# *COVID-19 and the Opioid Crisis*

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**Journal CME**

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**How to Earn this CME Credit:** Read the Article and complete the post-test online at UF CME.
**CME Credit Eligibility:** A minimum passing grade of 80% must be achieved. Certificates of credit/completion will be emailed automatically after completion of post-test with a passing grade, and a course evaluation.

**Learning Objectives:** Upon completion of this activity, participants should be able to:
1. Identify the effects that the COVID-19 Pandemic has had on both legal and illicit use of opioid drugs in America.
2. Recognize that patients with legitimate pain represent a distinct group from abusers seeking narcotics.
3. List social and economic factors that promote illicit drug use and recidivism in patients with Opioid Use Disorder.

**Target Audience:** This educational activity is intended for physicians.
**Accreditation:** The University of Florida College of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.
**Credit:** The University of Florida College of Medicine designates this enduring material for a maximum of 0.5 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
**Disclosures:** Dr. Jesse Lipnick disclosed that he has no relevant financial relationships. No one else in a position to control content has any financial relationship(s) to disclose.
**CME Advisory Committee Disclosure:** Conflict of interest information for the CME Advisory Committee members can be found on the following website: https://cme.ufl.edu/disclosure/.

**Contact Information:** For questions, please contact Jackie Owens at evp@acms.net.

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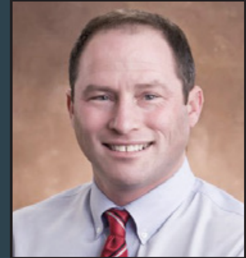
# COVID-19 and the Opioid Crisis



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Our focus on COVID-19 this past year has made it is easy to forget that we are still in the midst of an opioid overdose crisis. Approximately 450,000 people in the United States have died from opioid drug overdose since 1999. Death from opioids peaked in 2017 with 70,723 reported deaths followed by a 4.6% decrease in overdose deaths in 2018. The CDC identifies 3 waves associated with opioid overdose. The first wave began in the 1990's from increased medical prescriptions of opioids. The second wave began in 2010 and it resulted from increased use of illicit heroin. The third wave started in 2013 and was due to synthetic narcotics, most notably fentanyl. In one study, the death rate from fentanyl increased every month from January 2015 (5,766 victims) thru December 2019 (36,509 victims). Reports out of U.S. Department of Health and Human Services (HHS) describe a 4th wave which began in 2019 and is due to the lethal combinations of stimulants and other illicit drugs alongside opioids. This current wave has continued to surge, in part due to COVID-19.

Together with the opioid crisis, the COVID-19 pandemic has transformed lives. Most states issued stay-at-home orders by mid-April 2020. The CDC recommended postponing any non-essential medical services. Even though many physicians continued prescribing opioids, urine drug testing which had been a key part of safe opioid prescribing suddenly decreased. Analysis of Quest Diagnostic urine specimens over the past year demonstrates the abuse of fentanyl has increased more than any other drug, and the fentanyl abuse occurs both alone and in combination with other illicit drugs. During this same time period, abuse rates for other drugs also increased, but not as quickly as fentanyl. Illicit use of methamphetamine and cocaine increased quickly in the past year while the abuse of heroin and use of prescription opioids has decreased during the COVID-19 Pandemic.

Comparing 2020 to 2019, the Overdose Mapping Application Program (ODMAP) found an 18% increase in opioid overdoses in March, 29% increase in April, and 42% increase in May. These figures include significant increases for both fatal and non-fatal overdose. The American Academy of Family Physicians together with the Well Being Trust estimates the economic recession from COVID-19 may lead to increased deaths from drug overdose, alcohol abuse and suicide in the next 10 years ranging from 27,644 to 154,037 victims, with approximately 75,000 excess deaths being most likely. There are a number of reasons for this pattern of drug abuse.

First, the CDC recommended delaying all non-essential medical care in April 2020, and to convert as many as possible routine medical care visits to a virtual format. Florida Governor Ron DeSantis' Executive Orders permitted Category II opioid refills with the use of virtual-health visits. This resulted in a temporary discontinuation in patient urine testing for drugs and alcohol. Many clinicians continued prescribing opiates without the same level of patient monitoring. Prescribers were "flying blind" in an attempt to treat pain using opioids, but without objective evidence of patient compliance. In addition, a variety of economic and social factors lead drug users to increase drug abuse. Associated factors include changes in daily routine, job loss, economic downturn, uncertainty for the future, loneliness and depression, all of which are associated with medication over-use, illicit drug use and relapse of drug abuse in patients with Opiate Use Disorder (OUD). Dr. Nora Volkow, Director of the National Institute on Drug Abuse (NIDA) notes that social isolation drives individuals to take drugs and vulnerable individuals to relapse. Abusers who abstained from drug abuse before COVID-19 suddenly found themselves alone and unemployed, with no clear light at the end of the tunnel.

Combination drug use remains the hallmark of lethal overdose. According to the CDC, methamphetamines, cocaine or benzodiazepines were present in 63% of recent lethal opioid overdoses. Quest Diagnostics indicates the majority of urine specimens positive for heroin were also positive for non-prescribed fentanyl, a trend that increased over the past year of COVID-19. Quest found non-prescribed fentanyl in 48% of urine specimens positive for cocaine before stay-at-home orders in April 2020, and this amount increased to 64% since states implemented these orders. Illicit fentanyl also increased in specimens positive for cocaine, amphetamines, and benzodiazepines. The coincidence of fentanyl mixed with methamphetamine increased by 90% since COVID-19 began. These increases in illicit drug use combinations are significant as they portend

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increased overdoses and hospitalizations at the same time hospitals are trying to avoid overcrowding while caring for COVID-19 victims.

In addition to the above factors, social distancing has isolated vulnerable individuals leaving them to use prescribed opioids or illicit narcotics alone. This isolation reduces chances a bystander could initiate emergency medical services or administer Naloxone. Also, COVID-19 has forced many substance use disorder (SUD) treatment centers to close or to scale back services, leaving less access for those in need. The Quest data also raise a question: is illegal fentanyl use temporary, reflecting early changes in drug abuse during COVID-19, or do these data signify a longer trend in drug abuse? Either way, we must not lose focus on the opioid crisis as numbers of overdose victims are still increasing.

Overdose victims represent a distinct group from the chronic pain population. Patients with chronic pain need and deserve our medical attention. Unfortunately, our medical community has become guarded in caring for this population. Physician communities received numerous important inhibitions over the past decades. First, our professional organizations published guidelines on opiate usage in the early 2000s. The American Society of Interventional Pain Physicians (ASIPP) published its first set of Consensus Guidelines on Opiate Prescribing in 2006, followed by revisions in 2008 and 2012. The CDC followed with "CDC Guidelines for Prescribing Opioids for Chronic Pain - United States" in 2016 specifically "for primary care clinicians who are prescribing opioids for chronic pain". These guidelines shared the common purpose of increasing safety for pain patients. They set rules for opioid therapy and recommended physicians evaluate patients' risks for OUD. They recommended minimizing opioid dosage and set limits on morphine milliequivalents (MME). Physicians were encouraged to use non-opioid therapies to treat pain. The guidelines encouraged referral of pain patients to pain management specialists and for psychological care. These guidelines recommended non-opioid therapy for treating chronic pain, and using the lowest possible effective dose. They warned physicians to exercise caution when prescribing opioids. The FDA followed suit in 2018 by publishing REMS - Risk Evaluation and Mitigation Strategy, requiring physicians to have extra education for prescribing anyone a specific group of opioids. The FDA attempted to establish a national drug dispensing database to track physician prescribing of controlled substances. That same year, CMS founded the Over-utilization Monitoring System (OMS) and the Cumulative Morphine Equivalent Dose (MED) programs to prevent opioid over-prescribing by physicians. Unfortunately, CMS was not able to secure funding for a national opioid dispensing database similar to Florida's E-Force, which by law must be checked before prescribing any category II medication.

All these limitations made our medical community acutely aware of the dangers of opioid prescribing. Physicians began discontinuing opioids. States mandated opioid limits of 50 - 90 MMEs. Insurance companies stopped paying for opioid therapy. Pharmacies set arbitrary limits on opioid prescriptions to slow dispensing or they stopped filling opioid prescriptions altogether.

Even though these limits on prescribing and dispensing were expected to reduce overdoses, they did not have the intended effect. Death rates from opioid overdose continued to rise, even as physician prescriptions for opioids decreased. In 2019, JAMA published "Limits on Opioid Prescribing Leave Patients with Chronic Pain Vulnerable." JAMA described physicians' indiscriminate refusal to prescribe opioids for pain patients, or even to acknowledge patient suffering, regardless of the cause or patient risk for OUD. Some physicians stopped treating pain in any patient, regardless of the cause or risk for OUD. Some doctors refused to treat cancer pain with narcotic medication, much less back-pain, neck-pain or headache, which are among the most common reasons a patient seeks medical care. These regulatory efforts limited opioid prescribing arbitrarily.

Our laws and professional regulations do not adequately distinguish patients with pain from those with OUD, and these groups differ in quintessential ways. First, chronic pain patients aspire to be more functional in life. They use narcotics to achieve this higher level of function. They do not obsessively concern themselves in obtaining and using these drugs. In fact, many chronic pain patients prefer not to take them at all, but untreated pain limits their daily living. Their pain removes freedom to perform normal functions in work, family or otherwise. Conversely, patients with OUD do not seek better daily function. They need the euphoria of drug abuse. The abuser will do or risk almost anything to obtain this "high," destroying their health, relationships, job opportunities and even their future. When physicians limit and distrust all patients with pain, they fail to treat the reason they seek our care and instead treat them all as though they are addicts. Many pain patients have become sensitive to our inappropriate perceptions and treatment. They feel ashamed bringing pain up to their physicians because they fear we will label them as drug abusers.

There is good evidence that patients with chronic pain represent a distinct population from those with Opioid Use Disorder. Lawhern et al. (2019) found no statistical

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relationship between regional prescribing rates and overdose rates in analyzing every state in the USA for 2006, 2010, and 2016. Regional opioid prescribing rates showed no relationship to ER Visits, overdose or death rates from opioids during any time period. In fact, the opposite was true. In 2016, mortality trends dropped in states with higher prescribing rates, leading Lawhern to conclude that opioid prescribing does not drive the Opioid Overdose Epidemic. On the contrary, illegal street drugs, patient poly-pharmacy, and patient suicide are driving the overdose epidemic. Opioid prescribing and dispensing rates in the USA have declined steadily since 2010 at the same time overdose deaths have continued to rise. These data tell a clear story: pain patients are not driving the opioid overdose crisis. According to the CDC Wonder Database, chronic pain patients and overdose patients are two distinct populations, with OD victims being much younger, more reckless, using illegal drugs, and more likely to overdose. Conversely, chronic pain patients tend to be older, with rates of OUD similar to the general population. Overdose rates have not increased in chronic pain patients since 1999.

In summary, the COVID-19 pandemic has invigorated abuse of illicit opioids and overdose by increasing social/economic stressors, and by isolating drug abusers. Physician opioid prescribing did not drive the opioid crisis in the past year of COVID-19 or in the past decade. Rather, the illegal manufacture and distribution of illicit Fentanyl and Methamphetamine has caused the increase in American overdoses. Finally, patients with chronic pain differ from those who overdose. Those with pain need and deserve our support more than they deserve our suspicion. We physicians must not neglect our primary responsibility to lovingly assess, treat and prevent patient suffering.

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## *COVID-19 and the Opioid Crisis*

**CME Post-Test**

### CME Questions (select one answer)

**1. Approximately how many people have died from opioid drug overdose in the United States since 1999?**
A. 70,000.
B. 100,000.
C. 250,000.
D. 450,000.

**2. Current laws and professional regulations do not adequately distinguish patients with pain from those with Opiate Use Disorder:**
A. True.
B. False.

**3. The analysis of Quest Diagnostic urine specimens over the past year demonstrates the abuse of fentanyl has:**
A. Remained the same over the past year.
B. Increased over the past year.
C. Declined over the past year.
D. None of the above.

**4. According to Dr. Nora Volkow, social isolation drives individuals to:**
A. Take drugs and vulnerable individuals to relapse.
B. Maintain their current routine.
C. Take fewer drugs.
D. All of the above.

**5. The majority of lethal overdoses are caused by:**
A. Methamphetamines.
B. Cocaine.
C. Benzodiazepines.
D. A combination of all of the above.

**6. Opioid overdose deaths ______________, as physician prescriptions for opioids declined in 2019 and 2020:**
A. Declined.
B. Remained the same.
C. Continued to rise.
D. None of the above

### CME Credit Information -

Post Test Link:

https://www.proprofs.com/quiz-school/ugc/story.php?title=1553-covid19-and-the-opioid-crisisq5

*To take the Post-test, click on the link above to access the UF CME ProProfs program. Please complete the evaluation form after receiving a passing grade. Your test will be graded upon submittal with a Certificate emailed automatically upon completion..*