

Understanding and Planning: A Prescription for Fighting Opioid Use Disorder

The rampant opioid misuse battering the nation represents one of the most virulent threats to employee welfare in the more than 100-year history of workers' compensation protections. Equipping key players with an understanding of what to look for and how to respond will lead to better chances of deterring the abuse of opioid analgesics that has proven so costly to workers' wellbeing.

To best respond to the crisis, we need to be clear about what opioid use disorder (OUD) is and how we identify it. By spotting misuse sooner, prescribers have a greater ability to intervene and perhaps prevent another of the more than [183,000 fatal opioid overdoses](#) that occurred from 1999 through 2015. Earlier intervention can also help to avoid the many other poor outcomes that can result from misusing opioids. The number of fatalities, as alarming as it is, veils the full scope of the problem. For every fatal overdose there are 11 treatment admissions for abuse, 28 emergency department visits for misuse or abuse, 133 people who misuse opioids or are dependent upon them, and 689 nonmedical users, according to statistics adapted from the Substance Abuse and Mental Health Services Administration ([SAMHSA](#)), which is the primary federal agency responsible for substance abuse and mental health services.

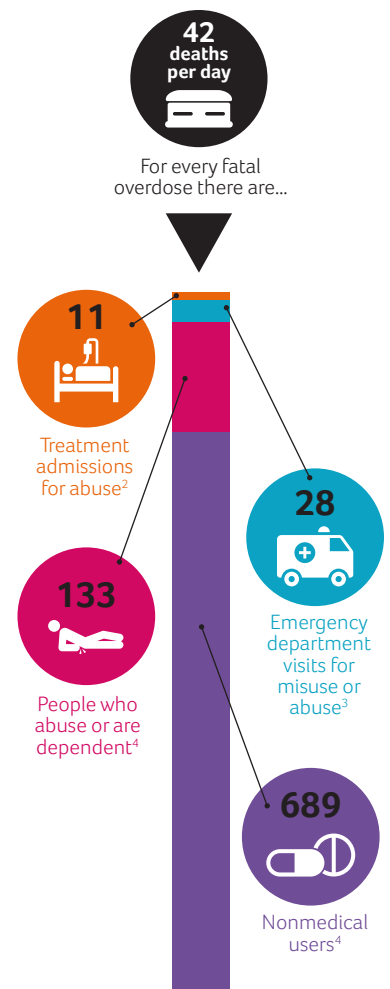
What is opioid use disorder?

The way we define issues with opioid use has evolved over time. In recent years, the view of addiction has shifted from that of a poor choice pathway to one of disease state management. For example, the [American Society of Addiction Medicine](#) describes addiction as a "primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestation." Further advancing this disease state approach, the terms "opioid addiction" and "dependence" are giving way to a broader definition of the condition known as "opioid use disorder." The American Psychiatric Association does not classify addiction within its Diagnostic and Statistical Manual of Mental Disorders, or DSM-5. Instead, when updating the DSM in 2013, it replaced two separate disorders—substance abuse and substance dependence—with a single category of "substance use disorder" (under which specific substances such as opioids are further differentiated). Regardless of the definitions used, OUD can present complex treatment challenges, and a multimodal approach is often required.

How can prescribers identify opioid use disorder?

Under the diagnostic criteria found in the DSM-5, a person is designated as having OUD if, within a 12-month period, he or she exhibits a problematic pattern of opioid use that meets with at least [two of nine to 11 characteristics](#) and that pattern of use leads to clinically significant impairment or distress. The characteristics include experiencing craving or a strong desire to use the opioid, continued use despite harm, or taking the medication for a longer period of time or in larger amounts than intended by prescription. Prescribers can monitor for these characteristics or behavior patterns in their patients who are taking opioids. Similarly, prescribers can incorporate urine drug screening as a best practice for patients who are taking opioids to rule out

In 2015, there were more than 15,000* deaths related to prescription opioids¹



*Excludes synthetic opioids other than methadone (i.e., tramadol, fentanyl) because reported fatal overdose stats do not delineate between pharmaceutical and illicit fentanyl.

the inappropriate use of the prescription or illicit drugs as well as identify cases of opioid prescription diversion.

Protocols from the Official Disability Guidelines (ODG) can also help providers distinguish possible occurrences of OUD. At the outset of an opioid regimen, ODG recommends prescribers watch patients for decreased functioning, intoxication, or a negative affective state. These and a number of other signs can indicate that patients are starting to display a preoccupation with opioids and perhaps starting to lose control over their medication use. These include:

- Failing to bring in unused medications
- Obtaining a higher dosage without approval of the prescribing physician
- Requesting early refills
- Reporting medication lost or stolen
- Arriving for unscheduled clinical appointments in a state of distress or missing appointments
- Making frequent visits to emergency departments
- Failing to comply with other treatment modalities
- Showing interest only in symptom control rather than rehabilitation
- Hearing reports from family of overuse or intoxication
- In general, failing to show improved function or relief from pain

There are still other red flags that are more pronounced than most of the above warning signs and could be identified by the prescriber or case manager. These include the selling of prescription drugs, forging or modifying prescriptions, stealing drugs, using prescription drugs in ways other than prescribed (such as injecting oral formulations, chewing long-acting agents, or using prescribed opioids for other conditions), using alcohol or other illicit drugs (as detected on urine screens), obtaining prescription drugs from outside the medical system, and doctor shopping.

What can prescribers do to help avoid misuse?

Knowing the warning signs of misuse is critical. Just as important is knowing when and how opioids should be used. The first questions prescribers should ask is whether opioids are the most appropriate choice to alleviate the individual's pain and return the patient to function, and whether an alternative could work as well or better. Other questions can help guide decision-making and avoid a path of risk often associated with opioid use, such as whether an evidence-based treatment plan has been established for the patient, whether non-pharmacologic and non-opioid therapies have been tried and failed first, and whether the patient has experienced improvements in pain and function or has returned to work. Then, if opioids are warranted, complying with sensible standards can decrease the likelihood that misuse will occur.

Opioids often are directed toward problems like chronic back pain even though these drugs are ill-equipped to ameliorate long-term discomfort. Opioids were designed for reducing pain in end-of-life care involving conditions like cancer and may also be appropriate in certain acute or short-term pain scenarios where other drugs are not effective. For long-term pain, over-the-counter remedies such as acetaminophen and ibuprofen can be just as effective at fighting pain and do so without risk of addiction. The distinction is important because several studies put the prevalence of opioid misuse among chronic pain patients around 20 percent; the Institute of Addiction Medicine [estimates](#) it is as high as 58 percent.

Some prescribers and patients look to opioids because of a lack of understanding around the effectiveness of alternatives such as over-the-counter drugs. A [poll](#) from the National Safety Council, a nonprofit chartered by Congress, found three quarters of doctors erroneously believed morphine and oxycodone were more effective than acetaminophen and ibuprofen. More education is also needed for the individuals taking prescription opioids. Roughly nine in 10 patients taking opioids were not concerned about addiction, according to a separate National Safety Council [survey](#).

Possible signs of opioid use disorder



Decreased function



Intoxication



Negative affective state

Nearly one in four doctors write scripts for at least a month's worth of opioids

While we as an industry have several resources when it comes to recommended management of pain and opioids and risk, these guidelines are only useful if they are applied. Educating providers and injured workers as to the best practices for opioid therapy may be the first step in achieving this objective.

When opioids are in order, complying with prescribing guidelines and engaging patients can help reduce the chances of errant use. There are helpful protocols from state-based medical societies, the Official Disability Guidelines (ODG), the American College of Occupational and Environmental Medicine (ACOEM), and agencies such as the CDC. Although guidelines and evidence-based medicine represent best practices, such recommendations are not always incorporated into everyday care. In a [2017 review](#) of nearly 400,000 nonsurgical claims, the Workers Compensation Research Institute (WCRI) found that use of recommended services such as urine drug testing and psychological evaluation and treatment remained very low for injured workers being treated with chronic opioids. The National Safety Council reported in 2016 that a survey of doctors revealed 99 percent were prescribing far more than the CDC recommends. Nearly one in four were writing scripts for at least a month's worth of opioids. That is alarming because physical dependence is more likely to occur among patients who take opioids beyond two weeks.

What should prescribers do to help patients come off opioids?

Regardless of whether signs of abuse are present, risk from opioids may be mitigated by discontinuing the drugs. Whenever it is considered appropriate to stop opioid therapy, establishing a thorough plan to assist patients in tapering opioid intake with frequent follow-up is crucial. Prescribers should make decisions around weaning in consultation with the patient and roll out any program gradually. The process might take months or even years, [warns](#) the government's National Institute on Drug Abuse (NIDA). The go-slow approach is to avoid withdrawal symptoms expected from the physical dependence caused by this class of drugs. In cases where patients are misusing, it is important to remember opioid use disorder is a chronic condition. This means there are no quick fixes.

Weaning often works in tandem with detoxification. "Detox" essentially refers to medical interventions surrounding the process of managing a patient through withdrawal syndromes related to stopping a particular drug such as opioids. For best results, the process of weaning should be agreed upon with and managed under the supervision of the injured worker's treating provider.

The type of opioid and the patient's comorbid conditions, including substance use disorder and the need for additional treatment, can affect the rate, intensity, and duration of the taper, as well as whether the patient is best suited for inpatient or outpatient detoxification. For example, psych conditions, risk of suicide, or a high risk of aberrant behavior could indicate that tapering in a primary care setting would be most appropriate. All of these considerations should be discussed with the provider.

As a general rule, the [CDC](#) calls for decreasing an opioid at a rate of 10 percent per week, while the [U.S. Department of Veterans Affairs](#) recommends decreasing an opioid at 20 percent to 50 percent of the original dose every week. Whatever the rate or weaning method, the patient should be evaluated at regular intervals, and adjustments to the intensity of the taper should be made as needed.

What tools can prescribers use to help wean patients?

Several medications proven helpful in managing symptoms associated with opioid withdrawal. It is important to understand that many of these assistive medications are not typically seen in workers' comp and might not be covered. It would be wise to coordinate with the claims adjuster should any of these medications be requested for an injured worker.

Prescribers should make decisions around weaning in consultation with the patient and roll out any program gradually

Opioid withdrawal meds are not typically seen in workers' comp

An approach referred to as medication-assisted treatment, or MAT, may help reduce a range of poor outcomes and is supported by several guidelines. The prescribers most adept at deploying MAT do so along with support services such as counseling. Typically, MAT incorporates the drugs methadone or buprenorphine as part of the opioid weaning process. The National Institute on Drug Abuse [recommends](#) using methadone and buprenorphine to help ease symptoms of withdrawal without giving patients feelings of euphoria. Methadone and buprenorphine are opioids themselves; however, they are associated with a lower incidence of producing a euphoric effect among patients who already have an addiction to opioids when used as part of a MAT plan and are FDA-approved for the treatment of opioid dependence. Due to the way these drugs perform at opioid receptor sites and because the body clears them more slowly, they are less likely to generate a euphoric feeling but can still curb cravings. Therefore, the risk is minimal if these medications are used as directed within a broader treatment program, according to the NIDA.

Non-opioid medications may also be incorporated to address specific withdrawal symptoms. For example, clonidine is an alpha-2 agonist typically used to treat heart-related conditions. This drug has been found to be helpful in attenuating the autonomic symptoms of withdrawal such as hypertension, nausea, cramps, sweating, and/or rapid heart rate. NSAIDs may be an option for muscle aches, dicyclomine for abdominal cramps and antihistamines or trazodone have been shown to help with insomnia and restlessness.

When using any of these medications, it is important that prescribers carefully monitor patients. Follow-ups, counseling, and continuing support are critical if a weaning program is to have the best chance of succeeding.

What else can be done to help?

Prescribers cannot counter the challenges of opioid use disorder on their own. In treating injured workers, enhanced clinical controls can help ensure patients, especially those struggling with dependency, have access to appropriate supports including cognitive behavioral therapy and alternatives for managing pain such as physical therapy. Pharmacy benefit managers (PBMs) can require that opioid refills receive prior authorization from the claims adjuster. PBMs also can routinely mine pharmaceutical data to help uncover signs of misuse. As potential patterns of abuse or inappropriate prescribing are identified, the PBM can communicate with the claims adjuster and, where appropriate, the medical providers.

All players from prescribers, caregivers, adjusters, and policy makers to employers and injured workers have a role in helping reduce misuse of opioids. All those who help care for injured workers must strive to achieve the highest possible degree of coordinated care. We must follow best-practice protocols and increase access to networks of providers who specialize in areas like detoxification and management of opioid use disorder. Payors also can boost coverage for alternative treatments that reduce pain such as cognitive behavioral therapy, and insurers can fully reimburse for substance-abuse treatment programs.

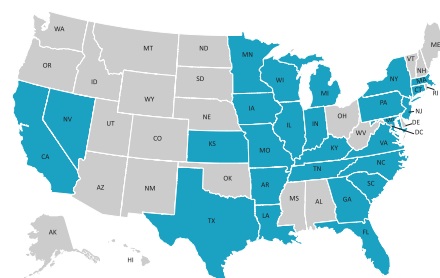
Like many prescribers, federal and state officials are responding. The Department of Health & Human Services (HHS) developed a five-point plan to fight the crisis. The top priority is improving access to prevention, treatment, and recovery services, including the full range of medication-assisted treatments. The agency also wants to more precisely distribute overdose-reversal drugs like naloxone, improve reporting and data on the crisis, foster research on pain and addiction, and advocate improved practices for managing pain.

A White House commission on the opioid crisis [outlined](#) 56 recommendations that include providing greatly expanded access to MAT, mandating prescriber education around proper prescribing, and increasing the number of drug courts. Congress would have to act to implement many of the recommendations including stepped-up funding for treatment. The commission's report came after President Trump instructed HHS to declare the opioid epidemic a public health emergency. The designation brings added focus to the problem though not additional funding. That would, again, require action from Congress.

The action is not limited to the federal level. Many states are marking wins in their fight to constrict the overall flow of opioids going to injured workers. WCRI [reported](#) in June that a majority of about two dozen states that it studied from 2009 to 2015 showed reductions in the frequency and amount of opioids dispensed to injured workers.

All players from prescribers, caregivers, adjusters, and policy makers to employers and injured workers have a role in helping reduce misuse of opioids

Of the 26 states below that were studied by WCRI from 2009 to 2015, a majority of them showed reductions in the frequency and amount of opioids dispensed to injured workers



Where do we go from here?

Those of us who are involved in helping injured workers recover—prescribers, health care providers, payors, case managers, PBMs, and others—share a profound responsibility to make a difference in the most pressing health crisis of our time. We must continue to sharpen our understanding of opioid use disorder and learn how we can intervene as effectively as possible when patients begin to drift toward misuse. This approach offers a critical path forward to help neutralize the frightening lethality of opioid use disorder. More than ever, the costs to the welfare of injured workers—and all patients—are simply too great to do anything less.

Coventry and First Script are here to help

Coventry and First Script have spent a tremendous amount of time and energy developing solutions to address OUD. Our PBM Solutions identify concerning prescriptions at the point-of-sale, and our bill review integration ensures that prescriptions dispensed in alternative settings don't slip through the cracks. Unlike other standalone PBMs, the integration benefits we are able to achieve with our provider networks, utilization review, and case management programs are delivered in a comprehensive risk profile to the adjuster desktop. Contact Coventry to be sure you are getting everything you need to identify OUD, and collaborate on ways to get your injured workers weaned off unnecessary opioids and back to work.

<p>Pharmacy Benefit Management (PBM)</p> <p>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.</p>	<p>Smart Prior Authorizations</p> <p>First Script Smart PAs provide first adjusters with clinical recommendations and therapeutic alternatives that have similar clinical outcomes but are safer or less costly.</p>	<p>Urine Drug Monitoring</p> <p>A comprehensive test panel including the most commonly abused prescription drugs. Risk-modeling tools ensure the right injured workers are tested.</p>
<p>RxRN</p> <p>Specially trained RNs manage all aspects of the injured worker's plan for care and recovery by focusing on emerging and complex pharmacy utilization.</p>	<p>Rx Profile</p> <p>Risk-stratification tools identify injured workers requiring a higher level of clinical review to target adverse opioid utilization and drive potential interventions.</p>	<p>Naloxone</p> <p>Providing naloxone to rapidly reverse opioid effects and restore normal respiration allows the injured worker to seek treatment.</p>

Contact us to explore ways to identify opioid risks and be prepared when recovery alternatives are needed: info@cvty.com | 800.790.9662



- Nurse Triage | Case Management
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- Pharmacy | Bill Review

1. CDC Prescription Opioid Overdose Data <https://www.cdc.gov/drugoverdose/data/overdose.html> 7/12/2017
2. Treatment Episode Data Set (TEDS): 2002-2012 State Admissions to Substance Abuse Treatment https://www.samhsa.gov/data/sites/default/files/TEDS2012N_Web.pdf 7/12/2017
3. Substance Abuse and Mental Health Services Administration, The Drug Abuse Warning Network (DAWN) Report 2011 <http://www.samhsa.gov/data/2k13/DAWN127/sr127-DAWN-highlights.htm> 7/12/2017
4. Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health, 2014 <https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf> 7/12/2017

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