INTENSIVE OPIOID MONITORING AND MANAGEMENT: AN EARLY INTERVENTION MODEL
(CLMO09)

Speakers:

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Learning Objectives

At the end of this session, you will:

• **Learning Objective 1**
  • Understand current evidence on opioid use and misuse. Recommendations of specialty societies and national guidelines will be reviewed.

• **Learning Objective 2**
  • Learn how the First Opioid Fill program was designed to improve quality of care and reduce costs.

• **Learning Objective 3**
  • See preliminary outcomes of the randomized, controlled First Opioid Fill pilot.
AGENDA

I. Employer perspective
   A. Impact of substance abuse in the workplace
   B. Tactics
      1. Policies
      2. Education
      3. Drug screens
   C. What to expect from your TPA/carrier
   D. Case studies

II. Impact of opioid use and abuse
   A. Costs
   B. Morbidity and mortality
   C. Who is responsible?

III. A comprehensive approach to pain
   A. Biopsychosocial model
   B. Evidence-based guidelines
   C. Systematic and customized pain management and its outcomes
   D. An early intervention model

IV. Summary Questions & Answers
I. Employer perspective

- Impact on individuals
  - 20% of patients presenting to physician offices with non-cancer pain symptoms receive an opioid prescription
  - In 2012 259 million prescriptions for opioid medication
  - People with opioid dependence are at high risk for opioid-related adverse events and comorbid conditions
  - Opioids affect the respiratory, gastrointestinal, musculoskeletal, cardiovascular, immune, endocrine, and central nervous systems
  - Chronic opioid use can cause adverse events such as constipation, sleep-disordered breathing, fractures, hypothalamic-pituitary-adrenal dysregulation, and overdose
1. Employer perspective (cont’d.)

- **Impact on individuals (cont’d.)**
  - People with opioid dependence require more visits to or stays in hospitals or clinics than their peers
  - 11.2 times more likely to have had at least 1 mental health outpatient visit
  - 12.2 times more likely to have had at least 1 hospital inpatient stay
  - Nearly a half million emergency room (ER) visits were due to opioid dependence in 2011
  - People with opioid dependence were significantly at higher risk for conditions associated with drug abuse than their peers.
I. Employer perspective (cont’d.)

• Social impact for employers
  • Opioid dependence cannot only have negative effects on individuals but also can have tremendous social costs.
    — Destroys families
    — Low educational achievement
    — Lower productivity
    — Unemployment
    — Homelessness
    — Destabilizes communities
    — Increases crime
    — Increases transmission of disease (such as HIV and hepatitis)
    — Increased healthcare costs
1. Employer perspective (cont’d.)

• Economic impact

  • The economic cost of opioid dependence is enormous

  • $56 billion per year in total US costs in lost workplace productivity, healthcare, and criminal justice

  • Healthcare costs account for $25 billion

  • Average healthcare cost per patient is 8 times higher compared to non-dependent patients

  • Inpatient hospital costs are 24 times higher for patients with prescription opioid dependence
I. Employer perspective (cont’d.)

• How is Adecco addressing this challenge on global basis?

  • Adecco’s drug policy is under review and revision (HR, Operations, Risk, and Legal are reviewing the policy and revising the drug testing protocols). Including prescription medication in our revised testing program.
  
  • Adecco is providing education to our colleagues on the dangers of prescription painkiller use and misuse. Working with our carrier/broker to provide resources.
  
  • Making our front line managers more aware of enforcing the drug policy. Training them to be observant for potential signs of drug impairment.
  
  • Promoting our EAP program as a confidential and cost-effective method to address the issue of opioid utilization.
1. Employer perspective (cont’d.)

- What to expect from TPA/Carrier
  
  - Claim Management Process
    - Periodic claim review — utilization and history
  
  - Constant interaction with nurse case managers – Alerts when a claimant surpasses certain thresholds of utilization
    - long term use of opioid over a period of 120 days
    - excessive utilization within the first 90 days of an injury
  
  - Targeted education for all adjusters and nurse case managers
  
  - Targeted letters sent to prescriber during key times in the usage cycle
  
  - Communication !!!!
I. Employer perspective (cont’d.)

- What to expect from your TPA/Carrier
  - Strategic approach customized to the patient’s medical history
  - Targeting more specifically to the injured body part and nature of injury
  - Alternatives to opioids and quantity limitation
  - Clinical reviews (Medical Management)
    - Medication Reviews
    - Pharmacy Peer reviews
    - Pharmacist and Nurse involvement
    - Risk Assessment and Scoring – Predictive modeling
    - Urine Drug Monitoring Program
    - Benchmark doctors in the network – How are they doing?
I. Employer perspective (cont’d.)

• Case Studies

Case Study 1

• 31 year old female

• Job entails “shooting bolts” in an awkward position

• DOI 12/18/14: painful right wrist

• 12/23/14: restricted duty, ice, ibuprofen (NSAID)

• 2/11/15: tramadol (opioid)

• 3/6/16: refill of tramadol

• 3/6/16: FOF intervention initiated

• No further opioids. Treatment included Naprosyn (NSAID), splinting, and PT.
1. **Employer perspective (cont’d.)**

• Case Studies

  **Case Study 2**

  • 34 year old female
  
  • Previous history of cervical disc disease and **opioid dependence**
  
  • DOI 2/2/15: lumbar pain after lifting a computer
  
  • Treatment: meloxicam (NSAID), flexeril (muscle relaxant) and PT
  
  • 2/24/15-3/2/15: percocet, fentanyl and oxycodone (all opioids)
  
  • 3/12/16: FOF intervention initiated
  
  • Opioids discontinued 3/26/16
II. Impact of Opioid Use and Abuse

- A 20 year trend of increased opioid usage, peaking in 2013
- 259M opioid prescriptions per year
- "Long-term" opioid use ranges from 4% to 17% varying by state
- Pharmaceuticals represent 18% of total WC medical costs
- "Narcotics" represent 25% paid Rx costs
II. Impact of Opioid Use and Abuse (cont’d.)

- Canada and U.S. combined consume most of the global supply of opioids
  - 99.9% of hydrocodone
  - 87.3% of oxycodone
  - 60.1% of morphine

- Average opioid dosage (MED) had increased from 80 mg to 140 mg between 1996 and 2002

- Prescription opioid deaths: 16,235 in 2013 (= 46/day) quadrupled since 1999 (exceeds mortality from heroin and cocaine combined)

- ER visits for prescription opioid complications have doubled in 7 years, to 488,000 annually
II. Impact of Opioid Use and Abuse (cont’d.)

- Opioid mortality and morbidity correlates with the morphine equivalent dose (MED)

<table>
<thead>
<tr>
<th>MED</th>
<th>Relative Risk of Fatal OD</th>
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<tbody>
<tr>
<td>1-19</td>
<td>1</td>
</tr>
<tr>
<td>20-49</td>
<td>2.2</td>
</tr>
<tr>
<td>50-99</td>
<td>6.0</td>
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<tr>
<td>≥ 100</td>
<td>11.3</td>
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</tbody>
</table>

- Opioid mortality correlates with the rise in opioid prescribing

- 2.1M Americans are addicted to opioid pain relievers

- Addiction rate is 3.27%
II. Impact of Opioid Use and Abuse (cont’d.)

Annu. Rev. Public Health. 36:559–74
II. Impact of Opioid Use and Abuse (cont’d.)

II. Impact of Opioid Use and Abuse (cont’d.)

- Opioid use predicts high claim costs, longer claim duration, and delayed return-to-work

- Opioid use has been declining slowly: one PBM reports 3.8% reduction in prescriptions per claim, and percentage of opioid users down from 61.8% to 60.2% (annual)

- Diversion and abuse of Rx opioids increased between 2002 and 2010, and plateaued or decreased between 2011 and 2013
II. Impact of Opioid Use and Abuse  
(cont’d.)

• Relative rates of opioid prescriptions by specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Rate</th>
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<tbody>
<tr>
<td>Internal Medicine</td>
<td>0.965</td>
</tr>
<tr>
<td>General/Family Medicine</td>
<td>1.0</td>
</tr>
<tr>
<td>OB/Gyn</td>
<td>1.116</td>
</tr>
<tr>
<td>ENT</td>
<td>1.248</td>
</tr>
<tr>
<td>Other</td>
<td>1.392</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>2.715</td>
</tr>
<tr>
<td>Dentists</td>
<td>3.461</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>7.115</td>
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</table>

• Survey: Most practicing physicians do not use clinical guidelines “in most cases”. However, a substantial 44% claim to do so “consistently”; 12% are “planning’ to do so; and 26% are “considering” using them.
Ill. A Comprehensive Approach to Pain

Psychosocial Risk Factors

- ADL’s
- Illness Behaviors
- Psychological Distress
- Work
- Attitudes
- Beliefs
- Personality Disorders
- Pain
III. A Comprehensive Approach to Pain (cont’d.)

• So how do we minimize pain?

A multi-faceted approach using resources and expertise within a systematic framework that recognizes the biopsychosocial nature of pain

• Research
• Guidelines
• Education
• Intervention
III. A Comprehensive Approach to Pain (cont’d.)

• Guidelines – a plethora
  • Multiple states (especially Washington)
  • ACOEM (American College of Occupational and Environmental Medicine)
  • APS (American Pain Society)
  • ODG (Official Disability Guidelines)
  • Veterans Administration/Dept. of Defense
  • AAPM (American Academy of Pain Medicine)
  • WHO (World Health Organization)
  • Canadian Pain Guidelines
III. A Comprehensive Approach to Pain (cont’d.)

- Core Guidelines
  
  - Opioids are generally recommended only for acute, severe pain (not for moderate or chronic pain)
  
  - EBM research confirms that
    - Opioids significantly delay an IW’s return to work
    - There is no scientific medical evidence of benefit of long-term opioid therapy in achieving sustained pain relief or functional improvement
  
  - Opioids may aggravate pain symptomatology through development of hyperalgesia (increased pain sensitivity)
III. A Comprehensive Approach to Pain (cont’d.)

- Core Guidelines (cont’d.)

  - Opioids have numerous adverse effects that often create the need for additional drug therapy to manage these conditions (e.g., cognitive problems, sexual dysfunction, somnolence, constipation, etc.)
  
  - Opioids present a significant risk of dependency, misuse, drug diversion and at times addiction, sometimes culminating in overdosage and death
  
  - Opioids should typically be used only for up to a 6 week duration post acute injury, and (with few exceptions such as major bone, spine, or joint surgeries) should not exceed 12 weeks in total duration. Opioids should be discontinued if there is no substantial pain relief or functional improvement in activities of daily living and/or when untoward side-effects cannot be easily managed.
III. A Comprehensive Approach to Pain (cont’d.)

• Core Guidelines (cont’d.)

• There are multiple other pharmacological and non-pharmacological alternatives to opioid therapy that should be considered in preference to opioids:
  • anticonvulsants (e.g., gabapentin)
  • NSAIDS (e.g., ibuprofen) and acetaminophen
  • tricyclic or SNRI antidepressants for neuropathic pain (e.g. amitryptiline, venlafaxine)
  • restorative physical/occupational therapy
  • cognitive behavioral therapy (CBT)
  • interdisciplinary pain management/functional restoration programs
III. A Comprehensive Approach to Pain (cont’d.)

- **Core Guidelines (cont’d.)**

  - Physicians should calculate and document morphine equivalent dosages (MEDs) for all opioid users, and ensure that dosages do not exceed 120mg without justifiable written exceptions

  - All opioid users should be subject to periodic urine drug testing/monitoring (UDT/UDM) to determine patient compliance, possibility of drug diversion, and concurrent use of illicit substances. Most authorities suggest UDT/UDM be performed:
    - at baseline
    - 1-4 times per year if opioid use is warranted for a prolonged period, based on risk level
    - whenever ‘red flags’ are identified (e.g. early refill requests, lost prescriptions, cognitive decline/somnolence, intoxication, drug-seeking behavior, presence of unprescribed drugs and/or illicit substances, etc.)
III. A Comprehensive Approach to Pain \textit{(cont'd.)}

- **Core Guidelines \textit{(cont'd.)}**
  
  - Benzodiazepines (and other hypnotics/psychoactive medications) and muscle relaxants should be avoided in general and particularly when opioids are prescribed
  
  - Physicians should check their state’s PDMP (prescription drug monitoring program) to identify inconsistent and duplicative drug patterns prior to prescribing controlled drugs to the patient
III. A Comprehensive Approach to Pain (cont’d.)

- **Structure of a comprehensive program**
  - Early identification of high risk individuals, leading to timely evaluation and intervention to prevent and/or impact chronicity
  - Effective use of internal and external resources, ensuring coordinated management by the selection and application of appropriate expertise
  - Setting and measuring program outcomes using metrics related to clinical quality, medical costs, return-to-work, and participants’ satisfaction
III. A Comprehensive Approach to Pain (cont’d.)

C.A.M.P. Umbrella

Comprehensive Assessment and Management of Pain

- Pharmacogenomics
- Chronic Pain Program
- First Fill Opioid Monitoring
- Urine Drug Monitoring
- Opioid Tapering Program
- Medication Utilization Management
- Cognitive Behavioral Therapy
It takes a village...

- utilization review RNs
- case management RNs
- physician (peer) reviewers
- pharmacy benefit managers (PBM)s
- urine drug monitoring (UDM) labs
- function restoration/multidisciplinary pain programs
- psychologists (CBT)
- addiction specialist MDs
- prescription drug monitoring programs (PDMPs)
III. A Comprehensive Approach to Pain (cont’d.)

Opioid Trends

- % of Claimants on Opioids:
  - 2012: 65.2%
  - 2013: 62.5%
  - 2014: 61.7%
  - 2015: 57.3%

- % of Spend for Opioids:
  - 2012: 39.9%
  - 2013: 37.6%
  - 2014: 35.4%
  - 2015: 33.0%

- % Opioid Claimants COT >90 days:
  - 2012: 39.6%
  - 2013: 48.6%
  - 2014: 41.3%
  - 2015: 41.0%

- % Opioid Claimants >=120 mg MED:
  - 2012: 11.7%
  - 2013: 11.7%
  - 2014: 10.6%
  - 2015: 10.7%
III. A Comprehensive Approach to Pain (cont’d.)

Early Intervention: The First Opioid Fill Program

- Pharmacy Benefit Manager (PBM) notification of first fill
- Randomization of claimants by odd/even claim numbers
- Control group receives “usual” care
- Active group receives:
  - educational packet to physician
  - opioid information letter to claimant
  - monitoring for continued opioid fills
  - case manager assignment at 4 weeks
  - physician review and peer-to-peer contact at 10 weeks
  - consideration of additional non-pharmacological interventions (CBT, etc.)
III. A Comprehensive Approach to Pain (cont’d.)

Early Intervention: The First Opioid Fill Program

- Educational materials sent to prescriber:
  - Pain Guidelines
  - Opioid Risk Tool
  - Articles on long-term opioid ineffectiveness
  - Two item graded chronic pain scale
  - Link to MED calculator
  - Urine drug monitoring (UDM) risk/frequency guideline
  - Sample opioid treatment agreement
  - 4 A’s (analgesia, activities of daily living/ADLs, adverse side effects, aberrant drug-related behavior)
  - Prescription Drug Monitoring Program information
III. A Comprehensive Approach to Pain (cont’d.)

Outcomes (Bill Review Data)

First Opioid Fill Outcomes
Active v Control Groups

- Pharmacy Spend
  - Book of Business: -22%
  - Adecco: -25%

- Opioid Prescription Count
  - Book of Business: -14%
  - Adecco: -21%
III. A Comprehensive Approach to Pain (cont’d.)

Outcomes (PBM A)

First Opioid Fill Outcomes: Active vs Control Groups

- Avg Pharmacy Cost/Claimant/Month: $165 (Control) vs $95 (Active)
- Avg Opioid Cost/Claimant/Month: $70 (Control) vs $44 (Active)
Outcomes (PBM A)

III. A Comprehensive Approach to Pain (cont’d.)

First Opioid Fill Outcomes
Active v Control Group

Average Morphine Equivalent Dosage (mg)

<table>
<thead>
<tr>
<th></th>
<th>Avg Daily MED</th>
<th>Avg MED per prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>46 mg</td>
<td>44 mg</td>
</tr>
<tr>
<td>Active</td>
<td>39 mg</td>
<td>55 mg</td>
</tr>
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</table>
III. A Comprehensive Approach to Pain (cont’d.)

Outcomes (PBM B)

First Opioid Fill Outcomes
Active v Control Group

<table>
<thead>
<tr>
<th>Total Pharmacy Cost</th>
<th>Total Opioid Cost</th>
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<tbody>
<tr>
<td>Control</td>
<td>$58,910</td>
</tr>
<tr>
<td>Active</td>
<td>$47,366</td>
</tr>
</tbody>
</table>

$187,536  $158,981
III. A Comprehensive Approach to Pain (cont’d.)

Outcomes (PBM B)

First Opioid Fill Outcomes
Active v Control Groups

Avg prescription cost

Control
$63

Active
$54

Avg opioid prescription cost

Control
$40

Active
$34
III. A Comprehensive Approach to Pain (cont’d.)

Outcomes (PBM B)

Days of supplied opioids

First Opioid Fill Outcomes
Active v Control Groups

Control: 16,635
Active: 14,326
IN CONCLUSION:

• Opioid misuse remains a major concern despite recent mitigation of the trend

• Employers and managed care organizations need to collaborate in order to successfully address the problem

• There are ample evidence-based guidelines, tools, and resources available to address opioid misuse

• Structured initiatives founded on EBM principles can favorably impact the utilization of opioids in workers compensation