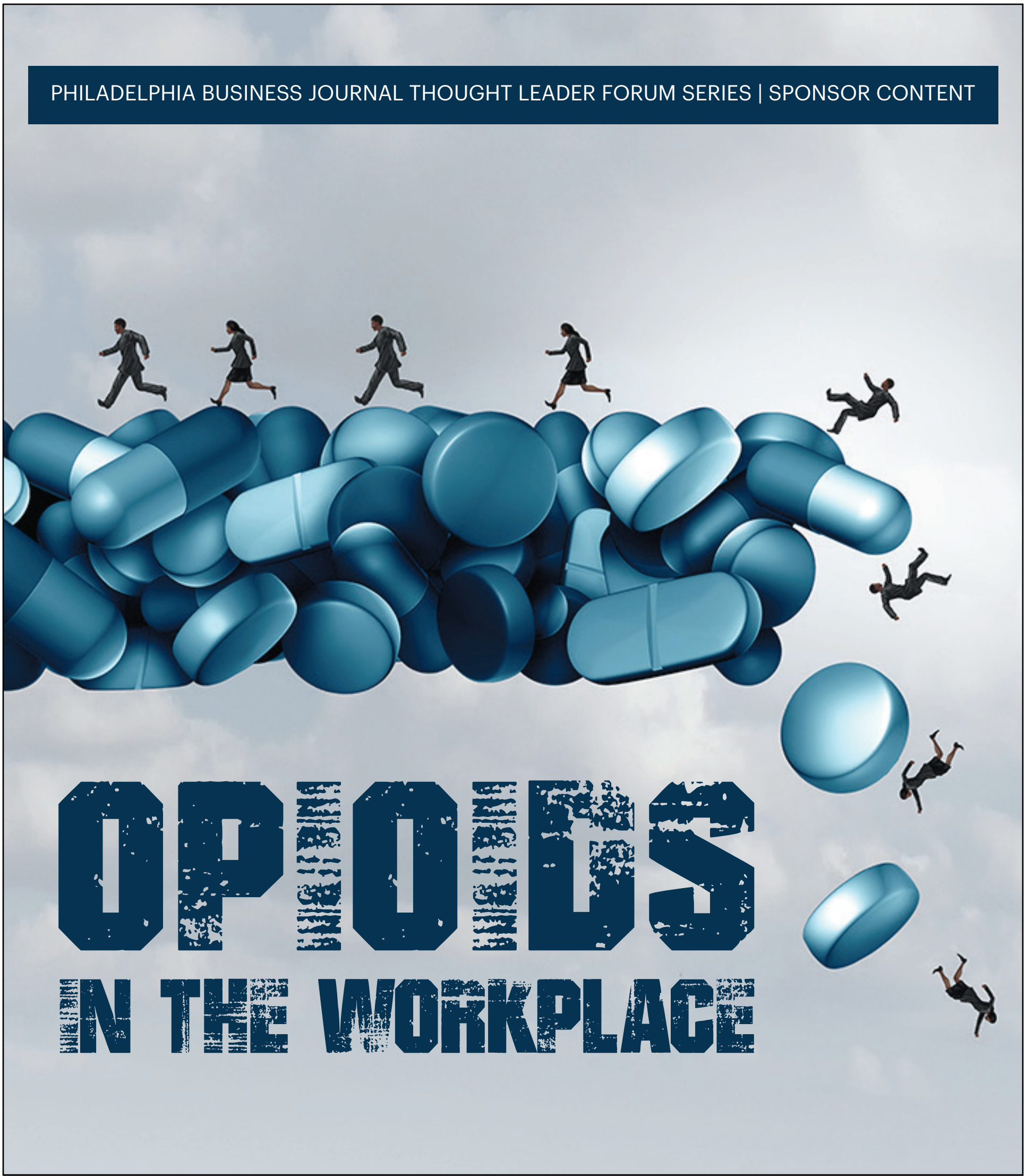

OPIOIDS IN THE WORKPLACE

THOUGHT LEADER FORUM

OPIOIDS
IN THE WORKPLACE

With opioid use and abuse rising dramatically, business leaders are seeking information about how to navigate the legal and ethical challenges in their organizations. The Philadelphia Business Journal hosted a Thought Leadership Forum with representatives from a civil defense law firm and major health system.

Participants were Drs. J. Michael Kowalski and Serge-Emile Simpson of Einstein Healthcare Network and Stuart T. O'Neal, III, Esq. of Burns White LLC.

What changes have various industries undertaken to combat the opioid crisis? What has resulted from those changes?

O'Neal: It starts with vigilance and education. Once companies and employers started seeing the destructive effects the abuse of these drugs had on people and communities, changes occurred. It started, and continues, with education at the grass roots level all the way to social media. Companies in particular have been more vigilant in supervising the distribution of some of these medications, and constantly keep an eye on "red flag" scenarios that warrant attention and action. The issue is, and remains, there are so many actors in this arena that it difficult, if not impossible, to notice everything. But what has changed is vigilance and knowing consequences of a problem that, if left unchecked, can cause some real problems.

Is there any empirical data that shows a definitive causal relationship between any one industry or source and the overall crisis? Have there been any studies done in this regard?

Kowalski: There is strong evidence that pharmaceutical companies like Perdue (manufacturer of oxycodone) paid speakers to enforce the concept that the medical community undertreated pain. Their paid speakers referenced a letter to the editor that opined, without data, that the risk of becoming addicted to opioids was negligible. This was a false narrative that few people fact checked. Government organizations supported this and began to teach pain as a "vital sign". As a result of pressures from multiple fronts, physicians started prescribing more opioids. Unfortunately, they were prescribed for conditions that likely didn't benefit from opioid medications. The surge in prescribing resulted in readily available "prescription" medications that were abused and diverted.

O'Neal: There are no empirical studies that I am aware of to date on this exact issue, but that does not mean it does not exist. That said, those industries where the access to this type of medication is part of the job, may see a higher rate of usage and possible abuse. Likewise, any profession that uses as part of its healing/recovery process, these drugs and/or gateway drugs, may see a higher rate of usage and possible abuse and addiction.

What role does the legal system have in this epidemic, if any?

O'Neal: This is a fluid response insomuch as I believe all segments of society are trying to address this issue and there has been no consistent, data-driven successful response across a broad spectrum of society. That said, I do believe the legal system can have a large role. First is in enforcement obviously. The closer this epidemic is monitored the more this problem is contained (goal). Assuming that is not the case, that traditional law enforcement measures are not working to contain this issue, which is a likely outcome from what we have seen so far based upon the sheer spread of this epidemic, the legal process may be able to assist through recovery. I know in the central part of the state, Courts have tried to have an opioid intervention court for those that are detained. The results of such a court, and foundations that support it, such as The Sherman Foundation, may be the out-of-the-box thinking society needs to address this issue.

Kowalski: By criminalizing overdose and possession of drug paraphernalia, law enforcement agencies force clandestine drug use, unsanitary injection use, illegal dumping of biohazardous materials, etc. The ongoing criminalization of drug use has placed opioid use disorder in the odd space of being simultaneously a disease and a crime. This makes tackling the crisis more laborious.

Are there case studies and/or examples of prevention methods that have worked over a large cross section of the population?

Kowalski: Unfortunately, we are just realizing the full scope of this crisis. There are no proven prevention methods yet. The current strategy by the medical community consists of better prescription tracking, reducing inappropriate prescribing, education, and referring to rehabilitation or maintenance programs.

The controversy surrounding CUES (Philly's name for safe injection sites) highlights this tension. A similar dynamic existed some 30 years ago when needle exchanges were proposed (and subsequently validated) as very effective means for reducing the spread of HIV and Hepatitis caused by needle sharing.

Simpson: Certainly, you could make a case for avoiding prescribing opioids to opioid naive patients. The CDC's data on first time opioid prescriptions suggest limiting first time opioid prescriptions to less than 7 days minimizes the risk of converting a patient into opioid addiction.

O'Neal: Aside from education and a strong support system, I am not aware of any studies that illustrate a consistent solution to this epidemic across society, which is unfortunate. The effort is there obviously, but when an issue comes at a society from so many different angles, it is hard to completely prevent it, and sometimes contain it. I am a big believer of education, starting at an early age, including targeted use of social media. The catch-22 of that social media is that as much as it could potentially help, it also potentially hurts due to its unregulated nature.

Who are the players in attacking the opioid crisis and how can they be supported?

O'Neal: Those who are on the front line of this problem and

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epidemic are the ones that need the support. Family. Friends. Loved ones who are trying to help a family member with addiction. To a lesser extent, employers and HR folks who may be the ones seeing and recognizing the abuse and the addiction. I think those that are closest to the individual day in, day out are the ones that need the immediate support, and a lot of it.

Kowalski: Doctors and providers need to be educated about evidence-based prescribing, alternative non-addictive analgesic options and the real dangers of dependency when patients are exposed to opioids. Conversely, these same prescribers need to be supported by their hospital administration and credentialing bodies to not dispense opioid analgesics if the medications are not warranted. Medical professionals currently get complaints or negative reviews from patients if opioids are not prescribed. Addressing pain and the patient experience is important but safe, evidence-based prescribing should be paramount.

How can employers, and their employees, identify and destigmatize opioid abuse in their organization?

Kowalski: There are many individuals who suffer from dependency who are, or could be contributing members of the community, and the workforce. These employees cannot be shunned or feel like they must live in the shadows. Offering mentorship, support for rehabilitation and encouraging support groups among employees may be ways to destigmatize opioid use disorder (OUD). This is especially true nowadays where nearly everyone has been impacted directly or indirectly by the epidemic.

O'Neal: Again, I believe at the heart of every solution to this problem, both to those in the throes of addiction, as well as those aiding in the recovery, the key is education. Understanding the signs, symptoms, and effects of addiction as well as trying to understand how horrible the addiction is for people. When you change the narrative or when you change the perspective, from one of naivety to that of being educated and informed about a topic, perhaps there is less likelihood of a stigmatization and a greater awareness by employees and employers to recognize this issue and immediately refer the individual to resources that could aid the situation. But in the end, it's all about education for all those involved, not just from an employment perspective.

What do you think has more detrimental impact on a workplace, illicit opioid usage or legally prescribed opioids?

O'Neal: That is extremely hard to tell, and I am not aware of any empirical data to shed any light on the issue. Situations I have seen in the workplace involve a misappropriation or a diversion of an opioid from a patient to an employee in several ways, thereby introducing a very serious criminal element into the equation on top of the addiction. One would think that having a criminal inquiry on top of now an employment issue (likely termination if caught) and addiction is a worse situation, but that is very hard to tell. On the surface though, I would think illicit consumption would be worse on several levels. None of the options are attractive though.

Kowalski: In a nutshell, legally prescribed opioids most likely have a more detrimental effect. First, because many opioid use disorders (OUD) stem from legally prescribed medications. The prescriptions can then lead to dependency directly or can be diverted to others to whom the medications were not originally prescribed. When prescription opioids are stopped abruptly in patients, he or she may look elsewhere to avoid withdrawal. These options may include illicit street drugs like heroin or diverted prescription meds. So legally prescribed medications can impact abuse both directly and indirectly.

What guidelines or protocols are in place for employees with potential opioid use disorder (OUD) currently? What distinguishes abuse from use regarding opioids?

O'Neal: I would assume that this issue needs to be taken up on an employer by employer basis. However, all companies should have something in place, regardless of size, location, industry, etc. Additionally, any such policy should have a strict privacy component to it and have resources at the ready to assist in a very short time frame. Counseling for loved ones, if applicable, should also be offered. The policy should also potentially include providing as much information as possible for any Employee Assistance Plan and related hot-lines for numbers for folks to reach out for help. The policy will need to balance a discipline component to a helping component to the extent the addiction is either done on campus, at a work-related activity or affects performance.

Kowalski: Prescription use becomes abuse when medications are taken in a way that exceeds the dose or frequency that was prescribed OR when prescription medications are taken by someone other than the intended user. Other features that help distinguish use from abuse (or USE DISORDER) can be found in the DSM-V. They include features such as drug craving, preoccupation with obtaining opioids, using them in hazardous situations or places, developing tolerance, and going into withdrawal.

Should an employee's opioid abuse be regarded in the same manner as any other chronic disease such as cancer, diabetes, hypertension, etc.?

Kowalski: The current stigma associated with opioid dependency is such that the user has a choice in their addiction or that the problem lies with the individual. This does not happen uniformly across recognized medical conditions. For instance, we do not look at people with skin cancer and accuse them of spending too much time outside. The drugs are highly addictive, and many individuals may have become trapped by addiction after suffering a painful injury that was treated with opioids. We need to appreciate that an opioid use disorder is multifactorial. Some factors may be within a patient's control but not all of them. Likely there is an intersect of genetics, environment, exposure and opportunity that collide to result in a tragic situation.

O'Neal: Yes, if it would attract the same amount of attention and support as the other chronic diseases mentioned. Addiction is certainly a disease and certainly warrants the same amount of attention and caring as any other disease. I think we start getting onto a slippery slope if we start classifying, as a society, conditions that are "chronic" versus those that may be chronic. It is a very subjective analysis. Overall, yes.

How can an employer diminish the barriers that exist in obtaining adequate care in treating an opioid abuse disorder? How can employers facilitate an employee's participation in an opioid treatment program?

O'Neal: I would say by offering affordable, comprehensive health insurance that has a thorough treatment component as an election if needed; in-house seminars on the benefits provided by the employer; additional services and outlets through any applicable Employee Assistance Plan, and a non-punitive HR component that would recognize the need for assistance at the front end of a potential issue as opposed to a reactionary set of tools that most likely would not benefit either the company or the employee. The policies of any given company are drafted and governed, in most respects, by the company itself. Therefore, having members of the team versed and educated on the addiction related issues, or seeking assistance from those that do, would make the most sense in the policy drafting or implementation stages.

Kowalski: From a medical perspective, acknowledgment that this condition exists and a stated support for anyone willing to participate in a maintenance program may be the first step to someone turning their lives around. Ultimately, the individual needs to WANT to participate. The employer can significantly reduce the stress of participating in an opioid treatment program by acknowledging that the employee will need to attend daily, weekly or monthly visits to their treatment center. Being flexible with the employee's schedule and offering to work closely with them to assist in their ongoing participation is tremendously helpful.

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J. Michael Kowalski, DO is the Medical Director of the Emergency Department at Einstein Medical Center Philadelphia and a board-certified Medical Toxicologist. Serge-Emile Simpson, MD is the Director of the Division of Medical Toxicology and a board-certified Medical Toxicologist. As part of the Medical Toxicology Division within the Einstein Healthcare Network, both provide outpatient and bedside consultations. Drs. Kowalski and Simpson have a focus on addiction medicine and regularly provide phone consultations for the Philadelphia Poison Center.

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Stuart O'Neal is a trial attorney whose practice focuses on all types of professional liability cases, employment matters, and healthcare and long-term care matters. His depth of knowledge in these specific areas uniquely positions him to offer insights into the legal implications and risks associated with today's national opioid crisis for employers, healthcare providers, and healthcare facilities.

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