The Pain Pill Problem: How the opioid epidemic is impacting the workplace and what employers can do about it

Sponsored Content Jan 19, 2018

The opioid epidemic has become a serious problem in the United States, impacting every demographic segment of the population. Employers are on the front line of this problem, both because of the impact employees with opioid addiction can have on workplace safety and because these addictions can begin with prescriptions for work-related injuries. The Milwaukee Business Journal recently assembled a panel of experts to explore what companies – large and small – need to know about the opioid epidemic and the role they can play in mitigating its impact.

LAURIE GREENLEES (Moderator): How serious of a challenge for society is opioid addiction, and how does it compare to other addiction challenges the nation has faced or currently faces?

MICHAEL MILLER: Addiction has been affecting workers and workplaces for a very long time. Alcohol has been a perennial problem. There were methamphetamines in the 1970s and the cocaine epidemic of the late 1980s and 1990s. The opioid epidemic is grabbing everyone's attention today because of the overdose deaths. Alcohol kills, too, but it's not as sudden – it can take decades.

KEVIN HILDEBRANDT: That is a very good point. Opioids are definitely a concern, but alcohol and other types of addictions are very prevalent.

JIM MUELLER: Drug addiction is costing us $80 billion annually in medical care, addiction treatment

and lost productivity. There were 63,632 drug overdose deaths in 2016, with two thirds of those deaths opioid-related. To put that in context, the Foxconn deal was $3 billion and that was considered a really big deal and the 9/11 terrorist attacks killed about 3,000 people. We're losing 63,000 Americans to drug overdoses every year. If those were war casualties, it would be front-page news and on all of the networks daily. It's a very serious problem.

GREENLEES: How is it impacting employers?

HILDEBRANDT: It directly affects employers in terms of safety issues, productivity and lost work time. It can also have an indirect impact if the addiction is in the employee's family. They're distracted because their mind is on their loved one. I don't know how big an issue it is nationally, but I know what I see and it's frightening. There's a young guy at work whose sister is addicted and there's an older person whose son is addicted. It is hard for me to believe, but it's true.

MILLER: Another problem is presenteesim, which is when an employee shows up to work, but is not productive. They may be hung over, in withdrawal or under the influence. They may be distracted because of a family member's addiction. That impacts productivity, and can lead to workplace errors and injuries.

HILDEBRANDT: It can be very difficult for an employer to help when it is an employee's family member who is addicted. You can tell something is wrong because the employee is distracted, but it is very difficult to understand how you can help.

MILLER: That's why employee assistance programs (EAPs) are so important. They let people get help confidentially.

MUELLER: Drug problems are an especially big problem for employees right now because there is such a supply and demand issue for workers. Employers' priorities change over time. Ten years ago it was health care. Right now it is hiring and retention. I also think opioid addiction is a big workplace safety issue. Not only for the worker, but for the people around them. I think the impact of drug problems on workplace safety is going to be fertile ground for legal liability in the future, especially for employers who are not proactive in this space.

GREENLEES: From an employment perspective, is opioid addiction more or less of a problem than other addictions?

HILDEBRANDT: I would go back to some of the comments Dr. Miller made. The addiction problem is probably more pronounced when you look at alcohol or tobacco, but opioid addiction is more impactful from a perception standpoint.

MILLER: One of the challenges with opioid addiction is that there is such a significant overlap with the chronic pain population. It is very difficult to get those suffering from chronic pain back to work at a functional level after an injury. It really requires two different approaches. One is effective pain management and the other is addiction treatment, if necessary.

HILDEBRANDT: When someone who has an addiction problem is injured, the time it takes to get them back to work is extended. It's even more challenging if it is an opioid addiction. It definitely extends the recovery time.

MUELLER: I would make two points here. The first point is that when it comes to addictions involving alcohol or tobacco, the solution is to eliminate the person's need for those substances. When it comes to opioids, however, there is often an underlying issue related to pain. The cure needs to focus on returning the person to functionality, not eliminating the pain, and that requires a different type of treatment. The second point is that, unlike other addictions, opioid addiction often starts in the medicine cabinet. One study found that 54 percent of the time, the drug comes from a friend or relative. I have pain, you have medication. And, 82 percent of the time, that friend or relative obtained it from a physician.

MILLER: The pills may be given to them by a friend or relative or they may be stolen from the medicine cabinet. People with a 30-day supply of opioids for acute pain typically use three to five days' worth, which means they have up to 27 days' worth of supply sitting in the medicine cabinet. That's why there's been a major public health strategy to focus on safe medication storage and disposal. You shouldn't keep extra prescription pills around. You need to take them to a designated medication drop location.

MUELLER: I agree. There are a lot of people who don't realize that there are drug drops in Walgreens and most other pharmacies where you can dispose of your unused prescriptions.

GREENLEES: Many employers think they are inoculated from the opioid problem because they have drug screening programs in place. Is that an accurate assessment?

HILDEBRANDT: There are ways to beat drug tests so it is a question of what type of drug testing program you have, how effective it is and how representative it is of what is going on in your workplace. And the goal should not be to "catch" people, but to identify and help people so that you can have a safe and healthy workforce.

MILLER: There's a tremendous misunderstanding when it comes to drug testing, which is that employment-based drug testing will detect people who are taking pain pills. Often, it won't. The test looks for opiates – codeine, morphine, heroin and other substances that come from opium itself. Pain pills like OxyContin, hydrocodone and methadone are synthetic drugs. They are opioids, not opiates, and they are not detected by the common, commercially available drug-screening tests.

GREENLEES: What are the most effective treatment options for opioid addiction?

MILLER: The treatment for opioid addiction is unique in that medications play a key role. The medications are extremely important for improving outcomes because they block the opioid receptors, making it difficult for the drug to work. That creates a new issue, however, because the counselors who are on the front line of therapy cannot prescribe medications. You need to have licensed prescribers, which is why we are working to get primary care physicians more involved in

treating opioid addiction.

MUELLER: An important issue is early identification, which can be a problem in our current, production-based health system where primary care physicians need to see 38 or so patients per day. You need to spend time with patients to identify this issue.

MILLER: Early identification is critical, and the best places are often in the workplace or schools. You want to get the problem identified – whether it is alcohol, cocaine, opioids or methamphetamines – before physical health and functionality are impaired.

GREENLEES: What role can employers play in reducing the opioid challenge? What programs and/or policies do you think we should have in place?

HILDEBRANDT: There are three or four different things. First, they have to be open to the concept that the addiction problem exists and that it is counterproductive to their organization. That starts the conversation. Reasonable suspicion training, which helps supervisors detect signs and symptoms of alcohol and drug abuse, can have a significant impact on early identification. The next component is having a robust drug testing program. Without that, you are not doing anything. The final component is being committed to helping employees by pointing them in the right direction and being accommodating to that EAP process. You do those things and you will have an impact. The worst thing an employer can do is nothing, because they will just be letting their problems compound.

MUELLER: The best practice I know of is QuadGraphics. They have an education program that involves all of their members – all of their employees, their families and their other dependents. You have to reach out to everyone.

GREENLEES: What would you say to employers who forego drug testing due to their concerns about finding a sufficient number of drug-free workers in a highly competitive job market?

MILLER: I can't imagine a more misguided decision than to forego pre-employment drug testing. All you are doing is hiring people you don't know anything about.

HILDEBRANDT: Drug testing can play a critical role in both weeding out job applicants and in helping employees. If you have a good employee who has an addiction problem, imagine how great they could be if they had a clear mind. Unions also play an important role. They can have just as much impact as employers on educating and influencing employees. Unfortunately, some people in union leadership do not want to address the issue.

MUELLER: A lot depends on the size of the employer. Small employers are at a significant disadvantage due to the time and financial commitment of a drug program. They do not have the ability to hire someone like Kevin with his expertise and focus. Drug testing alone can be a burden. For larger employers, it is a matter of priority and culture. When it comes to drug programs, about 20 percent of large employers are proactive, 20 percent are reactive and 60 percent are passive. Action is recommended, obviously. You have to know who you are hiring and you want to be able to identify and help your existing employees with robust EAP programs that provide counseling and treatment.

Those programs that can really make a difference. Unfortunately, too many employers look at their EAP programs as a checkbox, something they have as part of their long-term disability coverage. It offers three consultations, period.

MILLER: I agree. EAPs can be a major part of solution, but they have to be high quality. They cannot be window dressing.

GREENLEES: What steps can employers take to increase awareness of EAP benefits?

HILDEBRANDT: You can treat it the same way you treat your retirement planning. Make them aware of it. You can also encourage employees to guide employees to an EAP instead of turning a blind eye.

GREENLEES: The Legislature is reportedly looking at the opioid challenge as part of a broader look at workers compensation issues in the state. What role can employers have in minimizing opioid prescriptions as a form of pain management for workers compensation claims?

HILDEBRANDT: One thing that I think can be done is for the employer to work with health care providers, workers and insurers. The communication has to be very effective and open. Employers can also do a better job of early detection using reasonable suspicion training programs and by working with insurers and providers to identify individuals who may be going from emergency room to emergency room in search of prescription drugs.

MUELLER: You have to look at the problem holistically and comprehensively. You need to have drug testing for opioids, which is beyond the regular five panel tests. You need to have education at the supervisor level, the employee level and the dependent level. You need to have good communication with your workers comp carrier. You also need to have access to treatment and to EAPs that have some depth to them.

MILLER: A lot of this work falls on the health care system. Educating and training doctors, nurse practitioners and physician assistants to prescribe differently is really key. Benefit structures are also important. Current benefit designs incentivize the use of injections, nerve blocks and other types of interventional pain management. Unfortunately many insurers won't pay for comprehensive pain treatment that uses counselors, physical therapists, massage therapists and alternative medicine. The same is true for pharmacy benefits, which incentivize the 30-day supplies that can be problematic when it comes to opioids. What if you had a plan design that had no copay for a five-day supply and the usual copay for a 30-day supply? That change would incentivize a safer prescribing process for opioids.

MUELLER: I agree. Acupuncture and alternative pain treatments are becoming more popular, but are still not frequently prescribed. We need to be trying different methods of treatments beyond prescriptions.

HILDEBRANDT: You need an aggressive post-injury, return-to-work policy where the person is not allowed to fall out of the work cycle. You need to get them back to work as soon as you can. When people stay away from work, they go backward. The sooner they get back to work, the better they are

for themselves and society.

TABLE OF EXPERTS

Moderator

Laurie Greenlees, MBA, PHR, SHRM-CP

Human Resource Business Advisor Manager and HR Hotline, MRA
Laurie is a certified Professional Human Resources manager with expertise in talent management, employee relations and engagement, compliance and best practices in FMLA and ADA administration and leadership development. As manager of MRA's 24/7 HR Hotline, Laurie and her team of professional HR Advisors answer questions regarding the opioid crisis and its impact on area workplaces.

Kevin Hildebrandt

Director of Risk Management, Miron Construction Co., Inc.
Kevin provides support for Miron's field operations, enhancing production while controlling risk for employees as well as customers, their facilities and equipment, and the public. He supervises the safe operation of all Miron equipment, and serves as the lead instructor for Miron's professional crane operator development program.

Michael Miller, MD, DFASAM, DLFAPA

Medical Director, Herrington Recovery Center at Rogers Behavioral Health
Dr. Miller is a board-certified general psychiatrist and addiction psychiatrist. He has practiced for more than 30 years, and is a Distinguished Life Fellow of the APA and ASAM, as well as at-large director of the ABAM. He serves as a faculty member for the Addiction Psychiatry Fellowship and the Addiction Medicine Fellowship at the University of Wisconsin School of Medicine and Public Health.

Jim Mueller

Owner, Mueller QAAS
Jim has more than 30 years of employee benefit experience serving as president of Frank F. Haack & Associates and Zywave, one of the largest technology companies in the metro Milwaukee area. Jim helped Frank F. Haack & Associates grow into the largest benefit broker/consultant in Wisconsin and a top 70 brokerage firm nationally. He is now committed to providing employers objective advice on their employee benefit programs through Mueller QAAS.

Opioid-TOE-panel.jpg

TABLE of EXPERTS

Moderator

LAURIE GREENLEES, MBA, PHR, SHRM-CP
Human Resources Business Advisor and HR Hotline Manager, MRA

Laurie is a certified Professional Human Resources manager with expertise in talent management, employee relations and engagement, compliance and best practices in FMLA and ADA administration and leadership development. As manager of MRA's 24/7 HR Hotline, Laurie and her team of professional HR Advisors answer questions regarding the opioid crisis and its impact on area workplaces.

KEVIN HILDEBRANDT
Director of Risk Management, Miron Construction Co., Inc.

Kevin provides support for Miron's field operations, enhancing production while controlling risk for employees as well as customers, their facilities and equipment, and the public. He supervises the safe operation of all Miron equipment, and serves as the lead instructor for Miron's professional crane operator development program.

MICHAEL MILLER, MD, DFASAM, DLFAPA
Medical Director, Herrington Recovery Center at Rogers Behavioral Health

Dr. Miller is a board-certified general psychiatrist and addiction psychiatrist. He has practiced for more than 30 years, and is a Distinguished Life Fellow of the APA and ASAM, as well as at-large director of the ABAM. He serves as a faculty member for the Addiction Psychiatry Fellowship and the Addiction Medicine Fellowship at the University of Wisconsin School of Medicine and Public Health.

JIM MUELLER
Owner, Mueller QAAS

Jim has more than 30 years of employee benefit experience serving as president of Frank F. Haack & Associates and Zywave, one of the largest technology companies in the metro Milwaukee area. Jim helped Frank F. Haack & Associates grow into the largest benefit broker/consultant in Wisconsin and a top 70 brokerage firm nationally. He is now committed to providing employers objective advice on their employee benefit programs through Mueller QAAS.

SPONSORS

MRA Where HR Means Business.

Miron Building Excellence

ROGERS BEHAVIORAL HEALTH

mueller