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When Epidemics Collide: Coronavirus Disease 2019 (COVID-19) and the Opioid Crisis

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With the coronavirus disease 2019 (COVID-19) pandemic projected to be the largest mass casualty event in U.S. history, large-scale efforts are under way to contain the spread through social distancing and to divert resources to acute care. Before the first COVID-19 case in the United States, a different epidemic—the opioid crisis—was taking the lives of 130 Americans per day (1). Given that infection epidemics disproportionately affect socially marginalized persons with medical and psychiatric comorbid conditions—characteristics of those with opioid use disorder (OUD)—we are gravely concerned that COVID-19 will increase already catastrophic opioid overdose rates. Besides the threat of infection to persons with OUD, there is serious risk that system-level gains in expanding access to medication for OUD, conducting critical research, and exacting legal reparations against opioid manufacturers will all reverse. We call for urgent action to counteract these risks.

Treatment systems need to facilitate uninterrupted access to the most effective medications for OUD treatment: methadone and buprenorphine (2). Regarding methadone, federal agencies relaxed requirements for physical examinations and allowed extended medication supply for stable patients (3). We need to rapidly expand methadone delivery via mobile teams (for example, repurposed syringe service programs) for quarantined patients. Opioid treatment programs—federally regulated facilities that primarily dispense methadone—should increase use of buprenorphine because of its safer pharmacologic properties and formulations that can be dosed thrice weekly and monthly. Federal agencies should leverage funds from a recent settlement about misuse of regulatory procedures by a buprenorphine manufacturer (4) to address financial barriers to buprenorphine provided through opioid treatment programs.

Buprenorphine prescribers should be allowed and encouraged to engage in all phases of care—evaluation, initiation of therapy, and monitoring—via telemedicine when appropriate. The Drug Enforcement Administration recently took a significant step by permitting teleprescribing of buprenorphine if 2-way audiovisual communication between the prescriber and the patient is in place, allowing for telephone-only communication when needed (5). Given that patients may not have adequate data access plans, we recommend that funding be allocated to support data plans for teleprescribing visits for patients initiating or continuing buprenorphine (and methadone) treatment. In-home initiation of buprenorphine is feasible and safe and is supported by new dose titration protocols that eliminate the need for opioid withdrawal (6).

We recommend several additional steps to ensure access to buprenorphine in preparation for shifts in prescribers' work duties or sick leave due to COVID-19 and potential treatment disruptions as patients move in and out of hospitals. The federal government should temporarily remove limits on the number of patients an individual prescriber may treat concurrently. At present, clinicians are limited in the number of patients for whom they can treat concurrently in their first year. For the near future, these limits should be removed. In addition, we recommend that federal, state, and local governments be funded to form and support networks of experienced buprenorphine prescribers to address the needs of local patients and providers. For instance, the mentors from the federally funded Prescriber Clinical Support System, and those identified through primary care, addiction medicine, and addiction psychiatry societies, could be rapidly expanded and authorized to temporarily support clinicians and potentially prescribe for patients in their region if usual prescribers are unavailable. As more patients with OUD are admitted to hospitals, these networks would be available to provide remote consultative services to help reduce length of stay. To help reduce emergency department and hospital crowding, federal training requirements for buprenorphine should be eliminated to allow emergency medicine and hospitalist clinicians without waivers to write buprenorphine prescriptions at discharge to provide enough medication for patients to become engaged in outpatient treatment. Federal and state agencies should ensure that skilled-nursing facilities do not refuse patients receiving methadone or buprenorphine.

Beyond day-to-day OUD treatment, COVID-19 threatens to grind essential clinical research to a halt unless proactive steps are taken. During the past 2 years, Congress authorized approximately $1 billion in the HEAL (Helping to End Addiction Long-term) initiative. Much of this work is just starting. In 2019, HEAL funded approximately 375 projects in 41 states, including 4 states as part of the HEALing Communities Study testing a "community-engaged intervention designed to increase the adoption of an integrated set of evidence-based practices delivered across health care, behavioral health, justice, and other community-based settings" (7). With virtually all research involving face-to-face contact stopping, these results will be delayed and study viability will be threatened. The effect of the COVID-19 pandemic on scientific validity will also need

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to be considered as the crisis profoundly changes patients and treatment systems. At a minimum, the federal government will need to devise a mechanism to provide ongoing funding for all persons supported to conduct laboratory and clinical research, including those working on opioid-related projects, while projects' safety and scientific validity are considered.

Finally, before the COVID-19 pandemic, important strides had been made in compensating victims of opioid manufacturers' malfeasance. For example, in August 2019, the state of Oklahoma won a $572 million lawsuit against Johnson & Johnson, with the judge ruling that the company overstated the benefits and understated the risks of opioid products, thus violating the state's public nuisance laws (8). These monies will go to victims' families and help bolster Oklahoma's addiction treatment resources. Delays in court hearings could backlog 2000 similar lawsuits and significantly delay remuneration, which is especially damaging given the looming economic crisis in the United States. To provide much-needed funding in the midst of these 2 crises, we urge acceleration of cases nearing resolution, a prominent one being Purdue Pharma's bankruptcy case, resolution of which could mean more than $10 billion to families and addiction treatment agencies (9).

Persons with OUD are especially vulnerable to not only COVID-19 but also interruptions in life-saving treatment. The response to COVID-19 and the speed with which regulatory barriers are being reconsidered and removed should be translated to opioid-related clinical, research, and legal policy. Bold efforts are needed to reduce the adverse effect that COVID-19 will have on progress in addressing opioid-related morbidity and mortality. In the absence of such efforts, we risk more catastrophic effects from these colliding epidemics.

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Correction: This article was corrected on 21 April 2020 to correct the statement about the limits on the number of patients an individual prescriber may treat concurrently.

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