Opioid Use, Misuse and Overdose: A Continuing Issue for Healthcare

Healthcare

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In this paper, we will provide insight on the following developments:

1. Opioid misuse and deaths have been a public health issue for several years. We need to refocus our efforts on treating opioid use disorder as a medical condition, provide treatment options to help curtail the ongoing public health issue and stem the economic burden associated with opioid misuse.
2. We provide an overview of the concerns that medical professional liability insurance carriers have raised with healthcare organizations and the requirement to provide information about your organization's opioid monitoring protocols as part of the underwriting submission. We also include some risk management tips and resources that can help your organizations as you develop and refine your strategy to tackle this issue.
3. Gallagher is at the forefront of addressing this epidemic in the workplace with strategies that can help healthcare organizations with their risk management efforts to mitigate the risk of treating patients impacted by opioid use disorder. We are available to assist your organization with your own employees to help them access treatment programs, leading to recovery.

In 2017, there were 70,237 drug overdose deaths in the United States, with approximately 68% of these deaths stemming from opioid misuse.[1] The misuse of and addiction to opioids, including prescription pain relievers, heroin and synthetic opioids such as fentanyl, continue to be a serious national crisis impacting public health, as well as social and economic welfare. The Centers for Disease Control and Prevention estimates that the total economic burden of prescription opioid misuse alone in the United States is $78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment and criminal justice involvement.[2 3]

Despite the ongoing drumbeat of concern from policymakers, healthcare organizations and consumer advocates, the crisis has proven complex and without any quick fixes.

How did this happen?

In the late 1990s, pharmaceutical companies, including some of the largest companies that developed and sold these drugs, reassured the medical community that patients would not become addicted to prescription opioid pain relievers, and healthcare providers began to prescribe them at increasing rates, leading to widespread diversion and misuse of these medications before we recognized that these medications could be highly addictive.[4 5]

Opioid overdose rates began to increase. In 2017, more than 47,000 Americans died as a result of an opioid overdose, including prescription opioids, heroin and illicitly manufactured fentanyl.[1] That same year, an estimated 1.7 million people in the United States suffered from substance use disorders related to prescription opioid pain relievers, and 652,000 suffered from a heroin use disorder.[5]

What do we know about the opioid crisis?

According to the National Institute on Drug Abuse (NIH), as of January 2019:

- Approximately 21% to 29% of patients prescribed opioids for chronic pain misuse them.
- Between 8% and 12% develop an opioid use disorder.
- An estimated 4% to 6% who misuse prescription opioids transition to heroin.
- Approximately 80% of people who use heroin initially misused prescription opioids.
- Opioid overdoses increased 30% from July 2016 through September 2017 in 45 states.
- The Midwestern region saw opioid overdoses increase 70% from July 2016 through September 2017.

In addition, prescribing opioids puts patients at risk for opioid use disorder. According to information included in Prudential's Mental Health Quarterly Series 2020, Volume 1, the report highlights statistics from a study entitled "Opioid Prescribing at Hospital Discharge Contributes to Chronic Opioid Use," following post-hospital discharges of 6,689 patients who had not used opioids within one year prior to their hospital admission and found the following:

- "Patients had substantially greater risk of developing chronic opioid use one year after hospital discharge.
- Physicians felt the incentive to prescribe opioids to protect patient satisfaction scores. They feared that patients in pain could negatively impact scores and consequently negatively impact reimbursements.
- Physicians did not adequately explain risks of opioid use to these patients, contributing to the risk of chronic use."[6]

Drug diversion in healthcare.

Drug diversion in healthcare (employee stealing for their own use) results in care delivered by an impaired provider, denial of essential pain therapy, and potential outbreaks from hepatitis C virus or bacterial pathogens when tampering with injectable opioids. The adverse consequences of diversion in healthcare settings include harm not only to the drug diverter, but also risk of harm to patients. In addition to denial of essential drugs to treat patients in pain, outbreaks of hepatitis C virus (HCV) transmission from an infected healthcare worker to a patient have been reported in the setting of narcotic diversion when tampering with injectable opioids, as well as transmission of bacterial pathogens, with fentanyl being the most commonly implicated opioid.[7]

But what now?

America needs to see opioid use disorder as a medical condition and approach treatment like any other form of healthcare, not as a weakness of the individual. It is helpful to draw comparisons to other chronic medical conditions. Consider one statistic: According to the 2016 surgeon general's report, just 10% of people with a substance use disorder get specialty treatment for their addiction, in large part because local treatment options do not exist or, if they do exist, they are unaffordable or have waiting periods of weeks or even months. If we treated patients with heart disease as we do addiction, 90% of Americans would be allowed to suffer and die without access to healthcare. Heart patients would be turned away from facilities because they have no way to treat them, or they would have to wait weeks or months to receive treatment.

This would be a public health catastrophe. America's leaders would do everything they can, under public demand, to remedy such huge gaps in healthcare.

HHS and NIH efforts.

In response to the ongoing opioid crisis, the U.S. Department of Health and Human Services (HHS) and NIH are concentrating their efforts on the following priorities:

1. Improving access to treatment and recovery services
2. Promoting use of overdose-reversing drugs
3. Strengthening our understanding of the epidemic through better public health surveillance
4. Providing support for cutting-edge research on pain and addiction
5. Advancing better practices for pain management

Insurance carriers' response to the crisis.

Over the past few years, medical professional liability insurance carriers have elevated concerns, and required healthcare systems and providers to provide a thorough overview of their opioid protocols. While the claims against the pharmaceutical companies that made and sold these drugs are staggering, the rise of medical professional liability claims against the actual providers who prescribed them is increasing.

For example, a jury in St. Louis, Missouri, awarded a plaintiff husband $1.4 million and the plaintiff wife $1.2 million against a physician and his employer, finding that they were negligent in prescribing and monitoring the use of opioids for the husband. The jury also awarded an additional $15 million in punitive damages against the defendants.

According to data that Coverys released, 24% of medical professional liability claims involving prescription medications involve opioid drugs, with allegations stemming from improperly prescribing opioid medication, improperly administering opioid medication and failure to monitor patients.[8]

During underwriting meetings and as part of the underwriting submission process, insurance carriers that underwrite healthcare systems and providers require detailed information about opioid monitoring protocols in order to understand what policies are in place, and how the provider is monitoring the exposure and mitigating the risk.

Beyond medical professional liability, some D&O and regulatory liability underwriters focused on the healthcare industry require information about the health systems' opioid policies and procedures as well. If the health system does not have protocols in place, the carriers are including exclusions on the policies.

Risk management tips.

While most healthcare and state organizations have concentrated their efforts to tackle this issue and develop solutions the past few years, organizations must continue their efforts and collaborate to prevent opioid misuse, improve treatments for chronic pain, and support patients struggling to recover from opioid use disorder. States facing the highest numbers of overdose deaths, the most tangible and acute measure of the crisis, are working with first responders and law enforcement to expand access to drugs such as naloxone and Narcan, which can reverse an opioid overdose if administered quickly.

According to PWC, some healthcare organizations are reducing the sheer volume of prescription opioids in circulation and require new rules for prescribers. "We are using higher-level analytics in our retail pharmacies to understand if a doctor has a high level of inappropriate prescriptions," said Troy Brennan, executive vice president and chief medical officer at CVS Health. CVS Caremark is limiting opioid prescriptions for acute pain to seven days, a restriction supported by PhRMA, a biopharmaceutical trade organization. And the PBM has placed a daily dosage limit of 90 morphine milligram equivalents per patient, in keeping with the CDC guidelines, Brennan said.[9]

Risk management professionals and providers should consider the following strategies:

- Healthcare organizations should provide updated materials to patients and families, including education about the medications and the associated risk for abuse.
- The development of prescription monitoring programs to detect physician or pharmacy shopping.
- The requirement to present photo identification to pick up an opioid prescription at a pharmacy.
- Provisions for safe disposal of unused opioids.
- Referrals to pain and addiction specialists
- All healthcare facilities should have systems in place to deter controlled substance diversion to include methods to promptly identify and investigate possible diversion, intervene when it is occurring, and follow up to deal with outcomes of confirmed diversion. Some of the most comprehensive resources for developing programs to prevent and respond to drug diversion are available from the Mayo Clinic (Mayo Clinic protocol with 77 best practices) and the Minnesota Department of Health.

Supporting these approaches by healthcare organizations and health insurers, while educating providers and patients on the risks associated with chronic pain medication, can help minimize the risk of prescription opioid abuse, addiction and diversion. These efforts will also help to reduce health services utilization associated with opioid abuse, improve patient outcomes and reduce overall costs.

Gallagher's approach to risk.

Gallagher is at the forefront of addressing this epidemic in the workplace with strategies that can help healthcare organizations with their risk management efforts to mitigate the risk of treating patients impacted by opioid use disorder. We are available to assist your organization in helping your employees access treatment programs, leading to recovery.

When it comes to selecting a broker, you deserve a partner that takes a comprehensive approach to evaluating your risk management program. **CORE**360™ is our unique comprehensive approach to evaluating our client's risk management program that leverages our analytical tools and diverse resources for custom, maximum impact on six cost drivers of their total cost of risk.

We consult with you to understand all your actual and potential costs, and the strategic options to reallocate these costs with smart, actionable insights. This will empower you know, control and minimize your total cost of risk, and improve your profitability.

[1] https://www.cdc.gov/drugoverdose/data/statedeaths.html; Drug Overdose Deaths; online January 30, 2020.

[2] CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2018. https://wonder.cdc.gov.

[3] Florence CS, Zhou C, Luo F, Xu L. The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013. Med Care. 2016;54(10):901-906. doi:10.1097/MLR.0000000000000625.

[4] Morone NE, Weiner DK. Pain as the fifth vital sign: exposing the vital need for pain education. Clin Ther. 2013;35(11):1728-1732. doi:10.1016/j.clinthera.2013.10.001.

[5] Van Zee A. The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy. Am J Public Health. 2009;99(2):221-227. doi:10.2105/AJPH.2007.131714.

[6] Calcaterra, Yamashita, Min, Keniston, Frank, Binswanger (2016). "Opioid Prescribing at Hospital Discharge Contributss to Chronic Opioid Use." Journal of General Internal Medicine, 31:5, 478-485 and highlighted in The Prudential Insurance Company of America Mental Health Quarterly Series 2020, Volume 1, "Case studies in outcomes-based solutions Opioid Epidemic How employers can advocate for safer and effective treatment."

[7] https://www.premiersafetyinstitute.org/safety-topics-az/opioids/drug-diversion/; Opioid Drug Diversion; online March 10, 2020

[8] https://www.erlegal.com/medical-malpractice-claims-filed-prescription-opioid-drugs/; Are Medical Malpractice Claims Being Filed Over Prescription Opioid Drugs?; online January 30, 2020.

[9] https://www.pwc.com/us/en/industries/health-industries/top-health-industry-issues/opioid-crisis.html; The health industry tackles the opioid crisis; online January 29, 2020.

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About the author.

Audrey N. Greening has more than 25 years of experience in risk management and risk financing for healthcare clients, including integrated delivery systems, physician groups, academic medical facilities and rehabilitation hospitals. She is recognized as an expert in developing creative alternative risk financing program structures, identifying unique healthcare industry-specific concerns, developing non-conventional solutions and creating new products that provide long-term solutions for clients' evolving risks. Her experience includes consulting for healthcare clients throughout the United States. She holds a Bachelor of Arts degree from LaSalle University and a Master of Business Administration from Loyola University. Audrey is an active member of the Virginia Chapter of ASHRM, the MD-DC Chapter of SHRM and the North Carolina Chapter of ASHRM. She was recognized with the prestigious Power Broker® award from *Risk & Insurance* magazine in 2008.

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