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Workers' Compensation: It's Been A Long, Strange Trip

Prescription & Other Drugs in the Workplace

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PRESCRIPTIONS AND OTHER DRUGS IN THE WORKPLACE

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Prescription drug abuse is the country's fastest growing drug problem and has now been classified as an epidemic. Drug distribution through the pharmaceutical supply chain was the equivalent of 98 mg of morphine per person in 1997. It was approximately 700mg per person in 2007 and far exceeds that number now. More than twice as many Americans have died from the prescription opioid overdose epidemic than during the Vietnam War.

Decades ago, when these opioids came on the market, pharmaceutical companies told doctors that these painkillers were not addictive. This coincided with insurance companies beginning to use "pain relief" as a measurement by which to determine reimbursement. It was the perfect storm.

Attorney General Mike DeWine came into office with one of his goals being to close down the pill mills and stop the opiate dependence, abuse and addiction in Ohio. He was successful in shutting down many of the known pill mills. The Ohio legislature has passed numerous laws in the last few years directed to controlling prescription pain relievers.

However, an unintended consequence is that one Vicodin pill costs $25 on the street and a hit of heroin costs $5. So users, abusers and addicts simply moved from pills to heroin – which can be snorted, smoked or injected. And it is very available. The folks who have moved from prescription pain killer abuse and addiction are not your stereotypical heroin addicts. They cross all races, genders, ages, occupations and socioeconomic barriers. They are high school athletes,

soccer moms, young professionals, unemployed, factory workers, single, married and grandparents.

In 2015 heroin killed at least 23 Ohioans a week. In 2015 there was a drug overdose death every 2 hours and 53 minutes in Ohio. Eight people in Ohio died from drug overdoses every day. Deaths in Ohio from drug overdoses have risen 20.5% since 2014. In 2016 there were 3,050 drug overdose deaths in Ohio – 1/3 of those deaths involved fentanyl.

The most common ages of fentanyl users are between 25 and 34. Men are twice as likely to die of an overdose as women. The numbers by county (for the top 13) are as follows for 2015:

Hamilton County – 195 deaths

Summit County - 111 deaths

Butler County – 104 deaths

Montgomery County – 102 deaths

Cuyahoga County – 83 deaths

Clermont County – 54 deaths

Clark County – 48 deaths

Lucas County – 41 deaths

Franklin County – 40 deaths

Stark County – 26 deaths

Trumbull County – 25 deaths

Lorain County – 21 deaths

Greene County 20 deaths

Those numbers are even higher for 2016 and are predicted to go even higher for 2017 as there are new and more deadly drugs on the market every day.

In 2016 there were more drug overdose deaths in the United States than motor vehicle accident deaths.

Users are getting their drug of choice – heroin, cocaine and meth – and it is being "cut" or laced with fentanyl, an extremely strong opiate, carfentanyl, a large animal sedative, and any number of other substances that lead to death. One of the newest drugs on the market is "grey death", a meth substance that looks like concrete – either in rocks or a grey powder.

What most drug users do not know is that a hit of fentanyl that is no larger than a grain of salt can kill. Drug addicts might know that but will take the hit regardless because of their addiction. Commonly used opiates are: Hydrocodone (Vicodin or Lortab), Oxycodone (Oxycontin and Percocet), Morphine, Codeine, Heroin and Fentanyl. These people are your employees and your clients.

How Opiates affect the Brain

There is opiate tolerance, opiate dependence and opiate addiction. In other words opiate use, opiate abuse and opiate addiction. Understanding the neurobiology of dependence and addiction is helpful in providing insights into an employee's behaviors and may be helpful in determining treatment methods. Specifically, if your employee or client is dependent on opiates, the abnormalities in the brain appear to resolve after detoxification within days or weeks once he/she stops taking opiates. However, the abnormalities that produce addiction are more wide-ranging and long lasting. They can involve a number of factors such as the social context of the use, stress (maybe on the job) as well as a genetic predisposition in the form of brain pathways that were abnormal even before the addict took the first dose.

As the opioid travels through the brain it attaches to proteins called mu opioid receptors. This triggers feelings of intense pleasure. One of the brain circuits activated is the mesolimbic (midbrain) reward system. This generates signals in the ventral tegmental area (VTA) that result in the release of dopamine (DA) in another part of the brain. This is what causes the feeling of intense pleasure. Another part of the brain stores a memory of that pleasure, associating it with the opioid.

However, the more opioids a person takes and the longer they are taken, he/she can build up a tolerance that creates a need for higher doses and harder drugs to achieve that intense pleasure feeling. The two things that keep a dependent or an addict taking opioids are 1) the craving for the intense pleasure and 2) the fear of withdrawal symptoms.

Some signs of opiate use/abuse/addiction are: noticeable elation/euphoria, marked sedation/drowsiness, confusion, constricted pupils, slowed breathing, intermittent nodding off or loss of consciousness, doctor-shopping, frequent trips to various emergency rooms, shifting or dramatically changing moods, social withdrawal/isolation, nausea and vomiting, fatigue and anxiety. Some other effects of opiate abuse are a weakened immune system, constipation and gastric problems so severe they result in a perforated bowel. Long term opiate use may even cause a person to become more sensitive to pain.

Opioid tolerance occurs because the brain cells that have the opioid receptors on them gradually become less responsive to the opioid stimulation. Opioid dependence and some of the wicked symptoms of withdrawal result from changes in another area of the brain, at the base. The combination of the need for more stimulation to get the high and the fear of the symptoms of withdrawal

leads to increased drug use as well as the compulsive drug-seeking behavior and related behaviors that are the signs of drug addiction – stealing, missing work, arriving to work late and leaving early are a few of the adverse behaviors that effect the workplace. But, most importantly, safety in the workplace is compromised.

Prescription Drug Use, Abuse and Addiction at Work

When addressing prescription drug use at work, employers have to consider and balance federal and state laws with the employer's goal for a safe workplace with the rights of privacy of the employee. Results from more than 5.5 million urine drug tests reveal an 18 percent jump in opiate positives in the U.S. workforce in a single year (2008-2009) and more than a 40 percent increase from 2005 to 2009.

Of course, some of those positive tests were from employees who had legitimate prescriptions for the drugs they tested positive for. The difficulty for the employer in that case is knowing 1) that the employee has been prescribed the drug, 2) the potential effects it might have on the employee and his/her work and 3) whether the employee is taking the medication as prescribed. How much information can an employer request without violating HIPPAA? How does an employer balance privacy with the goal of a safe workplace?

The flip side of that equation is knowing when an employee may be taking illegal drugs (either those not sold with a prescription or those for which the employee does not have a prescription). And, if you suspect the employee of abusing illegal drugs in the workplace, 1) how does the employer make the determination that there is "reasonable suspicion" and a drug test is warranted?

And, 2) if it is determined that there is not "reasonable suspicion" and a drug test isn't done and the employee injures himself/herself or another employee, what is the employer's liability?

Drug abusers and addicts are more vulnerable to stress than the general population. Numerous studies have documented that physical stressors and psychological stressors can cause research animals to reinstate drug use and that stressors can trigger drug craving in addicted humans. So, an addict (even an addict in recovery), who is subjected to stress in the workplace, may crave drugs as a result of that stress.

For obvious reasons, employers have a substantial incentive to provide a drug-free workplace. Federal and state grants and discounts are provided to employers who provide a drug-free workplace. But how to do that in the face of this drug epidemic is problematic.

Research shows that for most types of pain related to the common workplace injuries, such as soft tissues injuries and minor musculoskeletal problems, opioids are no more effective than ibuprofen. Non-steroidal anti-inflammatory drugs (NSAIDS) are a safe and cost effective alternative to opioids. For most short term pain, non-opioids have been shown to be as effective as opioids.

A Drug-Free Workplace policy should have five components. 1.) An employer must have a clear, well-written policy. 2.) There must be employee education. 3.) Maybe most important is supervisor training as they are the first line of management that interacts with the employee. 4.) An employee assistance program is important. 5.) Drug testing is crucial.

The clear, well-written policy is an absolute. Many employers think they can get this from Legal Zoom or another online resource. They would be wrong. Each policy should be crafted and formed to each specific employment situation. Each policy should meet federal and state guidelines and these guidelines should be clearly spelled out in the policy. This is particularly true when considering prescription drugs. Unlike an alcohol breath, blood or urine test, with prescription drugs or even illegal drugs, it is difficult to prove an objective test of impairment.

The prohibited behavior should be clearly spelled out. It should prohibit possessing, selling, trading or offering alcohol, illegal drugs or intoxicants. It should spell out that prescription drugs must be taken as prescribed and, if an employee is prescribed a drug that could impair his/her functioning (as determined by a doctor or pharmacist) and place himself/herself or co-workers at risk, the employee must notify the company so that it can be determined if the employee should be kept home or re-assigned to a less safety-sensitive position. Abuse and intentional misuse of a prescription drug should be prohibited.

Appropriate disciplinary actions should be spelled out for any violation of the drug-free work policy. Many employers indicate this behavior can result in immediate termination without the employer having to follow disciplinary steps.

Employee Education should inform the employees about the potential effects of both prescription drugs, alcohol and illegal drugs. It is much more productive and less expensive to educate an employee to avoid abuse and addiction than to have work injuries or treat an employee for an addiction.

Employee education should be addressed from several directions. First, educate your employees about the dangers of opioids. Employees should know

to discuss their concerns about taking opioids with their doctors. If an employee has a dependency or addiction issue, often times the physician who treats them for a work-related injury is unaware of that fact. A prescription for opiates at the emergency room may either send that employee back into the dependency or addiction cycle or may keep someone in that cycle. Employees should be educated to ask the medical provider if there is a non-opiate prescription that can serve the purposes of pain relief.

Employees should know to ask whether driving is permitted or discouraged when using this prescription and should know to advise the employer of any side-effects of any medication that might put work safety at risk. This should apply to prescriptions for work-related injuries and for prescriptions that are for nonwork-related conditions.

Employees should be educated to practice other safety issues as well. They should be advised regarding the safe storage of medications, the safe disposal of medication and not to mix medications or mix medications with alcohol. Employees should be educated not to share medications.

Employees should be encouraged to self-report if they have a dependency issue or an addiction issue. And employers should implement an employee assistance program (EAP). Many employers have EAP programs but employees are reluctant to use them for fear of being labeled as an addict or as having mental problems. Or they don't use them because they are too embarrassed to admit they have a problems. Or they don't use the employer's EAP because they are concerned about losing their job.

If you have a client who you suspect may have a drug dependency or addiction issue, find out if their employer offers an EAP and encourage your client

to avail him/herself of the program. Or, if an EAP isn't available, have information available to give them regarding local recovery resources. Encourage them to seek help.

Supervisor training is crucial. The supervisor is at the front line of safety in the workplace. Supervisors are the first eyes and ears on the employees and the ones who see and hear what goes on. Supervisors must be trained and updated regularly on the workplace drug policy and trained with respect to what to watch and listen for. Not only are they often the ones who are responsible for transmitting that information to the employees, they are often the ones who are in the first position to recognize "reasonable suspicion" that an employee may be impaired.

Supervisors should be trained to recognize signs of impairment – psychological or behavioral. The company should establish a threshold for reasonable cause to test employees and the threshold should be consistent with legal and policy requirements.

HR should regularly meet with supervisors to make sure they are well-versed in the drug policy. They also need to be made aware that the American with Disabilities Act (ADA) protects a worker's right to use over-the-counter and prescription medications. As such, they should be aware that, if an employee indicates he or she is impaired for doing their regular job as a result of medications, reasonable accommodations should be made, whether it be keeping the employee at home or placing him/her in a less safety-sensitive position or modifying the current position to accommodate the impairment.

Employee Assistance Program (AEP) is important, as indicated above. It costs an employer between 25% and 200% of an employee's compensation to

replace an employee. Then you have to factor in the loss of productivity, knowledge and job continuity that results when you lose an employee.

Ninety percent of Fortune 500 companies and 70% of all American employers have an EAP. This is because there is a very favorable return on investment when an EAP is used. The return is anywhere from $1.49 to $13.00 return on every dollar spent. However, as mentioned above, employees are reluctant to use and EAP, particularly for drug-related problems. Employers need to take away the stigma associated with the use of an EAP and must be diligent in making the employee feel confident that the use of the EAP, for any reason, will be kept strictly confidential.

Many treatment options are available to people with abuse and addiction issues. Detoxification is through an in-patient program and can utilize drugs that will wean a patient off whatever they addicted to. Detox alone is rarely successful and most people return to using within six months of detox unless follow up treatment is given. Often, this is where overdoses occur as the addict goes back to using at the same level he/she used before detox and the physical system is not prepared for that.

Detox with intensive therapy, often with the long-acting injectable drug Naltexone (an opioid blocker) can be more effective than detox alone. Then there are medication replacement therapies, using methadone or buprenorphine. Because of the physical changes to the brain of the addict or abuser, he/she may need to be on this therapy for months, years or the rest of his/her life.

Twelve-step programs, such as Alcoholic Anonymous and Narcotic Anonymous have proven to be successful routes to sobriety and getting and keeping clean. This takes a clear recognition of the problem by the abuser or the

addict and takes a lifelong commitment to being clean and sober. No one is ever "cured" of being an alcoholic or drug addict. These are recognized as diseases and, at best, an abuser or addict can be "in recovery" or "a recovering addict".

Drug testing has been a tool in the toolbox of employers for years now. Written policies for drug testing must reflect the specific actions that must be taken by the employer and the employee. Drug testing in the workplace has proven to be a very effective tool for safety. In a study that involved Southern Pacific Railroad, after the implementation of drug testing, accidents resulting in injuries dropped from 2,234 per year to 322 after drug testing was implemented. This is a 71.2 percent decrease in accidents. The problem many employers are currently facing is the inability to find workers who can pass a pre-employment drug test.

The problems with drug testing is that it can be considered intrusive. Employers should be made aware that, pulling a standardized drug test from Legal Zoom probably will not be sufficient. Each policy should be customized to the employer.

What employers need to consider when implementing drug testing are:

- Using a U.S. Department of Health certified lab or an equivalent state agency certified lab.
- Consulting a lawyer to develop policies and procedures for testing.
- Utilizing a testing format that respects the privacy of the employee.
- Having a well-written policy that spells out the circumstances leading to a drug test and the disciplinary actions that could follow a positive drug test.

- Requiring employees to read and then sign and date an acknowledgement of the drug policy.
- Documenting why each drug test was determined to be necessary and how it was performed.
- Ensuring that the test information is kept strictly confidential.
- Being consistent with responses to each worker who tests positive.

Employers should be aware that updating a drug test and drug policy may be necessary as new substances come on the market. If a company is using a standardized five-panel test, that test will miss oxycodone and most other abused drugs. A typical test will test for five drugs – opiates/heroin, cocaine, marijuana, PCP and amphetamines. Many of the most commonly used prescription drugs are not included in these panels. However, these tests are successful for what they do test for: Positive tests for hydrocodone and oxycodone have risen 172 percent and 71 percent respectively since 2005.

Test panels should include at least seven compounds: benzodiazepines, opiate, oxycodone, methadone, cocaine, amphetamines and THC. Oxycodone and methadone will not show up in the standard five panel test as they are synthetic opioids. Dilaudid and fentanyl and carfentanyl are becoming commonly abused substances as well so the test panels should include tests for these substances as well.

Utilization of the employer's healthcare benefit plan provider is also essential in this fight against drug abuse/addiction in the workplace. Long term use of opioids can result in a number of debilitating side effects and health problems that will only result in a burden on the general health care system and the employer's health care policies. The Washington State Department of Labor

and Industries found that when an injured worker receives more than a week supply of opioids after an injury, it doubles that worker's risk of disability one year later.

It should be specifically noted that courts in four states have held employers financially responsible for overdose deaths involving injured workers.

Use of a case worker – in either work-related injuries or with nonwork-related conditions – can be very important in monitoring am employee's use of prescriptions drugs.

- The primary goal should be that the use of opioids results in a meaningful reduction of pain.
- Employees and case workers should stay in contact to assess the situation.
- Expectations of pain should be clarified.
- Case managers can interface with the prescribing physician.
- Case managers can encourage the use of prescriber-physician agreements.
- The program should include on-going compliance monitoring.
- The program should avoid the transition from use of opioids for an acute condition to chronic use of opioid medications.

Another exceptional resource is Prescription Benefit Managers (PBMs). PBMs can assist in the following ways:

- Provide information regarding past, current and total opioid use to evaluate how the prescribers are using opioids, drug levels and duration of therapy.

- Provide "flags" such as asking for refills too early, asking for replacements for "stolen" or "lost" prescriptions.
- Checking dosage levels and length of therapy.
- Flagging when drug combinations are counter-indicated.
- Flagging when an employee is seeing multiple providers.
- Targeting providers who are "outliers" in the system.
- Reviewing pharmacies' ability to override the system at the point of dispensing.
- Identifying how cancer and other individual cases are handled if they fall outside the system's flags.

Finally, employers should utilize Fitness for Duty and Return to Work physicals, including drug testing. Working closely with counsel is strongly recommended in these situations in order to develop a concise and effective policy.

The BWC and Legislative Response to the Prescription Drug Epidemic

The Bureau of Workers' Compensation has faced the high cost of prescription drug addiction in the workplace in the way of more frequent injuries, longer return-to-work times, more frequent hospital/doctor visits and increased prescription costs. In response to these increases and to some degree in direct response to this issue, the BWC has passed several rules.

O.A.C. 4123-6-21.2 establishes a "Pharmacy and Therapeutics Committee" which became effective initially in 2012 and the updates on October 1, 2016. This Committee is comprised of medical providers and pharmacist providers and is tasked with the following:

* Development, approval and annual review of a formulary of approved medications.

* Development, approval and annual review of a list of non-covered, non-reimbursable medications.

* Development and approval of prior authorization criteria.

* Review and approval of proposed medication treatment guidelines.

* Review and approval of Bureau policies and procedures related to drug utilization review of specific medication issues.

* Review of the Bureau's pharmacy providers' professional performance.

* Review of the Bureau's medical providers' performance.

* Review of the performance of the Bureau's pharmacy benefit manager.

O.A.C. 4123-6-21.3 establishes an Outpatient Medication Formulary.

O.A.C. 4132-6-21.4 establishes a Coordinated Services Program. This deals primarily with providing oversight and regulation of drugs prescribed in a workers' compensation claim.

O.A.C. 4123-6-21.5 provides Standard Dose Tapering Schedules to be followed by prescribers in a workers' compensation claim.

O.A.C. 4123-6-21.6 governs the First Fill of Outpatient medications in a claim.

O.A.C. 4123-6-21.7 regulates the Utilization of Opioids in the Subacute or Chronic Phases of Pain Treatment for a work-related injury or an occupational disease.

O.R.C. 3719 is the general legislation that governs prescriptions and has been recently updated by the Ohio Legislature to restrict the prescription of opioids.

The following sources were used in researching this issue and preparing this program:

- National Safety Council, "The Proactive role employer can take: Opioids in the Workplace" *www.ncs./RXOverdoseDocuments/Opioidsintheworkplace*.

- OpiateAbuse Symptoms, Signs and Addiction Treatment, *Drugabuse.com/library/opiateabuse*
- The Opiate Addict in Your Office/Psychology Today. *www.psychologytoday.com*
- The Neurobiology of Opiod Dependence: Implications for Treatment. *Scientific Practical Perspective, 2002 July.*