CHAPTER 20

THE OPIOID CRISIS: EMPLOYERS HAVE THE ANTIDOTE

Tom L. Shupe is a senior manager at an Oklahoma manufacturer. For 37 years, he has been on the frontlines of the challenges facing U.S. manufacturing. He's full of insight, but the most surprising is that he blames substance abuse—specifically opioids—for the majority of these challenges. "It's all addiction issues," says Shupe. He calls the opioid crisis, which is really an epidemic of addiction, "probably the biggest threat in manufacturing, period." [106]

Here's something even more shocking: Employers are unwitting accomplices, enablers, and victims of this public health crisis, the largest since the 1918 flu epidemic.

Let's look at just one example. A major challenge of physically demanding, hourly jobs is that if you don't work, you don't get paid. An injured worker must choose between not working and not getting paid, or continuing to work in pain and getting paid. Opioids start as a short-term fix, enabling the worker to stay on the job, but they also slow healing—and can even prevent it. If the worker has the predisposition to addiction, this launches a vicious escalating cycle.

There is a growing trend that equates long-term chronic pain patients with people suffering from opioid addictions. There are an array of rare diseases, such as Ehlers–Danlos syndrome, where well-managed opioid regimens can be the appropriate course of treatment. We must be careful that the zeal to address the opioid crisis doesn't inflict unnecessary suffering on those with these types of long-term chronic pain. This is where physicians having adequate time to treat patients as individuals is imperative. Other countries manage to work with these long-term pain patients without the opioid crisis that America is dealing with.

Beyond the obvious human toll, there is a compelling business imperative to solve this crisis. Supporting early identification of addiction, along with access to effective treatment and relapse prevention, doesn't just help the sick and suffering. It makes great *economic* sense in ways we'll discuss throughout this chapter.

Make no mistake: The opioid crisis is a complicated issue over thirty years in the making. But companies have played a major role in creating and sustaining the crisis. However, a vanguard of employers are realizing that they have a major role to play in solving it, recognizing the solutions fall well beyond what the government alone can do. The opioid epidemic is a microcosm and mirror of the role employers can play in creating and fixing our failing health system as a whole. Ending it will meaningfully move us down the path to solving our larger health crisis.

Primary Drivers

There are 12 primary drivers of the opioid crisis, all of which must be addressed by the country and, specifically, by employers.

1. Economic distress

Drug, alcohol, and suicide mortality rates are higher in counties with more economic distress and a larger working class. Many counties with these high mortality rates have also seen significant manufacturing employment losses over the past several decades.[107] For every 1% rise in unemployment, there's a 4% rise in addiction and a 7% increase in emergency department visits.[108] Remember health care costs can consume as much as 50% of an employee's total compensation package for the half of the workforce making less than $15 per hour.[109] For many, many industries, health care costs are the primary driver suppressing wages and job growth.

2. Health-related state/local budget challenges weaken community resilience

Governments can only raise taxes so much. We've seen how out-of-control health care costs have eaten away at the very items that make a community more resistant to public health challenges. Nearly every budget item that has been cut or affected is an element of solving the opioid crisis. One example is mental health funding, a particularly powerful antidote to the opioid crisis. At the local level, funding shortfalls are exacerbated by tax-exempt health systems that are often among the largest property owners, yet pay no taxes. Yet America's perverse health care incentives continue to reinforce the common view that building hospitals is an economic driver.

3. Declining physician reimbursement increases likelihood of prescribing

The current reimbursement amounts for most physicians in private practice continues to decline, despite an escalation of both operating costs and administrative burden. As a result, patient volume increases and the average amount of time a provider can spend with each patient decreases. As patient interaction

time decreases, the probability of writing an opioid prescription increases.

These pressures to increase volume make it incredibly challenging for most providers, who typically are not well versed in addiction medicine, to identify and effectively manage patients with chronic pain, mental illness, and potentially undiagnosed substance abuse.

4. Mental illness treated with opioids

According to a recent study, more than half of all opioid prescriptions in the United States each year go to adults with a mental illness, yet just 16% of the U.S. population suffers from mental illness.[110] It's important to note that depression and anxiety worsen pain and vice versa. Healthy and effective stress and life-coping skills can decrease the impact of this pain. Conversely, a lack of effective coping skills can leave one vulnerable to experiencing a much greater degree of suffering from pain.

5. Undertreated pain leading to a 5th vital sign

Pain as a vital sign was initially promoted by the American Pain Society to elevate awareness of pain treatment among health care professionals. The Veteran's Health Administration made it a 5th vital sign in 1998, followed by their creation of the "Pain as the 5th Vital Sign Toolkit" in 2000. This made pain equal to things like blood pressure—a number to be managed with medications or lifestyle changes. In 2001, the Joint Commission established standards for pain assessment and treatment in response to the national outcry about widespread undertreatment, putting severe pressure on doctors and nurses to prescribe opioids.

6. Patient satisfaction scores influence hospital income

Results from Press Ganey and HCAHPS patient satisfaction surveys directly impact hospital income, further amping up the pressure. Administrators have often harangued nurses and doctors to make patients happy by giving them opioids.

7. Pharma's sales and marketing blitz

Pharmaceutical companies capitalized on the previous drivers. Through major marketing campaigns,[111] they got physicians to prescribe opioids such as Percocet and OxyContin in high quantities—even though evidence[112] for using opioids to treat long-term, chronic pain is very weak[113] and evidence that they cause long-term harm is very strong.[114] Additionally, no organization has potentially had more ability to flag the growing crisis than pharmacy benefits managers. Instead, they let the crisis explode in severity. In contrast to other countries, U.S. physicians stopped prescribing slow and low, a byproduct of which is that huge amounts of opioids are readily available in medicine cabinets for people suffering any level of pain—and for teenagers to abuse. Direct-to-consumer advertising also significantly increased patient requests for opioid prescriptions.[115]

8. Patients looking for a quick fix

An unfortunate part of American culture is seeking quick fixes. Patients want a pill for instant pain relief and advertising has conditioned them to expect this. This tendency is exacerbated by doctors looking for a quick fix during short appointments with patients. The reality is most patients hear more from pharmaceutical companies (16-18 hours of pharma ads per year[116]) than from their doctor (typically under 2 hours per year).

With this "instant-fix" conditioning from players across the health care system, many patients aren't willing to invest time in things like cognitive behavioral therapy, mindful meditation, or a regular program of physical therapy/exercise. At the same time, we've forgotten that some pain is a good indicator of an issue to solve and shouldn't be instantly numbed.

Ironically, careful opioid-based treatment can be appropriate for some people suffering from certain types of long-term chronic pain, but they are often denied appropriate medications, instructions, or supervision as a result of the other drivers.

9. Opioids used for non-cancer chronic pain (e.g., back pain)

Eighty percent of people will have lower back pain in their lifetime, making it one of the most common reasons for missing work.[117] Stress or inappropriate posture, a sedentary lifestyle, and poor workplace ergonomics can all lead to back, neck, and other kinds of musculoskeletal (MSK) pain. The American Academy of Neurology (AAN) told its members that the risks of opioids in treating noncancer chronic pain patients far outweighed the benefits, yet the practice is widespread. The AAN observed that if physicians stopped using opioids to treat conditions such as fibromyalgia, back pain, and headache, long-term exposure to opioids could decline by as much as 50%.

10. Lack of access to specialists

For many physicians in rural areas, where pain specialists with high-quality experience and training are shockingly rare. The only tool in the toolbox has often been more pills.

11. Criminals abuse of the system

In many locales, doctors lacking ethics have been easier to find than proper pain treatment. "Pill mills" disguised as "pain clinics" gave legitimate pain doctors a bad name. Pharmacy benefits managers and pharmacies were more than willing to go along with the game, making billions in the process. The public and private sector purchasers dropped the ball on this by not having opioid prescribing databases in place to catch the bad actors. As prescription opioid availability has tightened up, cheap black tar heroin has filled the need for individuals suffering from addiction. People addicted to opioids are 40 times more likely to become addicted to heroin.[118]

12. Insurers' refusal to cover validated treatments

Insurance companies have generally refused to cover scientifically validated approaches for pain management—such as

mindful meditation, cognitive behavior therapy, psychological support, or interventional pain procedures. Even when a physician appeals to an insurance company to approve treatments that may help the patient, several months or even years can go by, especially in worker's compensation cases.[119] As a result of increased tolerance, the patient may then be on escalating doses of opioids just to function. This results in more anxiety and depression, often leading to financial devastation as a result of losing their employment.

While we are talking about physicians, let's clear up one misunderstanding. Most good doctors, even those who aren't salaried employees, have no financial incentive to get their patients hooked. The waiting lists to be seen by a pain specialist are weeks long and these doctors aren't going to run out of patients anytime soon. The vast majority really want their patients to get better. A chronic pain patient who no longer needs pills or experiences pain is the best marketing a doctor could ask for. Most doctors have been trying to do the right thing based on what they knew about opioids and what insurers would cover.

A Weight Around Employers' Necks

Before delving into the antidotes, let's take a quick look at the damage opioids are wreaking on the American economy in general and employers in particular. This isn't to ignore the immense human suffering caused by the crisis, just to surface other damage that's often not seen or understood.

Here's a good starting point: Opioid related overdoses—often taken in conjunction with other central nervous system depressant drugs like benzodiazepines or alcohol—are now the leading cause of death for working age people under 50 years old, surpassing deaths from guns and car crash.[120]

LinkedIn's Work in Progress podcast had a couple big takeaways on how the opioid crisis negatively impacts employers.[121]

- At a Congressional hearing focused on opioids and their eco-

nomic consequences, Ohio attorney general Mike DeWine estimated that 40% of job applicants in Ohio either failed or refused a drug test.[122] This results in higher unemployment rates and solid middle class jobs go unfilled. In earlier Congressional testimony from July 2017, Federal Reserve chair Janet Yellen connected opioid use to a decline in the labor participation rate.

- The issue is amplifying labor shortages in industries like trucking, which has had difficulty recruiting qualified workers for the last six years. It's also pushing employers to broaden their job searches, recruiting people from greater distances when positions can't be filled locally. At stake is not just unemployment rates, workplace safety, and productivity—but whether workplaces need humans at all. Some manufacturers claim opioids are forcing them to automate faster.

Some may find drug testing intrusive, but accidents at many jobs—such as manufacturing and transportation—pose potentially huge consequences. For example, opioids were to blame for the Staten Island Ferry disaster that killed 11 and injured dozens.[123] Plus, "presenteeism," where an employee performs sub-optimally while at work, is a very big problem for employers. Impairing pain or medications, especially opioids, often causes this. Unlike cocaine or heroin, where a confirmatory drug screen results in termination, a "legitimate" prescription for Oxycodone and Xanax is a much murkier human resources problem.

The New York Times reported that workers who receive higher doses of opioids to treat injuries like back strain stay out-of-work three times longer than those with similar injuries who receive lower doses.[124] Between disability and medical care payments, the cost of a workplace injury is as much as nine times higher when opioids are used. An employee's medical expenses and lost wage payments averages about $13,000, but this triples to $39,000 when they are prescribed a short-acting painkiller like Percocet—and it triples again to $117,000 when a stronger, longer-acting opioid like OxyContin is prescribed.

In the same article, Dr. Bernyce M. Peplowski, the medical director of the State Compensation Insurance Fund of California said that insurer policies for covering painkillers, but not evidence-based physical therapy approaches, may "have created a monster."

The Path Forward

While we must be smarter about treating those already afflicted with opioid addictions, we must also turn off the spigot to clean up the mess. If there's a silver lining to the opioid crisis at all, it's that it shines a light on just how abysmally our health care system has been performing.

At the end of Sam Quinones' gripping book on the opioid crisis, *Dreamland,* he argues that the sustainable fix is community.

> *A community that addresses social determinants of health like safe neighborhoods, quality jobs, and a health care system that can treat those afflicted with opioid overuse disorders while preventing others from being drawn into the hell of addiction.*

Employers who use the opioid crisis as a catalyst to change their approach to health care also do their broader community a great service. By extension, they help create a better pool of prospective employees to draw on.

When one realizes that the opioid crisis isn't an outlier situation, but a microcosm of our larger health care dysfunction, it's clear how solving one of the largest public health crises in American history is a catalyst for dramatically improving our health care system.

Put simply, employers who adopt Health Rosetta type benefits programs are far more likely to have much lower rates of employees and dependents suffering from opioid overuse disorders.

Let's revisit our 12 drivers with examples of Health Rosetta type benefits from elsewhere in the book to show how this is possible. More details are available at healthrosetta.org.

Opioid crisis driver	Proven employer antidotes
Economic distress	The case study about Tulsa-based Enovation Controls shows how a manufacturer with a blue-collar workforce designed benefits that make smart decisions free (e.g., eliminating copays and deductibles when using high value surgical hospitals) and bad decisions expensive (e.g., going to low quality providers who have higher complication rates, poor outcomes, and overtreatment). (*Case Study: Enovation Controls)*
Health-related state/local budget challenges weaken community resilience	Examples abound in our case studies. On the East coast, the Allegheny County Schools case study shows how steering school district employees and dependents away from low-value (even if high reputation) medical centers can improve teacher pay and reduce class sizes. In the Midwest, the City of Milwaukee has avoided many budget struggles afflicting other large Midwestern cities by controlling health care costs. On the West coast, the city of Kirkland, WA has found that the best way to slash health care costs is to *improve* benefits.[125] While many communities are pulling back on investments that drive health outcomes (walkability, safety, parks, clean air/water), Kirkland is able to maintain or increase these investments in community well-being. *(Case Studies: Pittsburgh Schools; City of Milwaukee)*

Declining physician reimbursement increases likelihood of prescribing	In a value-based primary care model, patients have the proper amount of time with their doctor. More patient interaction time shuts down some of the onramps to opioids, whether it's inappropriate opioid prescribing or unnecessary and excessive surgeries that are typically followed by opioid prescriptions. *(Chapter 13)*
Mental disorders treated with opioids	Evidence-based benefits plans ensure behavioral health is woven into primary care, not an afterthought. A subtle, but critical, success factor is removing barriers to mental health professionals. Where there is sufficient employee concentration, behavioral health services should exist inside clinics, so there's no separate (and potentially stigmatized) visit with a mental health specialist. In other settings, it's more practical to have the mental health specialist connected remotely, an approach that also overcomes the disparity in different locations' access to mental health professionals. Behavioral health issues are particularly shortchanged in the rushed, "drive by" primary care appointments that are all too common in volume-driven primary care. Since mental health issues underlie so many exacerbations of chronic diseases, it is part of the "magic" of proper primary care that there is time to pick up on issues that may keep someone from adhering to a care plan. *(Chapter 13)*

Undertreated pain leading to a 5th vital sign	Value-based primary care is critical to physicians understanding the issues behind a patient's pain. With MSK-related costs accounting for ~20% of employer health care spending, wise employers integrate physical therapy specialists into primary care and workplace design, leveraging organizations using evidence-based physical therapy upfront in triage of pain. *(Case Study: City of Milwaukee)* Appropriate use of drug testing and regular checks of the state prescription drug monitoring reports can help identify a substance abuse disorder earlier, starting the process to wellness. *(Case Study: Rosen Hotel & Resorts)*
Patient satisfaction scores' influence on hospital income	Evidence is mixed on whether patient satisfaction correlates with improved outcomes—or greater inpatient use, higher overall health care & prescription drug spending, and increased mortality.[126] Wise employers contract with health care organizations focused on other metrics. For example, Net Promoter Score (NPS), a measure of customer likelihood to recommend a product or service, is more likely aligned with approaches focused on keeping people well. *(Chapter 1; Chapter 5)*.
Big pharmas' sales and marketing blitz	Let's face it, sales and marketing works. If a physician hears more about pharmaceutical approaches than non-pharmaceutical ones, this will influence their behavior. Value-based primary care organizations ensure clinicians receive education on treatment options that maximize value and come from unbiased sources—and have time to explain to patients how non-opioid treatment options are more effective. They also have viable, quantifiable treatment alternatives in place. *(Chapter 11; Chapter 13; Case Study: Langdale Industries)*

Patients looking for a quick fix	Value-based primary care organizations recognize that pain rarely has quick fixes. There is usually some issue beneath the pain and doctors need sufficient time with patients to uncover it.
Opioids used for non-cancer chronic pain (e.g., back pain)	Modern benefits programs weave non-opioid options into both the clinic and non-clinic settings. One example is physical therapy for back pain. Another is Rosen Hotel's incorporating movement training and ergonomic adjustments into the workplace. A well-informed plan should require that certain steps be taken before and after administration of opioids, such as placing a time limit on how long an employee can be authorized to take the medication. *(Chapter 5; Chapter 9; Chapter 10; Chapter 12; Case Study: Rosen Hotel & Resorts)*
Lack of access to specialists	As we have seen, sending employees to centers of excellence and using telemedicine are two increasingly common ways savvy companies are overcoming this problem. From both a lack of specialist access and burdensome pricing perspectives, the Langdale case study shows how it can be done and pay for itself many times over—including travel—in rural Georgia. *(Chapter 19, Case Study: Langdale Industries)*
Criminal abuse of the system	Mostly outside the domain of employers, however effective approaches make employees less vulnerable to pursuing illegal drugs.
Insurers' refusal to cover validated treatments	Health Rosetta type benefits pay for evidence-based services, such as physical therapy, cognitive behavioral therapy and other behavioral health services delivered via telehealth, value-based primary care, etc. *(Chapter 1; Chapter 5; Chapter 12; Chapter 13)*

Throughout this book, I have highlighted progressive employers and benefit strategies that have created replicable microcosms of high-performing health care as good as any in the world. It's in the enlightened self-interest of all employers to follow suit.