Best Practices and Partnerships Can Help Combat Opioid Misuse

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The worst drug overdose crisis in U.S. history is driving policymakers to declare opioid-use disorder a national emergency and to seek new ways to battle the epidemic. The workers' compensation industry must likewise step up efforts to protect patients and better understand how the number one drug class among injured workers affects return-to-work and quality of life.

We should start by recognizing the best methods to prevent overdose as well as to manage injured workers taking opioids. The next step is to attack the source of the problem by further constricting the flow of opioids going to injured workers. Last, we must find new, more effective ways to help injured workers recover from the negative effects of opioid misuse and, ultimately, return to productivity and good health.

The Costs — From Health to Families to Business

Opioid misuse is costly in every sense. Beyond the consequences for a person's health, the levy on a family can be devastating. These assaults on the wellbeing of individuals and families also feed broader societal harms. In workers' comp, the fallout from opioid misuse emerges in additional forms such as lost productivity, damage to workplace morale, and the expense of hospitalization and other treatments.

The numbers are akin to battlefield statistics in an unceasing war — grim, familiar, and yet hard to fathom:

- Drug overdose has overtaken automobile accidents to become the leading cause of accidental death among U.S. adults.
- More than one third of the nation's adults reported using a prescription opioid in 2015, according to the National Institute on Drug Abuse.
- Prescribers are writing fewer opioid scripts than in recent years though the number is still triple what it was in 1999.
- Prescription opioids are involved in roughly 42 deaths per day, according to the Centers for Disease Control & Prevention (CDC). This already sobering number excludes pharmaceutical fentanyl, tramadol, and synthetic opioids other than methadone because statistics on fatal overdoses do not delineate between pharmaceutical fentanyl and illicit fentanyl. Counting synthetics, the daily mortality rate involving opioid analgesics jumps to 62. Overall, including both legal and illicit opioids, more than 90 people die every day in the U.S. from overdose.

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The fallout from the crisis can be seen in other ways. Prescription opioid misuse siphoned $78.5 billion from the U.S. economy in 2013, reports the National Center for Injury Prevention and Control, in its most recent findings. More than one third — $28.9 billion — reflects increased costs for health care and substance-use treatment. About one quarter of the cost falls on the public sector in the form of health care, substance-use treatment, and criminal justice spending.

The severity of the problem prompted the White House to proclaim opioid misuse a national emergency. This latest salvo could inject more federal dollars into the fight and waive some regulations in order to give policymakers and caregivers more options in squaring off against the epidemic.

Overdose: The Ultimate Threat

The gravest risk from misusing opioids remains fatal overdose. This occurs when an opioid slows breathing to the point it ceases. The CDC reports that nearly half of the nation's fatal opioid overdoses involve a prescription analgesic and that deadly overdoses involving a prescribed opioid have quadrupled since 1999. But even after seeing such large increases, the industry must consider what is most relevant to injured workers. For example, headlines in the mainstream press have rightly called attention to a shocking rise in deaths tied to fentanyl. From 2014 to 2015, fatal overdoses caused by this synthetic opioid surged more than 70%. But data gathered by the CDC reveal that the jump appears linked to illicit fentanyl and not to an increase in fentanyl prescriptions. So while fentanyl remains an important concern, there are other steps the industry can take to try to curb misuse. We have to work more effectively with prescribers and caregivers to disrupt a cycle of repeat overdoses. Among the overall U.S. population, nine in 10 people who survive an overdose continue to be prescribed opioids — usually by the same prescriber. Depending on the dose, eight to 17 percent of those who experience a nonfatal overdose will overdose again.

9 in 10 people who survive an overdose continue to be prescribed opioids

If an overdose does occur, first-responders often will administer the overdose-reversal agent naloxone. That is followed by further treatment at a hospital. Beyond the immediate steps following an overdose, or even if a prescriber suspects there is a risk of one occurring, clinicians have a number of options for care. These include making a referral to a treatment program, medication-assisted therapy, a weaning program, and recommending alternatives to opioids. Prescribers can refer to the *Diagnostic and Statistical Manual of Mental Disorders*, or DSM–5, for diagnosis criteria around substance-use disorder or guidelines for using medicine such as methadone or buprenorphine.

The characteristics of the opioids themselves are important. Long-acting or extended-release formulations can carry higher risk and an increase in a patient's dosage poses an obvious threat. Doctors also must consider whether a patient is opioid tolerant. The U.S. Food & Drug Administration (FDA) defines opioid tolerance as taking 60 mg of oral morphine or its equivalent for seven days or more during the immediately preceding days. Guidelines indicate prescribers should not order extended-release or long-acting formulations for patients who have never taken opioids; this includes transdermal fentanyl.

Deliberate Action Can Protect Patients

Like a drug's formulation, the patient's complete medication regimen and comorbid conditions can shape his or her response. Doctors should exercise extreme caution when prescribing opioids for patients taking other central nervous system depressants such as sedative hypnotics (sleep aids), skeletal muscle relaxants, benzodiazepines, antihistamines, and illicit substances as well as alcohol or tobacco. Patients facing mental health conditions, untreated sleep disorders such as sleep apnea, and pulmonary disease also merit particular caution.

The CDC identifies men, middle-aged adults, people who live in rural areas, whites and American Indians or Alaskan Natives, and residents of states with higher sales per person and more non-medical use of prescription painkillers as those facing greater threat of overdose.

Asking the fundamental question of whether a patient even needs opioids can help prescribers sidestep an array of complications. Opioids are not recommended to treat pain that is not severe. ACOEM reports there is little evidence to support long-term opioid use for chronic pain unrelated to cancer. Morphine equivalent dosing (MED) should be limited to 50 mg per day, according to ACOEM. Furthermore, the CDC recommends naloxone accompany a daily MED of 50 mg or greater.

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Guidelines Can Help Us Avoid Some Problems from the Start

Evidence about what works should be the signpost guiding our collective response. Several national organizations have produced recommendations around when to prescribe opioids and when to continue or discontinue them. These evidence-based protocols include the appropriate durations of use according to injury type, dosing limitations, when to involve a pain specialist, how to identify whether a patient is a candidate for opioid therapy, what to monitor throughout treatment, and how to manage side effects.

Studies have shown that the risk of death from opioid overdose increases roughly fourfold at an MED of 50 or above. This risk jumps ninefold at MED of 100 or more. Other studies have shown that physical dependence to an opioid can occur in as little as two weeks with continuous daily use. Setting MED thresholds (or MED-directed recommendations) as well as limiting durations of treatment are just two ways guidelines can help prevent problems from occurring. The Official Disability Guidelines (ODG) and frameworks from the CDC and other organizations outline what should occur if prescribers identify risk or if an overdose takes place. The CDC created a mobile app to help prescribers adhere to its best practices.

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Partnerships Play a Vital Role in Enabling Success

Guidelines are critical because they are rooted in science and empirical evidence. Still, we cannot rely on these alone. We also must seek out additional clinical and social indicators that could help us better identify those most at risk for misuse, abuse, or the threat of overdose. Employing a biopsychosocial model in which we consider the whole patient is a strong approach. One important measure is identifying opportunities for partnerships in the addiction-recovery process. This means building relationships among prescribers, injured workers, clinicians, employers, and other caregivers. This web of interactions must foster trust and hold each party to account for their role in recovery.

There are other partnerships that can help prescribers safeguard patient safety and even forestall addiction. Both a Pharmacy Benefit Manager (PBM) and case management partner can prove strong allies. A robust PBM program can mitigate some of the risks associated with opioid use and help identify patients who might require direct clinical intervention and support. For example, risk-modeling tools can mine data for emerging patient risk around several of the indicators for opioid misuse, abuse, or overdose. These include opioid prescriptions filled from multiple prescribers or pharmacies, high-risk drug combinations, prolonged opioid use, and a high MED. Risk-modeling can trigger alerts for instances in which urine drug testing might be appropriate; and the system should guide the testing process and any necessary subsequent patient management.

A PBM also should be alerting claim management professionals to suspicious prescribing behavior and requesting that specific scripts be evaluated further before being approved. At a more fundamental level, prescribing protocols surrounding a PBM's drug formulary should include recommendations to avoid long-acting opioids for first-line use and to consider the addition of the overdose-reversal agent naloxone where appropriate. In essence, the PBM should be prompting claims personnel to engage clinical resources that can prevent a problem from taking root and also should have in place tools that can be deployed if signs of opioid-use disorder do emerge.

Another way to support program outcomes is through the triage of appropriate cases for further clinician engagement or additional oversight through case management. This extra scrutiny can pay dividends when the case manager is specially trained to focus on claims deemed at-risk based on pharmacy utilization. The use of a specially trained pharmacy nurse case manager can promote patient engagement, safety, and education. With the appropriate data resources — made available through the PBM and medical bill review — the pharmacy nurses can target the cases in which they can make the greatest impact. The nurses can work with the prescriber, injured worker, and claims personnel to confirm pharmacy utilization is medically appropriate and supports a timely recovery.

Risk-modeling tools should mine data for patient risk indicators such as:

Opioid prescriptions from multiple prescribers or pharmacies

High-risk drug combinations

Prolonged opioid use

High MED

There Are Other Steps We Can Take

Strong prescribing guidelines and strong partners are a necessity. Yet there are still other ways prescribers can work to reduce the risk of adverse outcomes from opioid use. The Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression (RIOSORD) draws on 14 patient variables when calculating the likelihood of opioid-induced respiratory depression, which is the leading cause of death related to opioid analgesics.

Prescribers can establish a pain agreement or an informed-consent agreement to ensure all sides understand the risks, commitments, proposed course of treatment, and the consequences of a breach. Additional risk-screening tools such as SOAPP-R, ORT, and DIRE have proven useful as have PADT, COMM, and ABC, which help flag opioid misuse. Simple steps such as providing baseline and random urine drug testing and practicing safe storage and disposal of the drugs can help deter abuse.

Prescribers can review state databases for prescription drug monitoring; these often are referred to as PDMPs or PMPs. Signs of errant utilization can prompt discussions around treatment options for opioid-use disorder. Prescribers also can help educate patients about pain and the risk of opioid-use disorder and, when warranted, recommend non-opioid analgesic medications or non-pharmacologic therapies.

Prescribers can begin to taper injured workers off opioids where appropriate, such as when a patient develops increased dependence on the drugs or demonstrates aberrant drug-taking behavior. In cases in which injured workers show signs of opioid-use disorder, prescribers can consider medication-assisted therapy (MAT) with drugs such as methadone or buprenorphine. These types of drugs, combined with counseling and support from family and friends, can offer another viable option for combating opioid-use disorder, according to the Substance Abuse and Mental Health Services Administration (SAMHSA), the primary federal agency responsible for substance abuse and mental health services. SAMHSA recommends employers make clear that help is available for workers struggling with opioid-use disorders in part because employees who seek treatment of their own accord — rather than solely at the behest of family and friends — are more likely to find success.

The Best Path Forward Is One That Welcomes Many Partners

There is no single fix that will eliminate opioid-use disorder within workers' compensation or within society in general. Arresting this deadly epidemic will instead require an assemblage of committed partners that includes injured workers, families, employers, PBMs, prescribers, clinicians, and other caregivers such as specially trained nurse case managers. These groups can employ a range of measures that, taken together, offer the best hope for reducing the scourge of opioid-use disorder and, in essence, decreasing adverse outcomes associated with opioid use, including death from overdose. These tools include patient education, evidence-based guidelines, biopsychosocial models that consider the full range of patients' needs, medication-assisted therapy, and countermeasures such as naloxone.

The grievous toll these painkillers can exact is clearer than ever as is the need to do all we can to help injured workers either avoid or recover from the ill effects of opioid-use disorder and return to good health. This undertaking could not be more profound given the enormous number of people whose lives are upended, endangered, and even cut short when opioids go from relieving pain to causing it.

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Reducing this deadly epidemic requires committed partners

Partnering with Coventry and First Script

Identifying Risk

Opioid management presents a challenge and early intervention is imperative to limit opioid risk and avoid dependence, addiction, or diversion. Tools such as the following are critical to effectively address the problem.

Pharmacy Benefit Management (PBM)

Integrated PBM programs, like First Script, ensure that the maximum number of scripts receive the benefit of the many checks and balances only possible on a pre-fill basis.

Smart Prior Authorizations

First Script Smart PAs provide adjusters with clinical recommendations and therapeutic alternatives that have similar clinical outcomes but are safer or less costly.

Urine Drug Monitoring

A comprehensive test panel including the most commonly abused prescription drugs. Risk-modeling tools ensure the right injured workers are tested.

RxRN

Specially trained RNs manage all aspects of the injured worker's plan for care and recovery by focusing on emerging and complex pharmacy utilization.

Rx Profile

Risk-stratification tools identify injured workers requiring a higher level of clinical review to target adverse opioid utilization and drive potential interventions.

Naloxone

Providing naloxone to rapidly reverse opioid effects and restore normal respiration allows the injured worker to seek treatment.

Minimizing Short-Term Risk

Early opioid intervention and prescriber outreach allows for meaningful provider engagement. This can include discussing best-practice guidelines, recommendations for alternative treatments, pain agreements, and consideration of urine drug testing to decrease ongoing opioid utilization.

Mitigating Long-Term Risk

We flag behaviors that indicate an injured worker might be at risk of dependence or abuse. If a concern arises, one of our specialized nurse case managers contacts the injured worker and consults with the prescriber. Our team (including our pharmacists and medical directors) works with the treating provider to develop a treatment plan that addresses the injured worker's pain while reducing the likelihood of abuse. We then adjust our point-of-sale system to ensure adherence and that the appropriate safeguards are in place when the worker seeks to fill a prescription.

Contact us to explore ways to identify opioid risks and be prepared when recovery alternatives are needed: info@cvty.com | 1.800.790.9662

About Coventry

Coventry offers workers' compensation cost and care management solutions for employers, insurance carriers and third-party administrators. With roots in both clinical and network services, Coventry leverages more than 30 years of industry experience, knowledge and data analytics. The company offers an integrated suite of solutions, powered by technology to enhance network development, clinical integration and operational efficiencies at the client desktop, with a focus on total claims cost.

Nurse Triage | Case Management
Utilization Review | Networks
Independent Medical Exams
DME | Ancillary Services
Pharmacy | Bill Review

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