Workers' Comp Insider

Lynch Ryan's weblog about workers' compensation, risk management, business insurance, workplace health & safety, occupational medicine, injured workers, insurance webtools & technology and related topics

March 4, 2013

Opioid Catastrophe: The Data Leads to Doctors

After two stimulating days at the Workers Comp Research Institute conference, the Insider is ready to solve the opioid problem. To be sure, WCRI is a research-driven organization and makes no claims of solving problems; it simply reveals them through stark, powerful data. However, in a series of presentations ranging from improving the way doctors prescribe drugs through the mobilization of entire communities to tackle the problem, the conference has illuminated the path toward a favorable resolution of this increasingly dire problem.

Dr. Karin Mack of the Centers for Disease Control established the parameters of the problem: death from drug overdoses - mostly involving prescribed medications - now kills more people than traffic accidents. While heroin and cocaine account for about 4,000 deaths annually, opioids kill four times as many people - more than 16,000 in 2010. Most of the drug overdoses involved people of working age (between early 20s and 60). Dr. Mack identified the population most at risk:
- "Doctor shoppers"
- People receiving high daily doses of opioids and those using a variety of drugs
- Low income people and those living in rural areas
- Medicaid populations
- People with mental illness or a history of substance abuse

When the discussion shifted specifically to workers comp, the data becomes even more alarming. In some states, over 80% of injured workers receive opioids for pain relief - way too many! The prescribed doses are often much higher than is medically necessary. For many workers, the prescriptions extend for many weeks, even though pain usually subsides relatively quickly. And finally, very few doctors are monitoring patients who have been prescribed opioids.

Doctor Problems
Given that drug abuse has reached catastrophic proportions, and given that most of the problem involves prescribed - as opposed to illicit - medications, it is becoming increasingly clear that doctors are a big part of the drug problem. They are too quick to prescribe opioids; they prescribe them for too long; and they fail to monitor injured workers who are on these medications. The first red flag, in other words, is raised over the heads of our medical practitioners.

Dr. Dean Hashimoto outlined a Massachusetts initiative that significantly reduced doctor mistakes in prescribing opioids (a summary of the state's approach can be found here). The guidelines:
1. Distinguish between *acute* and *chronic* pain. For acute pain, doctors should explore ady and all alternatives before prescribing opioids and then carefully re-evaluate before extending the initial prescription.
2. For chronic pain [in itself a red flag], doctors should run urine screens to determine whether the prescribed drug is being used properly and whether other drugs have been taken; they should meet fact to face with patients as frequently as needed; and they should try to focus on *function* rather than *pain*.

Note that these are steps that doctors *should*, but all-too-often *don't* take. Combine that with the fact that a small number of doctors are generally responsible for a huge number of prescriptions: in California, 3% of doctors prescribe over 50% of the opioids. Once again, doctors are at the root of the drug problem.

PDMPs
In addition to improving best practices in the medical use of opioids, we need to know more about prescription practices. This involves the evolving tool of prescription drug monitoring programs (PDMPs), which track prescription

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practices of doctors across a given state. Because the programs are state based, they vary widely on how they work: what is tracked, how often data is submitted, how it is analyzed and what is done with it. Ideally, to be effective, the data should be collected on a real-time basis, but in practice, it's generally submitted weekly. Ideally, there should be standards across all state PDMPs: everyone collecting the same data, in the same form, generating information on prescription practices and "hot spots" with consistency.

Brandeis University's Center for Excellence identifies the best practices for PDMAs. But we live in an age where uniform standards are anathema. It's just not going to happen, so we'll have to live with the current chaos - which, however inadequate, is better than nothing.

Community Mobilization
While there is much that can and should be done at the doctor-patient level to fix the opioid problem, such efforts cannot solve the problem. We can actually map the crisis across the country and identify specific communities that have been devastated by drug abuse. The conference highlighted efforts in eastern Kentucky, where in some counties half the children are being raised with *no* parents in the home (the parents being dead from overdoses, incapacitated by addiction or in prison). Under Operation UNITE, the community has responded with a combination of drug enforcement, coordinated treatment, support for families and friends of abusers, education and mentoring for young adults. They teach kids archery and fishing, among other things, surely an example of putting the beautiful natural surroundings to good use.

It is hardly surprising that one focus of UNITE is the pill mills that are frequently found in poor, rural areas. One doctor prescribed over 100,000 pills a month (!) by issuing 40-50 scripts each day (!). Don't bother asking whether Dr. Hashimoto's standards of treatment were followed.

The Path to a Cure
The WCRI conference illuminates the path toward solving the opioid abuse catastrophe: teach doctors how and when to use these powerful drugs and how to find alternative treatment forms; carefully monitor injured workers on opioids to ensure proper use; severely limit the use of these drugs over the long term; monitor prescription practices to identify doctors who are not with the program; and provide support, mentoring and education to young people in high risk communities.

There are many obstacles to implementing a comprehensive and effective program, but in those areas where key elements have been established, the incidence of opioid abuse has been dramatically reduced. It is ironic, of course, that the stakeholders who must "do no harm" are in fact in the forefront of the problem. They can and must do better. Medicine got us into this mess and it is medicine, with its highly trained and presumably well-intentioned practitioners, that must lead the way out.

By Jon Coppelman on March 4, 2013 1:30 PM | No Comments

Categories: Best Practices, Disability, Health Care, Medical Issues

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