and social distancing measures. Early recognition of COVID-19 in a pregnant patient admitted to a labor and delivery unit is necessary for appropriate infection control practices cannot be overemphasized. Given that some women with COVID-19 might be asymptomatic or pre-symptomatic, health care facilities may consider polymerase chain reaction testing for SARS-CoV-2 RNA admission.

Guidelines for the care of pregnant women known or suspected to have COVID-19 admitted for delivery have been developed by the Centers for Disease Control and Prevention (CDC) and several professional organizations (Box). On presentation, a mask should be placed on the woman and the mask should be isolated in a single-patient room with the door closed. Measures for the isolation of patients have been updated for aerosol-generating procedures. Clinical care of a pregnant woman with COVID-19 should be based on illness severity, diagnosis and treatment of neonatal COVID-19, and postnatal transmission. Given the risks of maternal respiratory depression, consideration for应该 be given to limiting the use of magnesium sulfate for seizure prophylaxis and fetal neuroprotection. Given concerns about potential harm from corticosteroid use in patients with COVID-19, antenatal corticosteroid use for fetal maturation should be carefully considered and should depend on the gestational age. Early epidural analgesia should be considered to mitigate the risks associated with general anesthesia in the setting of an urgent cesarean delivery (SARSMF, SOAM).

Box. Recommendations for Care of Pregnant Women Confirmed or Suspected to Have Coronavirus Disease 2019 (COVID-19)

**Recommendations**

- Place a mask on the patient on presentation and isolate in a single-person room with the closed door. Airborne isolation rooms should be used for aerosolizing procedures (ACOG, CDC, SMFM, SOAP).
- Consider separating patients with COVID-19 in one area of the obstetric unit and using a designated team of trained clinicians in these areas (SMFM, SOAM).
- Weigh benefits and risks of magnesium sulfate for fetal neuroprotection or for preeclampsia/intrapartum seizure prophylaxis given potential maternal respiratory depression (SARSMF, SOAM).
- Consider adjusting antenatal corticosteroid use for fetal maturation, given the risk of worsening patient outcomes with corticosteroid in patients with COVID-19 (eg, offer antenatal steroids for patients >34 weeks’ gestation, weigh risks and benefits and individualize decisions for >34 weeks’ gestation) (ACOG, SMFM, SOAP).
- Consider early epidural analgesia to mitigate the risks associated with general anesthesia in the setting of an urgent cesarean delivery (SMFM, SOAM).
- Do not alter delivery timing or mode (eg, cesarean delivery, operative vaginal delivery) due to patients’ COVID-19 infection status. However, for women with COVID-19 in the third trimester, it may be reasonable to attempt to postpone delivery to decrease risk of neonatal transmission (ACOG).
- Consider temporary separation of mothers with confirmed COVID-19 from their newborns (ACOG, AAP, CDC).
- Determination of whether to temporarily separate a mother with known or suspected COVID-19 should be made on a case-by-case basis, using shared decision-making (ACOG, CDC).

If temporary separation is chosen, mothers who intend to breastfeed should practice hand and breast hygiene and express their milk. Expressed milk can be fed to the newborn by a healthy caregiver (ACOG, AAP, CDC, SMFM, SOAP).

- If separation is not chosen, use other measures to reduce risk of infection, such as physical barriers and face mask use by the mother (AAP, CDC).

- Mothers who choose to feed at the breast should wear a face mask and practice hand and breast hygiene before each feeding (AAP, ACOG, CDC, SMFM, SOAP).

- Newborns born to mothers with confirmed COVID-19 at the time of delivery should be considered to have suspected COVID-19 and be isolated from healthy newborns (AAP, ACOG, CDC).

- Newborns born to mothers with confirmed or suspected COVID-19 at the time of delivery should be tested 24 hours after birth for SARS-CoV-2 and, if negative, at approximately 48 hours if testing capacity is available (AAP, CDC).

**Professional Organization Resources**

American Academy of Pediatrics (AAP) initial guidance and FAQs

American College of Obstetricians and Gynecologists (ACOG) practice advisory and FAQs

Centers for Disease Control and Prevention (CDC)

Society for Maternal-Fetal Medicine (SMFM) and Society for Obstetric Anesthesia and Perinatology (SOAP)

jama.com

*JAMA* Published Online June 5, 2020
COVID19 Public Policy and Public Health Response

• Federal (and State) regulations – eased in support of telehealth services
• Addiction Providers: decrease in volume (due to extended prescriptions, decreased hours and etc) leads to decrease income
• Prenatal Care Providers: slight decrease in volume (due to spaced out visits) with no change in clinic income (due to bundled payment)
• What about co-located services? The standard of care in addiction treatment during pregnancy?
• Increased attention to racial inequities in health (COVID-19 and Birth)
In Chicago, 70% of COVID-19 Deaths Are Black

The coronavirus pandemic is hitting black and brown Americans especially hard on all fronts.

The COVID-19 pandemic has revealed stark racial disparities in the United States, with black and brown communities disproportionately affected. According to data from the Centers for Disease Control and Prevention (CDC), as of [insert date], black and brown Americans accounted for a disproportionately high number of COVID-19 deaths compared to their share of the population. This disparity is evident in both urban and rural areas, highlighting the urgent need for equitable healthcare and support systems.

In Chicago, for example, the city has been hit particularly hard. As of [insert date], black and brown residents represented [insert percentage] of the city's population, but accounted for [insert percentage] of the total COVID-19 deaths. This statistic underscores the critical importance of addressing systemic racism and inequalities in healthcare access and public health initiatives.

Related content:
- Transportation: U.S. air travel and its impact on communities
- Routes beyond race: African American history and its role in pandemic response
- COVID-19 deaths by race and ethnicity in the U.S.

Search by state:
(Customize search to select more than one state.)

[Graph showing COVID-19 deaths by race and ethnicity in the U.S.]
Hospitalization and Mortality among Black Patients and White Patients with Covid-19

Eboni G. Price-Haywood, M.D., M.P.H., Jeffrey Burton, Ph.D., Daniel Fort, Ph.D., and Leonardo Seoane, M.D.

ABSTRACT

BACKGROUND

Many reports on coronavirus disease 2019 (Covid-19) have highlighted age- and sex-related differences in health outcomes. More information is needed about racial and ethnic differences in outcomes from Covid-19.

METHODS

In this retrospective cohort study, we analyzed data from patients seen within an integrated-delivery health system (Ochsner Health) in Louisiana between March 1 and April 11, 2020, who tested positive for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes Covid-19 on qualitative polymerase-chain-reaction assay. The Ochsner Health population is 33% black non-Hispanic and 66% white non-Hispanic. The primary outcomes were hospitalization and in-hospital death.

RESULTS

A total of 3626 patients tested positive, of whom 145 were excluded (84 had missing data on race or ethnic group, 9 were Hispanic, and 52 were Asian or of another race or ethnic group). Of the 3481 Covid-19-positive patients included in our analyses, 60.0% were female, 70.4% were black non-Hispanic, and 29.6% were white non-Hispanic. Black patients had higher prevalences of obesity, diabetes, hypertension, and chronic kidney disease than white patients. A total of 39.7% of Covid-19-positive patients (1382 patients) were hospitalized, 76.9% of whom were black. In multivariable analyses, black race, increasing age, a higher score on the Charlson Comorbidity Index (indicating a greater burden of illness), public insurance (Medicare or Medicaid), residence in a low-income area, and obesity were associated with increased odds of hospital admission. Among the 326 patients who died from Covid-19, 70.6% were black. In adjusted time-to-event analyses, variables that were associated with higher in-hospital mortality were increasing age and presentation with an elevated respiratory rate; elevated levels of venous lactate, creatinine, or procalcitonin; or low platelet or lymphocyte counts. However, black race was not independently associated with higher mortality (hazard ratio for death vs. white race, 0.89; 95% confidence interval, 0.68 to 1.17).

CONCLUSIONS

In a large cohort in Louisiana, 76.9% of the patients who were hospitalized with Covid-19 and 70.6% of those who died were black, whereas blacks comprise only 33% of the Ochsner Health population. Black race was not associated with higher in-hospital mortality than white race, after adjustment for differences in sociodemographic and clinical characteristics on admission.

Table 1 (Continued)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>White Non-Hispanic (N=1030)</th>
<th>Black Non-Hispanic (N=2451)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location of testing — no. (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care</td>
<td>222 (21.6)</td>
<td>337 (13.7)</td>
</tr>
<tr>
<td>Urgent care</td>
<td>196 (19.0)</td>
<td>215 (8.8)</td>
</tr>
<tr>
<td>Emergency department</td>
<td>391 (38.0)</td>
<td>1601 (65.3)</td>
</tr>
<tr>
<td>Inpatient</td>
<td>27 (2.6)</td>
<td>77 (3.1)</td>
</tr>
<tr>
<td>Other or unknown service area</td>
<td>194 (18.8)</td>
<td>221 (9.0)</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Characteristic</th>
<th>White Non-Hispanic (N=1382)</th>
<th>Black Non-Hispanic (N=1030)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age — yr</td>
<td>65.2±10.8</td>
<td>60.5±14.8</td>
</tr>
<tr>
<td>Female sex – no. (%)</td>
<td>127 (9.4)</td>
<td>578 (54.4)</td>
</tr>
<tr>
<td>Charlson Comorbidity Index score</td>
<td>3.6±1.8</td>
<td>3.3±2.2</td>
</tr>
<tr>
<td>Insurance – no. (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial</td>
<td>89 (27.3)</td>
<td>417 (39.2)</td>
</tr>
<tr>
<td>Medicare</td>
<td>178 (53.4)</td>
<td>458 (43.1)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>38 (5.6)</td>
<td>124 (11.7)</td>
</tr>
<tr>
<td>Self-pay or other</td>
<td>34 (10.7)</td>
<td>64 (6.0)</td>
</tr>
<tr>
<td>Residence in low-income area — no. (%)</td>
<td>108 (33.9)</td>
<td>643 (60.5)</td>
</tr>
</tbody>
</table>
COVID-19 is affecting people of color the most. We're tracking the data in real time.

The COVID Racial Data Tracker is a collaboration between the COVID Tracking Project and the Antiracist Research & Policy Center. Together, we're gathering the most complete race and ethnicity data on COVID-19 in the United States.

We've lost at least 20,399 Black lives to COVID-19 to date.

Black people account for:

- 13% of the US population
- 25% of deaths where race is known

This means Black people are dying at a rate nearly 2 times higher than their population share.

We've asked every state to report complete race and ethnicity data. Our Racial Data Dashboard has the latest.

States and territories reporting race and ethnicity data:

- 48 states/territories
- 42 states/territories

See the dashboard —
Get the complete dataset (CSV) —
Learn more about the tracker —

https://covidtracking.com/race
Covid-19 Restrictions on Birth & Breastfeeding: Disproportionately Harming Black and Native Women

By: Kimberly Seals Allers | March 27, 2020

COVID-19 Is No Reason to Abandon Pregnant People

New rules prohibiting spouses or doulas during labor and delivery in many New York City hospitals are putting vulnerable populations at greater risk

By Monica R. McLemore on March 26, 2020

National Advocates for Pregnant Women

What We Can Learn From Hospital Restrictions on Birth Support During the Coronavirus Pandemic

The coronavirus pandemic, and our country’s lack of preparedness for it, give us an opportunity to make important observations and learn (or relearn) key lessons. Foundational issues including severe income inequality, lack of a national health care system, and corporatization of public goods and services are being exposed during this pandemic. Also exposed are the Trump Administration’s totally inadequate, often misleading and counterproductive responses to the coronavirus that have put all of us at risk.

For example, as Dr. Anne-Marie Slaughter explained in a New York Times op-ed, South Korea institutionalized health care companies to make coronavirus tests in late January, when the country had only four cases. Soon, 10,000 Koreans a day were being tested, and now new infections are dropping. The first cases in the United States were identified in January, too, and yet we still don’t have enough tests.
COVID19 Pregnancy and SUD: Opportunities for Positive Practice Change But also Increasing Latitude of Harm
Home- versus office-based
Observed versus unobserved BUP inductions

• Home-based unobserved BUP induction and office-based observed induction are equally effective (Home induction not inferior)

• In-person is not essential to initiate BUP for OUD

• COVID-19 Response: can initiate via telephone (in addition to HIPAA-approved telehealth platforms)

• Hence pandemic response is not inferior care
Regula

Home- versus office-base for opioid-dep

Nancy L. Sohler (Ph.D., M.P.H.)a,b,c,d, Xuan Li, (M.D., M.P.H.)b,c,d, Gali Sacedaj, (M.D., M.P.H.)f,g, Susan Whitley, (M.D.)h, Chiñao

aSoraya DeSoto School of Biomedical Education, Community Health and Soci
bMount Sinai Medical Center and the Albert Einstein College of Medicine
bMount Sinai Medical Center and the Albert Einstein College of Medica
fBellevue Hospital Center, Opioid Addiction I

Received 25 May 2009; received in revised form 14 September 2009

Abstract

Recent legislation permits the treatment of opioid-dependent pa
t the development of new treatment models for opioid depen
dent patient self-management by giving patients the opportunity to choos
We examined whether patients who had home-based inductions ac
duced in a study of 115 opioid-dependent patients treated i
78.6% in office-based group versus 40 (78.6%) in home-base
which likely influ

Introduction

New legislation permits buprenorphine, a partial opioid agonist, to be used for the treatment of opioid dependence in the primary care setting (Drug Addiction Treatment Act, 2009). This provides opportunities to begin to develop and implement new treatment approaches for addiction care more generally. The Chronic Care Model (CCM), designed to improve long-term care for patients with chronic diseases (Wagner, 1998; Wagner et al., 2001), has great potential to

1. Introduction

Buprenorphine treatment is associated with positive health outcomes, including reduction in opioid use and HIV risk behaviors (Carriero et al., 2002; Fadul et al., 2003; Johnson et al., 1995; Johnson, Jaffe, & Findlay, 1992; Johnson et al., 2000; Liao, Wesson, Chantavata, & Klet, 1996; Lov, Strain, Brooner, Bigelow, & Johnson, 2006; March et al., 2005; Pari, Marmarou, Pirata, Tagliamento, & Gessa, 2000; Pertjewa et al., 2001; Schottenfeld, Pales, Oliveto, Zioda, & Kosten, 1997; Strain, Sitter, Liebow, & Bigelow, 1996; Sullivan et al., 2006). Despite these benefits, buprenorphine treatment is not widespread in the United States (Flinn, 2007). One reason for limited buprenorphine treatment is the challenge patients and providers face with buprenorphine induction (Cunningham, Kunis, Roose, Elam, & Sohler, 2007; Walley et al., 2008).

Fig. 2. Any drug use over time by induction strategy.
Remote Assessment for New Patients

- Establish Diagnosis (DSM-5)
- Review PMP
- History of recent drug use, withdrawal symptoms, etc
- Naloxone co-prescribing
- Consider symptomatic medications for withdrawal
- Drug testing (urine, saliva, etc) not essential
- Pregnancy test – not needed for medication initiation for OUD
Urine Drug Testing: Opportunity for Positive Practice Change

• Increase in tele-services decrease urine drug testing
• Urine drug testing not recommended for assessment of substance use disorder in pregnancy
• Urine testing at time of delivery – problematic

• Addiction Medicine response to COVID-19: Opportunity to rethink role of urine drug testing in prenatal and addiction care
The 4th Trimester - Postpartum

• Critical Period
  – Newborn care, breastfeeding, maternal/infant bonding
  – Mood changes, sleep disturbances, physiologic changes
  – Cultural norms, “the ideal mother” in conflict with what it is actually like to have a newborn
  – Insurance and welfare realignment

• Neglected Period
  – Care shifts from frequent to infrequent
  – From Mom-focused (PNC provider) to Baby-focused (Pediatrician)
  – From “medical” to “social” (WIC)
  – Continuity of Care: Addiction Provider
### Table 1

<table>
<thead>
<tr>
<th>Location</th>
<th>Sample size</th>
<th>Mean age</th>
<th>Racial composition</th>
<th>Mean (SD or 95% CI) treatment - SD delivery (mg)</th>
<th>MAT medication and dosage information</th>
<th>Discontinuation rates and other treatment attendance results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Randomized controlled trials</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hayes et al. (2011)</td>
<td>Johns Hopkins Center for Addiction and Pregnancy, Baltimore, MD</td>
<td>n = 133</td>
<td>27.4 (range 16.9-39.5)</td>
<td>30.0</td>
<td>17.4</td>
<td>African Americans, 25.36</td>
</tr>
<tr>
<td>Jones et al. (2010)</td>
<td>Johns Hopkins Center for Addiction and Pregnancy, Baltimore, MD</td>
<td>n = 36</td>
<td>27.9 (range 16.9-39.5)</td>
<td>28.4</td>
<td>22</td>
<td>African Americans, 25.36</td>
</tr>
<tr>
<td>Jones et al. (2009)</td>
<td>Johns Hopkins Center for Addiction and Pregnancy, Baltimore, MD</td>
<td>n = 13</td>
<td>27.9 (range 16.9-39.5)</td>
<td>28.4</td>
<td>22</td>
<td>African Americans, 25.36</td>
</tr>
<tr>
<td>Jones et al. (2008)</td>
<td>Johns Hopkins Center for Addiction and Pregnancy, Baltimore, MD</td>
<td>n = 30</td>
<td>27.9 (range 16.9-39.5)</td>
<td>28.4</td>
<td>22</td>
<td>African Americans, 25.36</td>
</tr>
<tr>
<td>Jones et al. (2007)</td>
<td>Johns Hopkins Center for Addiction and Pregnancy, Baltimore, MD</td>
<td>n = 13</td>
<td>27.9 (range 16.9-39.5)</td>
<td>28.4</td>
<td>22</td>
<td>African Americans, 25.36</td>
</tr>
<tr>
<td>Jones et al. (2006)</td>
<td>Johns Hopkins Center for Addiction and Pregnancy, Baltimore, MD</td>
<td>n = 13</td>
<td>27.9 (range 16.9-39.5)</td>
<td>28.4</td>
<td>22</td>
<td>African Americans, 25.36</td>
</tr>
<tr>
<td>Silverman et al. (2005)</td>
<td>Johns Hopkins Center for Addiction and Pregnancy, Baltimore, MD</td>
<td>n = 80</td>
<td>27.9 (range 16.9-39.5)</td>
<td>28.4</td>
<td>22</td>
<td>African Americans, 25.36</td>
</tr>
<tr>
<td>Biddle et al. (2007)</td>
<td>Johns Hopkins Center for Addiction and Pregnancy, Baltimore, MD</td>
<td>n = 80</td>
<td>27.9 (range 16.9-39.5)</td>
<td>28.4</td>
<td>22</td>
<td>African Americans, 25.36</td>
</tr>
<tr>
<td>Cohen studies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pires and Adinolfi (2008)</td>
<td>Tel Aviv, Israel</td>
<td>n = 45 pregnant women</td>
<td>31.5</td>
<td>27.9 (range 16.9-39.5)</td>
<td>28.4</td>
<td>22</td>
</tr>
<tr>
<td>McCarthy et al. (2005)</td>
<td>Sacramento, CA</td>
<td>n = 54</td>
<td>31.5</td>
<td>27.9 (range 16.9-39.5)</td>
<td>28.4</td>
<td>22</td>
</tr>
<tr>
<td>Labin et al. (2007)</td>
<td>Nashville, TN</td>
<td>n = 48</td>
<td>28.4</td>
<td>22</td>
<td>African Americans, 25.36</td>
<td>Caucasian, 21.3</td>
</tr>
<tr>
<td>Labin and Agee (1996b)</td>
<td>Nashville, TN</td>
<td>n = 28</td>
<td>28.4</td>
<td>22</td>
<td>African Americans, 25.36</td>
<td>Caucasian, 21.3</td>
</tr>
<tr>
<td>DePutte and Rose (1995)</td>
<td>Location not identified</td>
<td>n = 49</td>
<td>28.4</td>
<td>22</td>
<td>African Americans, 25.36</td>
<td>Caucasian, 21.3</td>
</tr>
<tr>
<td>Chappell and Sanaye (1975)</td>
<td>Special Treatment Unit, Illinois Drug Abuse Program, Chicago, IL</td>
<td>n = 11</td>
<td>28.4</td>
<td>22</td>
<td>African Americans, 25.36</td>
<td>Caucasian, 21.3</td>
</tr>
<tr>
<td>Case control studies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conrado et al. (2004)</td>
<td>Honolulu, HI</td>
<td>n = 116</td>
<td>28.4</td>
<td>22</td>
<td>African Americans, 25.36</td>
<td>Caucasian, 21.3</td>
</tr>
<tr>
<td>Observational studies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flax et al. (2007)</td>
<td>Johns Hopkins Center for Addiction and Pregnancy, Baltimore, MD</td>
<td>n = 160</td>
<td>28.4</td>
<td>22</td>
<td>African Americans, 25.36</td>
<td>Caucasian, 21.3</td>
</tr>
<tr>
<td>Flax et al. (2006)</td>
<td>Johns Hopkins Center for Addiction and Pregnancy, Baltimore, MD</td>
<td>n = 160</td>
<td>28.4</td>
<td>22</td>
<td>African Americans, 25.36</td>
<td>Caucasian, 21.3</td>
</tr>
</tbody>
</table>

### Fig. 1.
Kaplan-Meier estimates for remaining in methadone treatment after pregnancy.
Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts

Table 2. Opioid Overdose Rates Among Pregnant and Parenting Women With Evidence of Opioid Use Disorder in the Year Before Delivery (n=4,154)

<table>
<thead>
<tr>
<th>Period Relative to Delivery</th>
<th>All OD Events (per 100,000 person-days)</th>
<th>OD Events While Receiving Pharmacotherapy (per 100,000 person-days)</th>
<th>OD Events Not Receiving Pharmacotherapy (per 100,000 person-days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>7.99 (7.01-9.06)</td>
<td>4.43 (3.28-5.86)*</td>
<td>10.04 (8.67-11.56)*</td>
</tr>
<tr>
<td>Year before delivery (9-12 mo)</td>
<td>9.72 (6.91-13.29)</td>
<td>3.74 (1.02-9.57)</td>
<td>11.89 (8.28-16.54)</td>
</tr>
<tr>
<td>Trimester (weeks of gestation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st (0-12)</td>
<td>8.88 (6.04-12.61)</td>
<td>4.79 (1.56-11.18)</td>
<td>10.63 (6.94-15.58)</td>
</tr>
<tr>
<td>2nd (13-28)</td>
<td>3.23 (1.81-5.32)</td>
<td>1.20 (0.15-4.35)</td>
<td>4.35 (2.32-7.44)</td>
</tr>
<tr>
<td>3rd (29 or greater)</td>
<td>3.32 (1.59-6.10)</td>
<td>4.08 (1.13-9.51)</td>
<td>2.60 (0.91-4.53)</td>
</tr>
<tr>
<td>Postpartum (mo)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-3</td>
<td>7.41 (4.92-10.71)</td>
<td>3.17 (1.03-7.41)</td>
<td>10.44 (6.62-15.67)</td>
</tr>
<tr>
<td>4-6</td>
<td>6.89 (4.50-10.10)</td>
<td>1.31 (0.16-4.74)*</td>
<td>10.67 (6.84-15.88)*</td>
</tr>
<tr>
<td>7-9</td>
<td>12.2 (8.93-16.28)*</td>
<td>6.74 (3.23-12.40)</td>
<td>15.75 (11.03-21.80)</td>
</tr>
<tr>
<td>10-12</td>
<td>12.35 (9.07-16.42)</td>
<td>10.84 (6.20-17.60)</td>
<td>13.3 (9.04-18.88)</td>
</tr>
</tbody>
</table>

OD: opioid overdose.
Data are rate/100,000 person-days (95% CI).
* Denotes statistically significant difference between overdose rates among women receiving pharmacotherapy vs women not receiving pharmacotherapy.
† Denotes statistically significant difference between overall overdose rates during third trimester and 7-12 months postpartum.
Postpartum Issues

• Breast Feeding:
  Attachment and Neonatal Abstinence Syndrome management (ESC) vs COVID-19 hospital policies

• Contraception:
  Sterilization at time of delivery
  Postpartum LARC

• Medication and addiction treatment continuation
  Telehealth for Postpartum Visits
Abstract
The World Health Organisation (WHO) has provided detailed guidance on the care of infants of women who are a person under investigation (PUI) or confirmed to have COVID-19, which supports immediate postpartum mother-infant contact and breastfeeding with appropriate respiratory precautions. Although many countries have followed WHO guidance, others have implemented infection prevention and control policies (IPC) that impose varying levels of postpartum separation and discourage or prohibit breastfeeding or provision of expressed breastmilk. These policies aim to protect infants from the potential harm of infection from their mothers, yet they may fail to fully account for the impact of separation. Global COVID-19 data are suggestive of potentially lower susceptibility and a typically milder course of disease among children, although the potential for severe disease in infancy remains. Separation causes cumulative harms, including disrupting breastfeeding and limiting its protection against infectious disease, which has disproportionate impacts on vulnerable infants. Separation also presumes the replaceability of breastfeeding—a risk that is magnified in emergencies. Moreover, separation does not ensure lower viral exposure during hospitalizations and post-discharge, and contributes to the burden on overwhelmed health systems. Finally, separation magnifies maternal health consequences of insufficient breastfeeding and compounds trauma in communities who have experienced long-standing inequities and violence, including family separation. Taken together, separating PUI/confirmed SARS-CoV-2 positive mothers and their infants may lead to excess preventable illnesses and deaths among infants and women around the world. Health services must consider the short-and-long-term impacts of separating mothers and infants in their policies.

Key Words
COVID-19; SARS-CoV-2; Mother-infant separation; Breastfeeding

Key Messages
1. The World Health Organization has provided comprehensive guidance that promotes proximity and breastfeeding for mothers and infants affected by COVID-19.
2. Some settings followed WHO guidance, while others implemented policies that impose separation on COVID-19-affected mothers and infants.
3. Separation policies aim to protect infants from potential harm from maternal infection with SARS-CoV-2, but fail to account for the impacts of separation.
4. Separation policies have detrimental effects on breastfeeding, and do not ensure lower viral exposure, resulting in potential excess deaths.
5. Health services must consider the full impacts of separating mothers and infants in their policies.
Child Welfare: Concerning Trends

- Opioid Crisis and Foster Care Epidemic
- Racial Inequities Along Child Welfare Continuum

- COVID-19 Response:
  - Delay in Family Court Hearings
  - Denial of Visitation for Parents
  - Insistence on Tele-visits for Newborns (!)

  - In context of continued increase in reporting and removals
Child Welfare: Concerning Trends

• Children’s Bureau Response:

  • Refrain from making sweeping, blanket orders ceasing, suspending, or postponing court hearings;
  • Ensure that important decisions about when and how hearings are conducted are made on a case-by-case basis in accordance with the facts of each individual matter;
  • Encourage attorneys to file written motions raising issues of immediate concern;
  • Make maximum use of technology to ensure due process where in-person hearings are not possible or appropriate;
  • Ensure parents and youth have access to technology such as cell phones, tablets, or computers with internet access to participate in hearings or reviews and maintain important familial connections;
  • Consider utilizing CTP funds to support and enhance virtual participation for parents, children, youth, and their attorneys in hearings and reviews; and
  • Encourage attorneys to resolve agreed-upon issues via stipulated orders. For example, if all parties agreed that a child in foster care can be reunified with his/her family immediately, that issue should be resolved via a stipulated order, rather than waiting weeks or months for an in-person court hearing.
## Overdose: Concerning Trends

<table>
<thead>
<tr>
<th>Week</th>
<th>Opioid or Unspecified</th>
<th>Heroin</th>
<th>All Drug</th>
<th>Rate per 10k ED Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 1-7</td>
<td>187</td>
<td>37</td>
<td>351</td>
<td>26.7</td>
</tr>
<tr>
<td>March 8-14</td>
<td>172</td>
<td>33</td>
<td>328</td>
<td>24.5</td>
</tr>
<tr>
<td>March 15-21</td>
<td>183</td>
<td>28</td>
<td>323</td>
<td>33.0</td>
</tr>
<tr>
<td>March 22-28</td>
<td>142</td>
<td>32</td>
<td>260</td>
<td>32.1</td>
</tr>
<tr>
<td>March 29-April 4</td>
<td>155</td>
<td>31</td>
<td>270</td>
<td>41.2</td>
</tr>
<tr>
<td>April 5-11</td>
<td>152</td>
<td>29</td>
<td>283</td>
<td>41.9</td>
</tr>
<tr>
<td>April 12-18</td>
<td>153</td>
<td>33</td>
<td>254</td>
<td>42.1</td>
</tr>
<tr>
<td>April 19-25</td>
<td>167</td>
<td>28</td>
<td>314</td>
<td>43.4</td>
</tr>
</tbody>
</table>

Count of ED Visits and the Rate per 10k of ED visits for Unintentional Overdose by Opioid or Unspecified, Heroin and All Drug for Virginia state by Week.
Don’t Forget Naloxone!

• Remember to co-prescribe naloxone
• Naloxone availability may be decreased due to fewer public health and community-based organization efforts
• Overdose may increase due to social isolation
• Therefore make sure everyone has naloxone
• Consider asking all patients if they need naloxone script
Conclusions

• Opportunities and Unintended Consequences for pregnant people with OUD during COVID19

• Sheltering in place and isolation – potential triggers for people with OUD

• As providers, need to start discussing what care looks like post COVID19: The telefuture of telehealth
Substance Use Warmline
9 am – 8 pm (ET), Monday – Friday

1.855.300.3595

Free and confidential clinician-to-clinician telephone advice focusing on substance use evaluation and management for primary care clinicians.

Consultants include addiction medicine-certified physicians, clinical pharmacists, and advanced practice nurses who are available to discuss options and approaches in clinical care, from the most common problems to particularly challenging and complex cases.

Learn more at http://nccc.ucsf.edu/clinical-resources/substance-use-management/

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1OHA30039-01-00 (AIDS Education and Training Centers National Clinician Consultation Center) in partnership with the HRSA Bureau of Primary Health Care (BPHC) awarded to the University of California, San Francisco.
Treating Homeless Opioid Dependent Patients with Buprenorphine in an Office-Based Setting

Daniel P. Alford, MD, MPH1,2,3, Colleen T. Lobeck1,3, Jessica M. Richardson1, James J. O’Connell, MD4, Carole A. Hoeh, MD5, Debbie M. Cheng, ScD6,7, and Jeffrey H. Samet, MD, MA, MPH1,2,3

1Clinical Addiction Research and Education (CARE) Unit, Section of General Internal Medicine, Department of Medicine, Boston, MA, USA; 2Boston University School of Medicine, Boston, MA, USA; 3Boston Public Health Commission, Health Care for the Homeless Program, Boston, MA, USA; 4Department of Pharmacology, Boston University School of Medicine, Boston, MA, USA; 5Department of Social and Behavioral Sciences, Boston University School of Public Health, Boston, MA, USA.

CONTEXT: Although office-based opioid treatment with buprenorphine (OBOT-B) has been successfully implemented in primary care settings in the US, its use has not been reported in homeless patients.

OBJECTIVE: To characterize the feasibility of OBOT-B in homeless relative to housed patients.

DESIGN: A retrospective record review examining treatment failure, drug use, utilization of substance abuse treatment services, and intensity of clinical support by a nurse care manager (NCM) among homeless and housed patients in an OBOT-B program between August 2003 and October 2004. Treatment failure was defined as elimination before completing medication induction, discharge after medication induction due to ongoing drug use with concurrent nonadherence with prescribed treatment or discharge due to disruptive behavior.

RESULTS: Of 44 homeless and 41 housed patients enrolled over 12 months, homeless patients were more likely to be older, nonwhite, unemployed, infected with HIV and hepatitis C, and report a psychiatric illness. Homeless patients had fewer social supports and more chronic substance abuse histories with a 3- to 6-fold greater number of years of drug use, number of detoxification attempts and percentage with a history of methadone maintenance treatment. The proportion of subjects with treatment failure for the homeless (21%) and housed (22%) did not differ (P=0.94). At 12 months, both groups had similar proportions with illicit opioid use (6.9% vs 0.9% [CI, 0.5-1.7] P=0.8), utilization of counseling (homeless, 40%; housed, 49%; P=0.95), and participation in mutual-help groups (homeless, 25%; housed, 23%; P=0.96). At 12 months, 36% of the homeless group was no longer homeless. During the first month of treatment, homeless patients required more clinical support from the NCM than housed patients.

CONCLUSIONS: Despite homeless patients’ social instability, greater chronic drug use, and usage with buprenorphine was effective comparable to use with respect to treatment failure: utilization of substance abuse services.

KEY WORDS: buprenorphine; drug treatment; CO-OC.

Table 3. Outcomes of Homeless (N=44) and Housed (N=41) Patients after 12-months of Office-Based Opioid Treatment with Buprenorphine

<table>
<thead>
<tr>
<th>Attending counseling1</th>
<th>Homeless N (%)</th>
<th>Housed N (%)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>20 (46)</td>
<td>20 (49)</td>
<td>0.95</td>
</tr>
<tr>
<td>No</td>
<td>4 (9)</td>
<td>4 (10)</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>20 (45)</td>
<td>17 (42)</td>
<td></td>
</tr>
</tbody>
</table>

Attending mutual help groups1

<table>
<thead>
<tr>
<th>Currently homeless1</th>
<th>Homeless N (%)</th>
<th>Housed N (%)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>11 (25)</td>
<td>12 (29)</td>
<td>0.03</td>
</tr>
<tr>
<td>No</td>
<td>13 (30)</td>
<td>12 (29)</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>20 (46)</td>
<td>17 (42)</td>
<td></td>
</tr>
</tbody>
</table>

Currently employed6

<table>
<thead>
<tr>
<th>Involvement of social support in care7</th>
<th>Homeless N (%)</th>
<th>Housed N (%)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>22 (50)</td>
<td>24 (59)</td>
<td>0.50</td>
</tr>
<tr>
<td>No</td>
<td>2 (5)</td>
<td>0 (0)</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Data are presented as n (%) unless otherwise specified.

Figure 1. Kaplan-Meier estimates of the proportion of homeless and housed patients who did not fail office-based opioid treatment with buprenorphine. P = 94 for the comparison between homeless and housed subjects by the log-rank test.
60% completed Week 1 in each group