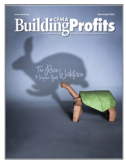


WAGING A COUNTERATTACK ON OPIOIDS: FIRST-DOSE PREVENTION STRATEGIES FOR THE WORKPLACE & AT HOME

BY CAL BEYER, RICHARD JONES & BRAND NEWLAND

"WE'VE BEEN HOODWINKED.

WE'VE BEEN DECEIVED INTO BELIEVING THAT, WHEN IT COMES TO MANAGING PAIN, THE 'GOOD STUFF'

ARE THE CONTROLLED SUBSTANCES, THE BY-PRESCRIPTION-ONLY MEDICATIONS, THE COUSINS OF MORPHINE.

"Now, with the fog of over 20 years of the opioid crisis lifting, **WE KNOW BETTER.** We know there are safer, more effective options for patients facing **the ACUTE PAIN OF INJURIES AND SURGERY.** That's not to say there is no place for opioid pain medications; they continue to be good options for cancer-related pain and end-of-life care. For many of the rest of us, though, the **RISKS OF THESE DRUGS ARE SIMPLY TOO GREAT."**

— BRAND NEWLAND

The U.S. opioid epidemic is complex and multi-faceted with no easy way out (Exhibit 1). From the increased risk of addiction facing construction workers and how workers' comp injuries are managed to addressing and preventing opioid misuse, waging a counterattack on opioids is an industry imperative.

Opioid Use Disorder (OUD) has been on the rise in the U.S. for over 20 years, and the consequences associated with it have reached new heights; from 1999 to the present, the U.S. experienced a 457% increase in overdose deaths.[1] Opioids are involved in an overwhelming majority of these overdoses.

To truly understand the opioid crisis and the need to protect construction workers before their very first use of opioids, the first part of this article presents a detailed background on the origins of the epidemic and risks of OUD in the U.S. The second part dives into eight strategies to help prevent first dose exposure through alternative pain management and prevention, improved communication with health care providers, and how to safely store and dispose of medication.

The Why Behind Waging a Counterattack

According to the Centers for Disease Control and Prevention (CDC), nearly 500,000 people died from an overdose involving prescription and illicit opioids between 1999-2019.[2] The CDC further reports that "deaths from drug overdose continue to contribute to overall mortality and the lowering of life expectancy in the U.S."[3] Further, the Bureau of Labor Statistics (BLS) reported 388 deaths from unintentional overdose from nonmedical use of drugs in the workplace for 2020,[4] which is the eighth consecutive annual increase in this area.

To grasp the potential risk of long-term opioid use, consider the likelihood that someone is still using that drug one year after the first use, which *increases most sharply* in the first days of use:

- One day of opioid use = 6% chance
- Eight days of opioid use = 13.5% chance
- 31 days of opioid use = 29.9% chance[5]

In March 2021, the National Institute of Drug Abuse (NIDA) cited frightening statistics about prescription opioids:

- 21-29% of patients who are prescribed opioids for chronic pain misuse them.
- 8-12% of people who use an opioid for chronic pain develop an OUD.
- An estimated 4-6% of people who misuse prescription opioids transition to heroin.
- About 80% of people who use heroin first misused prescription opioids.[6]

The Effect of the Pandemic on Opioid Addiction in the U.S.

The impact of the pandemic on OUD and overdose deaths has been substantial. In fact, in November 2021, the CDC reported that overdose deaths reached a record level (a 12-month rolling average) from May 2020 to April 2021, exceeding 100,000 deaths (Exhibit 2).[7]

The pandemic escalated substance use disorder (SUD) in general, and opioid misuse was no exception. While it is well known that opioids relieve *physical* pain, what is less understood is that opioids are highly effective in eliminating *emotional* and *psychological* pain. So as the pandemic pushed many people to unprecedented levels of stress, anxiety, fear, and loneliness, opioids offered a "way out" for some.

EXHIBIT 1: WAVES OF THE OPIOID EPIDEMIC

The epidemic has progressed in three distinct yet overlapping phases.

The first wave of the epidemic occurred in the late 1990s and early 2000s and was fueled by the pharmaceutical industry; the over-prescription of narcotic pain medication flooded the market with pain pills.

The second wave started in 2010 with an escalation in overdose deaths involving heroin. The reason for the heroin wave was two-fold: The most significant issue was the purity — and lethality — of the heroin; the second factor was that many people replaced pain pills with heroin. An increased number of users means an increase in overdose deaths. In addition, new users of heroin are at higher risk of overdose than those who have been using for years, and one reason for this is the lower tolerance level for new users.

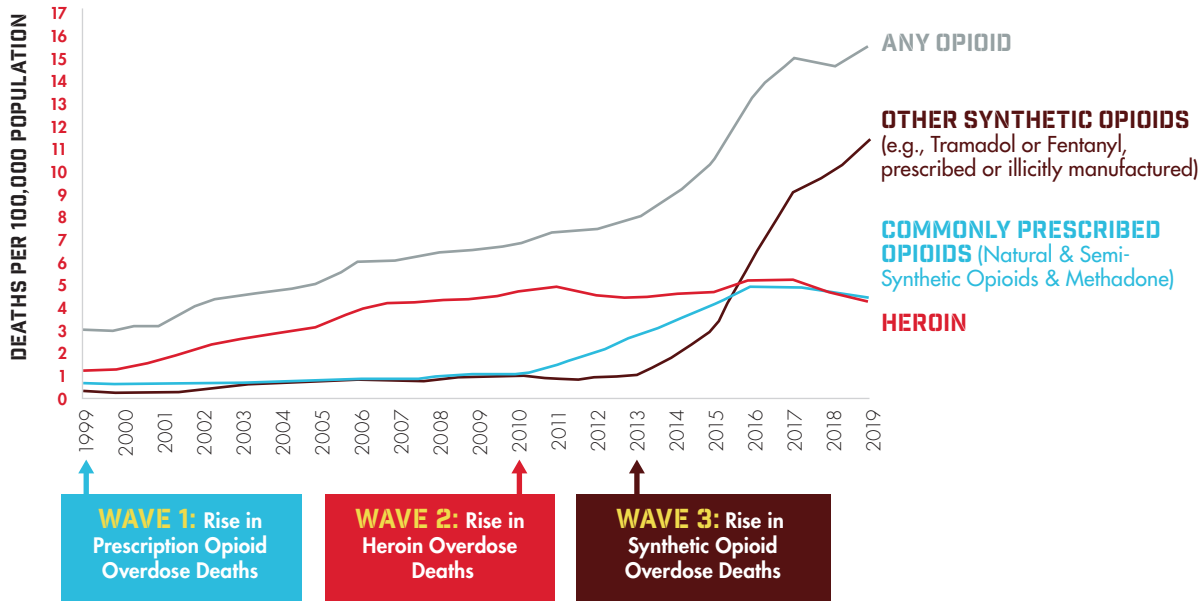
The U.S. is currently in the third and most dangerous wave of the epidemic, which started in 2013 with a steep increase in overdoses involving synthetic drugs. Fentanyl, carfentanil, and other analogs have created a poisoned drug supply. Synthetics are being cut into nearly all substances, and one of the most dangerous aspects of the synthetic wave is the prevalence of counterfeit pills. As people become dependent on prescription medication, they are often forced to purchase pills "from the street," which are commonly laced with fentanyl and other synthetics — an exceedingly dangerous dynamic.

But, there is a glimmer of hope. In 2019, the National Safety Council (NSC) reported that "the number of opioid prescriptions has dropped substantially, peaking at 259 million in 2012 and dropping to less than 192 million in 2017, as restrictions on opioid prescriptions have taken effect."[1] Similarly, the American Medical Association (AMA) reported a 37.1% decrease in opioid prescriptions, from 244.5 million in 2014 to 153.7 million in 2019.[2]

The NSC further reported that "both the number of prescriptions and the number of pills per prescription have decreased due to a combination of prescriber education, state prescription drug monitoring programs, limits on opioid prescriptions by insurance companies and pharmacies, and public awareness."[3] The National Council on Compensation Insurance (NCCI) confirmed this trend within the contracting industry as evidenced by a 49% reduction in per-claim opioid use.[4]

Endnotes

1. *www.nsc.org/getmedia/47e44256-f6fb-486d-9df3-256fbc9df53e/opioids-in-the-workplace.pdf.aspx.*
2. *www.ama-assn.org/system/files/2020-07/opioid-task-force-progress-report.pdf.*
3. *www.nsc.org/getmedia/47e44256-f6fb-486d-9df3-256fbc9df53e/opioids-in-the-workplace.pdf.aspx.*
4. *www.ncci.com/Articles/Pages/Insights-Opioid-Prescribing.aspx.*



Source: "Understanding the Epidemic." CDC. March 17, 2021. *www.cdc.gov/opioids/basics/epidemic.html.*

Another factor related to increased overdoses during the pandemic is the disruption in care that COVID-19 caused. Clinics were shut down and treatment plans were upended. The best example of this is regarding medication-assisted treatment (MAT). When methadone clinics were shuttered and office-based buprenorphine prescribing was hampered, those being treated for OUD had to go without these lifesaving medications during one of the most stressful times in modern history. Fortunately, the government changed regulations to better fit the circumstances, but the damage was significant.

Interestingly, during the pandemic, the total number of pain patients decreased while the total number of prescriptions increased. Researchers at Indiana University at Bloomington tracked treatment patterns for millions of patients struggling with limb, extremity, joint, back, and/or neck pain finding that "prescriptions for highly addictive opioid medications like oxycodone (OxyContin) rose 3.5% during the first half-year of the pandemic compared with the prior year — despite a 16% plummet in pain diagnoses."[8] This unhealthy dynamic indicates very high doses for those receiving pain medication and also seems to illustrate that the opioid issue has not totally shifted to "the streets" (e.g., drugs laced with fentanyl sold by drug dealers). Legally valid yet clinically questionable over-prescribing continues to be a major area of concern.

Construction Is at an Elevated Risk of Prescribed Opioids

Musculoskeletal Injuries & Disorders

In construction, a high degree of musculoskeletal injuries and musculoskeletal disorders (MSDs) exist with "about 34.2% of construction workers reporting at least one type of musculoskeletal disorder," according to research from CPWR — The Center for Construction Research and Training (a nonprofit created by North America's Building Trades Unions (NABTU) and a partner with the National Institute for Occupational Safety and Health (NIOSH)).[9]

Moreover, this research from CPWR determined an associated use of prescribed opioids; "compared to workers without MSDs, prescription opioid use tripled among construction workers with any type of MSD and quadrupled among those with MSD injuries."

Workers' Comp Impacts

Prescription opioids impact the total cost of care for workers' comp injury management as well. For example, the Workers Compensation Research Institute (WCRI) found that construction workers were the second highest among all industries to receive opioid prescriptions for pain at 55% of the time.[10] Second, among workers with low-back injuries, those receiving "longer-term opioid prescriptions received temporary disability benefits 251% longer than workers treated for low-back injuries without opioid prescriptions."[11]

Increased Dosage

In June 2020, the National Council on Compensation Insurance (NCCI) evaluated opioid prescription use across major industry groups and determined that, in the contracting industry, the "quantity of opioids prescribed to injured workers is more than double the average number prescribed to those in all other industry groups." Moreover, "these contracting industry group claimants, on average, receive both 20% more opioid prescriptions and opioid prescriptions that are 20% stronger" (as measured by morphine milligram equivalents (MME)).[12]

Consistent with the findings of the CPWR, the NCCI also found the higher frequency of greater severity injuries in construction as a contributing factor in the higher prescribed opioids. One specific measure is in injuries classified as "permanent total," where construction experiences 27% of the total of these claims among all industry groups despite only accounting for 10% of all workers' comp claims. In these permanent total claims for the contracting industry, the MME was more than 20 times higher than the average MME total for all claim types combined.[13]

Preparing to Combat the Opioid Epidemic

The opioid crisis affects more than 75% of employers;[14] construction employers ***must*** acknowledge that their companies and workforces are at risk.

Protecting your company also means helping those with OUD and other SUDs. "Employers spend an average of $8,817 annually on each employee with an untreated SUD"; in contrast "each employee who recovers from a SUD saves a company over $8,500."[15]

No longer does "being proactive" mean having a drug-free workplace policy or a drug and alcohol testing program. Companies must consider their protocols for preventing worker injuries.

A September 2021 NIOSH Science Blog offers a list of suggestions for employers and their workers, but the main takeaway is that there are "continued efforts to prevent injuries and expand opportunity for and education concerning alternative pain management, as components of an overall prevention plan..."[16] This approach is consistent with the

CPWR, which advocates for construction employers to adopt ergonomics to reduce exposure to MSD injuries as well as non-opioid pain medication methods.[17]

NSC Employer Resource Kit

"Begin Addressing Opioids in Your Organization" *(www.nsc.org/pages/prescription-drug-employer-kit)* is a free downloadable resource from the National Safety Council (NSC) for employers. It provides a comprehensive set of resources to help organizations understand the risks of opioids, including sample policies, fact sheets, presentations, safety talks, posters, white papers, reports, and videos.

These resources are intended to help increase the understanding of how opioids impact the workplace, recognize signs of impairment, educate supervisors and employees on the risks of opioid use, develop drug-related HR policies, and support employees who are struggling with opioid misuse.

Substance Use Employer Calculator

The Substance Use Employer Calculator *(www.nsc.org/forms/substance-use-employer-calculator)* is an effective tool for employers to consider the effects of substance misuse. The calculator requires minimal inputs including the industry, state(s) of operation, and the total employment for the company.

The calculator generates a summary report of the cost implications of substance misuse in three categories:

1) Lost time (excess number of days missed annually)
2) Job turnover and retraining (excess annual turnover in number of positions)
3) Health care (excess annual health care use, including days in hospital, emergency room visits, and outpatient visits)

The report also calculates a rate for excess roadway risks, which includes a projected number of employees who drove under the influence of alcohol or drugs in the prior year as well as who seldom or never wear a seatbelt when driving.

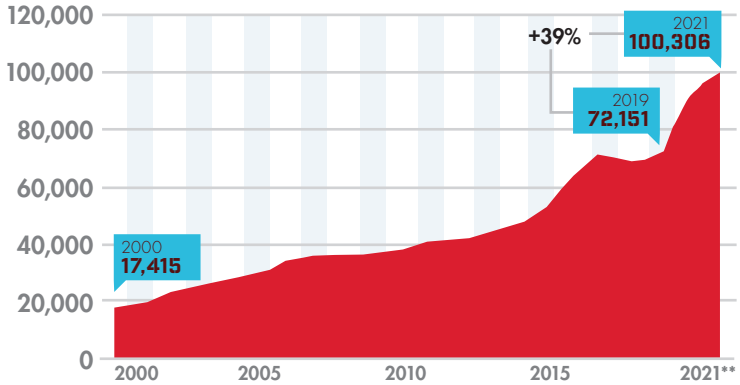
Naloxone

The deployment of Naloxone (also known as Narcan®), an opioid antagonist that reverses the effects of opioids to help prevent overdoses, is an important consideration within company and jobsite safety programs. In fact, there are many organizations advocating for the expansion of Naloxone/Narcan in the workplace. While such deployments are generally covered by Good Samaritan statutes, it is advisable for companies to request an attorney review of statutory requirements for obtaining, storing, training, deploying, and documenting the use of Naloxone/Narcan.

Although the use of Naloxone/Narcan on construction jobsites continues to expand, it's important to remember that this is *not* a strategy to prevent opioid use; it is a lifesaving tool to resuscitate individuals who are experiencing an opioid overdose.

EXHIBIT 2: U.S. DRUG OVERDOSE DEATHS SPIKE AMID THE PANDEMIC

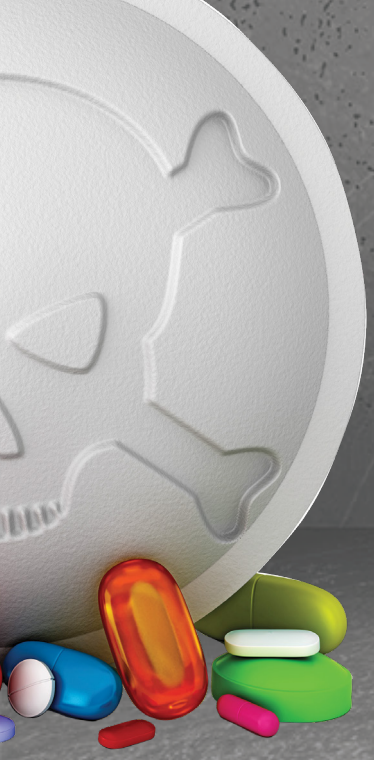
Number of drug overdose deaths in the U.S.*



*CDC estimates for 2020 and 2021 are based on provisional data.

**CDC 2021 estimate refers to 12-month period ending April 2021.

Source: Richter, Felix. "U.S. Drug Overdose Deaths Spike Amid the Pandemic." Statista. November 18, 2021. *www.statista.com/chart/18744/the-number-of-drug-overdose-deaths-in-the-us.*



FIRST-DOSE EXPOSURE: AN OUNCE OF PREVENTION IS WORTH A POUND OF CURE

WITH A DEEPER UNDERSTANDING OF THE OPIOID EPIDEMIC, the **IMPACTS OF COVID-19** and the pandemic on this crisis, and the **INCREASED RISK OF ADDICTION IN CONSTRUCTION,** it's time to arm yourself and your company with **EIGHT STRATEGIES TO PREVENT FIRST-DOSE OPIOID EXPOSURE.**

These upstream strategies cover a variety of options that are not only relevant in the workplace, but also at home — thwarting the risk of addiction and preventing opioids from being misused.

Strategy #1: Multi-Modal Pain Relief

When thinking about the consequences of both accidental injuries and nonaccidental ones (e.g., surgery), pain is at the top of the list.

The good news is that there are many options to manage a wide variety of pain. The *even better* news is that combining these therapeutic approaches, known as multi-modal pain management, leads to even better results.

The options begin with non-medication alternatives (heat, ice, rest, exercise, meditation, acupuncture, etc.). Every well-done pain management plan builds on a foundation of non-pharmacological options. Exhibit 3 illustrates major categories of medications used to manage pain as well as a summary of how each drug category works.

Combining the options in Exhibit 3 is key to the best pain management. Beginning prior to surgery works even better to get *and* stay ahead of the pain. Opioids may have a role, depending on the patient and specific clinical scenario, but that role is best described as *the last option* rather than the first. The Laborers' Health & Safety Fund of North America (LHSFNA) has created a list of 15 questions to ask before taking prescription opioids (Exhibit 4).

There are multiple manufacturers of non-opioid pain medications, and they can be incorporated into both multi-modal pain management and Enhanced Recovery After Surgery (ERAS) protocols. Moreover, insurance carriers and health care systems have searchable online directories for providers who specialize in non-opioid pain management.

Strategy #2: Opioid-Sparing Methods & ERAS Protocols

Over 20 years ago, physicians and surgical teams in Europe began experimenting with a redesigned surgery experience — before surgery, during surgery, and after surgery — with the patient at the center of each decision. These surgical teams created new ERAS protocols, which include:

- Replacing instructions for strict fasting the night before surgery with guidance to consume a clear, carbohydrate drink (e.g., Gatorade) up until two hours before surgery
- Multi-modal pain management (as discussed previously)
- Early return to eating, walking, and other activities as soon as possible after surgery
- Around 20 other individual interventions, all oriented toward physically and psychologically preparing the patient for the stress of surgery and recovery

ERAS has been found to have had a dramatic impact on patients:[18]

- Hospital stays are 30% shorter
- 50% fewer complications, like infections
- Up to 90% less need for and use of opioid painkillers
- Thousands of dollars saved with each case
- Higher patient satisfaction rates

Enhanced recovery is a widely tested formula that works when applied. Patients feel better supported and prepared through a surgery experience that is reimagined in 15 or 20 small ways. The biggest problem today is the lower-than-expected implementation of these protocols.

Generally, employers with self-funded employee benefit plans can easily modify their instructions for their third-party administrator in the summary plan document stating that they wish to adopt ERAS protocols. Patients are unlikely to find the experience on their own. They need to self-advocate, be prepared to ask the "right" questions, and perhaps even find an expert advocate to help them along the way. (Exhibit 5 presents questions to ask prior to surgery.)

Strategy #3: Monitor Utilization of the Prescription Formulary in Employer's Self-Funded Employee Benefit Plans

Employee benefit plans are complicated and bound by many state and federal regulations. Most employers retain specialty advisors to assist with plan design, provider and vendor selection, program funding (including employee cost-sharing options), population health measures, and program evaluation. Two related plan decisions include selecting a pharmacy benefit manager and the adoption of a formulary of approved tiers of prescription medications and corresponding reimbursement rates.

The purpose of a prescription formulary is to ensure the delivery of high-quality care while offering cost-effective medications; "formularies are the lists that act as the gateways to prescription drug coverage in health plans in the United States, and impact every prescriber, pharmacist, purchaser, and patient."[19]

It behooves employers, health plan administrators, and trustees to be educated on the formularies in order to balance limits without overly restricting access to pain management or other behavioral health medications through excessive preauthorizations, for example.

The Health Action Council (HAC) is a not-for-profit organization representing large-size employers. In its June 2020 publication, *Opioids in the Workplace*,[20] HAC outlines specific steps for employers to better understand the formulary process, including the following representative outlined actions for pharmacy benefit managers to reduce the potential for errors and misuse of prescriptions:

- What prescription drug monitoring programs are in place, including monitoring of pharmacies, automated claims review, and cross-checking with state-required inventories, prescribers, and beneficiaries?
- How are they adhering to federal prescribing guidelines?
- Do their utilization management protocols include enforced limits?

EXHIBIT 3: CATEGORIES OF PAIN MANAGEMENT MEDICATION

TYPE OF MEDICATION	WHAT IT DOES
ACETAMINOPHEN (e.g., Tylenol)	**Manages pain in the central nervous system.**
NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (NSAID) (e.g., ibuprofen (Advil) and naproxen (Aleve))	**Manages pain and inflammation at the site of the injury.**
GABAPENTIN/PREGABALIN (e.g., Gralise)	**Manages pain through the peripheral nervous system.**
ANESTHETICS (e.g., bupivacaine (Exparel))	**Manages pain through blocking pain signals in the nervous system. Provides relief for a targeted area and is relatively short-acting (such as with a dental procedure). It can be used for a region of the patient's body and for up to three days post-surgery.**
OPIOIDS (e.g., hydrocodone (Vicodin), oxycodone (OxyContin, Percocet), morphine, codeine (Tylenol #3), fentanyl, tramadol (Ultram))	**Blocks a specific receptor in the brain that mediates pain. Use of these medications has been linked to persistent use, withdrawal, and addiction.**

EXHIBIT 4: 15 QUESTIONS TO ASK YOUR DOCTOR BEFORE TAKING PRESCRIPTION OPIOIDS

1) Why **DO I NEED THIS** medication?
2) **WHAT ARE THE SIDE EFFECTS** of this medication? How can I reduce or prevent them?
3) **HOW WILL I KNOW IF I'M BECOMING ADDICTED** to or dependent on this medication?
4) Should I take this medication if **I HAVE A HISTORY OF SUBSTANCE ABUSE** disorder or addiction?
5) Should I take this medication **IF ADDICTION RUNS IN MY FAMILY?**
6) **ARE THERE ANY NON-OPIOID MEDICATIONS** I can take as an alternative?
7) **HOW LONG SHOULD I TAKE THIS MEDICATION?** When can I reduce the amount I'm taking or replace it with something else?
8) **SHOULD I START WITH A SHORTER PRESCRIPTION,** fewer pills, or a lower dose?
9) **HOW DOES THIS MEDICATION INTERACT WITH OTHERS,** especially medications for anxiety, sleeping problems, or seizures?
10) **CAN I DRIVE** a vehicle or operate heavy equipment while on this medication?
11) **ARE THERE ANY LIMITATIONS** on tasks I might need to perform at my safety-sensitive job?
12) **ARE THERE NON-MEDICATION OPTIONS** that could help with pain relief while I recover?
13) **HOW DO I DISPOSE OF UNUSED PILLS** once I no longer need them?
14) **SHOULD I HAVE NALOXONE** (also known as Narcan®) in my house?
15) **WHERE CAN I GET HELP** if I experience addiction or other adverse effects?

Source: Laborers' Health & Safety Fund of North America. *www.lhsfna.org/publications/what-to-ask-your-doctor-before-taking-opioids.*

Working with specialty benefit advisors, employers can request aggregated and deidentified population health data analytics on health claims data. Key data trends to assess include percent of the population with behavioral health claims, percent of pharmaceutical spend on opioids, average increased cost per claim for behavioral health claims, and underlying comorbid (co-occurring) chronic health conditions for behavioral health claimants.

Strategy #4: Pain Management, Medical Case Oversight of Claims & Data Analytics Strategies for Workers' Comp Injuries

As opioid prescriptions for injured construction workers remains relatively high among all industry groups, the importance of an aggressive and integrated process for workers' comp injury prevention, medical case management, claims oversight, and utilization review cannot be overstated.

Employers are encouraged to engage professional insurance advisors and claims management consultants to provide guidance on strategies to protect workers' comp programs and the workforce from the risk of opioids. Too often contractors solely focus on the experience modification rating (EMR) since it is used as a prequalification tool by owners and/or GCs. However, the EMR does not provide sufficient evidence of a hidden exposure to a lingering or emerging problem with opioid use in workers' comp claims. Like the utilization review and data analytics in employee benefits, a comprehensive review of workers' comp claims and costs by category will help identify targeted improvements.

Rules of Engagement

Understanding the "rules of engagement" in workers' comp is critical to identifying performance gaps and improvement opportunities. There are several important factors employers must understand to effectively reduce the risk of opioids in workers' comp, including:

- Whether their insurance carrier — and third-party administrator, if applicable — is conservative with medical case management, aggressive in monitoring opioid prescriptions, and encouraging of alternative pain management strategies.
- The company's risk tolerance combined with cash flow and financial strength, which influences its desired insurance program structure. Some companies wish to transfer all risk and select a guaranteed cost program. For various reasons, a company may not have the ability to pay

deductibles on current losses and fund collateral for future loss development. In contrast, other employers see value in having "skin in the game" and are incentivized either by loss cost management in self-funded large deductible programs or peer pressure in group insurance programs.

- Claim filing and compensability under workers' comp, which is defined by jurisdictional regulation and impacted based on all states in which the employer has operations, work locations, or employees living.
- Based on state regulations, determine whether the direction of care within workers' comp is controlled by the employer or their insurance company, by the employee, or a blend where level of choice in medical care is abridged, where employers need to select physicians for an approval panel.
- Some states have issued regulations for opioid pain management in workers' comp claims for providers, pharmacists, and claims adjusters to follow in terms of approved medication, dosage, and other limitations. They also may have a formulary for prescription medications that govern reimbursement based on prior approval from employers.

Additional resources available to evaluate workers' comp pain management guidelines include:

- "ACOEM Practice Guidelines: Opioids for Treatment of Acute, Subacute, Chronic, and Postoperative Pain" by the American College of Occupational and Environmental Medicine are best practices for the treatment of occupational medical care and disability management *(acoem.org/acoem/media/News-Library/Opioids-JOEM-2014b.pdf)*.
- "CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016" clinician in the CDC's *Morbidity and Mortality Weekly Report* provides recommendations for primary care *(www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf)*.

Strategy #5: Comprehensive Prenatal Wellness Education to Minimize Perinatal Prescription Opioid Usage

Maternal and infant health is a priority in the U.S. given that mortality rates are higher than in other economically advanced countries.[21] Perinatal wellness education contributes to a healthy pregnancy and a positive birth experience. A holistic and comprehensive perinatal wellness program can help expectant families thrive by developing skills to reinforce a healthy lifestyle.

In June 2020, BlueCross BlueShield (BCBS) reported a 31.5% increase in complications in both pregnancy and childbirth between 2015-18. This major finding determined a growing prevalence of chronic physical and behavioral health conditions before becoming pregnant. The data revealed that the largest increases were attributable to diagnosed obesity and major depression, with rising complications associated with gestational diabetes, preeclampsia, preterm labor, cesarean deliveries, and postpartum mood disorders.[22]

The same BCBS study further revealed that the number of women diagnosed with postpartum depression (PPD) is rising. In fact, nearly one in 10 women who delivered a baby in

EXHIBIT 5: 10 QUESTIONS TO ASK YOUR SURGEON

1) Is this considered a **MINIMALLY INVASIVE SURGERY?**
2) **HOW MANY TIMES** have you performed this surgery?
3) I am aware that **NOT EATING OR DRINKING** after midnight leading up to surgery is bad for my recovery. **MAY I DRINK A SPORTS DRINK** (like Gatorade or G2) two hours before my operation?
4) I understand most procedures can **HAVE ME HOME THE SAME DAY.** Is that possible with this operation?
5) I've heard about the benefits of Enhanced Recovery After Surgery (ERAS) protocols. **HAVE YOU ADOPTED AN ERAS PROTOCOL FOR THIS PROCEDURE?**
6) What do you do to **MINIMIZE THE NEED FOR OPIOID PAIN MEDICATIONS?**
7) **HOW SOON WILL I BE WALKING** and eating after the procedure?
8) **HOW LONG SHOULD I EXPECT TO BE AWAY** from my normal activities and out of work?
9) Is there anything else we can do to **MAKE MY RECOVERY EASIER?**
10) **WHAT KIND OF HELP** will I need at home and for how long?

Source: Goldfinch Health. *www.goldfinchhealth.com/wp-content/uploads/2021/09/10-Questions-for-your-Surgeon.pdf.*

2018 was diagnosed with PPD, which was a 28.5% increase from 2014. The study highlighted a relationship between PPD and pre-existing behavioral health conditions. These findings reinforce the need for perinatal education *before, during, and after* delivery, especially with the growing reports of stress, anxiety, depression, and substance misuse during the pandemic.

In October 2020, the *American Journal of Obstetrics and Gynecology* reported that "one in 75 women in the U.S. who fill an opioid prescription in the peripartum period will continue filling prescriptions up to one year postpartum." Moreover, "exposure to postpartum opioids has been linked to new persistent use after delivery, independent of the type of birth (vaginal vs. cesarean), suggesting the risk is inherent to the opioid prescription."[23]

Effective perinatal wellness education combined with ongoing prenatal medical care can teach expectant parents about the risks of opioids and alternative pain management approaches, which will improve the health of mothers and infants alike.

Strategy #6: Prescription & Over-the-Counter Medication Lockboxes at Home

All prescription and over-the-counter medications should be safely stored in a medication lockbox — a secure container that ensures medicine is only accessible to the prescription holder — or in a locked cabinet or closet.

Locking medicine storage containers are an effective deterrent to accidental poisonings, substance misuse, and theft leading to addiction. Unintentional poisonings are a top cause of both fatal and nonfatal injuries for children. Approximately 50,000 young children annually require emergency room visits due to improperly stored and secured medications.[24]

Locking up prescription medications can help keep them out of the hands of small children, teenagers, and those with suicidal ideations, thereby reducing the risk of poisoning and prescription drug abuse.

Medication lockboxes are available for purchase at local pharmacies, select retail stores, and online. The CDC's Up and Away campaign *(www.cdc.gov/medicationsafety/protect/campaign.html)* also provides information on medication storage fundamentals.

Strategy #7: Prescription Takeback Programs at National & Local Pharmacy Chains

A key prevention strategy is to eliminate or reduce the amount and type of excess opioid medications being diverted for nonauthorized use. Nearly nine out of 10 surgery patients with leftover opioid pills admit that they have not properly disposed of them, according to *Exposing a Silent Gateway to Persistent Opioid Use: A Choices Matter Status Report.* Respondents indicated that they kept the excess medications in their home, gave them to family or friends to help manage their pain, or improperly discarded the medications.[25]

A practical approach is to educate employees and families about the U.S. Department of Justice Drug Enforcement

SURGICAL QUALITY ANALYSIS

A surgical quality analysis of claims data from self-funded employee benefit plans offers key insights as to the historical performance of surgical results among insured employees and dependents and provides administrators and trustees of self-funded employee benefit plans with strategies to improve the outcomes of surgical procedures.

These beneficial outcomes include reducing patient safety risks, promoting faster healing, expediting return to work (and associated lost productivity) by decreasing lost work time, and achieving cost containment.

Elements of a surgery quality assessment, according to "Optimizing Surgical Outcomes" by Cal Beyer and Brand Newland *(www.insurancethoughtleadership.com/optimizing-surgical-outcomes),* include:

OUTPATIENT VS. INPATIENT PROCEDURES, highlighting the potential for significant cost-savings with outpatient procedures and the formula for getting there

MINIMALLY INVASIVE VS. LARGE INCISION (open) surgery approaches

POST-SURGERY use of opioids

BENCHMARKING surgical complications against industry standards

The assessment concludes with a set of recommendations for helping an employer's enrolled health plan members find higher-quality, lower-cost surgery as well as an expedited recovery.

Administration's (DEA's) search engine to identify year-round drug disposal sites[26] as well as its National Prescription Drug Take Back Day *(www.deadiversion.usdoj.gov/drug_disposal/takeback)*.

One positive sign of proactive action being taken in response to the opioid and other drug overdose crisis has been the rapid expansion of prescription takeback programs at many national and local pharmacy chains. Safe medication disposal kiosks or receptacles offer confidentiality and convenience to safely dispose unused or expired medication at no cost to prevent unintended misuse.

Strategy #8: Drug Deactivation Pouches for Safe Disposal

For environmental reasons, it is recommended that excess, unwanted, or expired medications should not be flushed down the toilet or in septic systems or disposed of in the garbage. The Deterra Drug Deactivation and Disposal System is an innovative example used to counter both the safety and environmental threats of excess prescription medications.

There are a growing number of employers that are providing employees with pouches to encourage safe disposal methods of expired and excess prescription medications. The technology — designed to provide an effective and environmentally safe way of promoting at home disposal — consists of a proprietary blend of activated carbon that permanently deactivates the molecular composition of the drug. By adding water and shaking the pouch, the resulting chemical reaction renders the medications inert and safe for normal garbage disposal.

Conclusion

The opioid epidemic currently confronting the industry is unnervingly reminiscent to risks of suicide in construction. Before industry-specific data on suicide rates was available, it was easy to ignore that crisis. As was the case with suicide, ***doing nothing is not an option.***

The industry and demographic factors of suicide are similar to the opioid crisis in construction. The good news is we have research, resources, and validated tactics to successfully confront the opioid crisis head-on. ■

WILL YOU JOIN IN THE MOVEMENT to **ENSURE WE FIND AN END** to this **SLOW-MOTION TRAGEDY** that has played out in the **CONSTRUCTION INDUSTRY AND OUR SOCIETY?**

Goldfinch Health's Prepared for Surgery Kit, which includes Deterra's Drug Deactivation & Disposal System. Photo courtesy of Brand Newland.

ADDITIONAL RESOURCES

CDC's Opioids in the Construction Industry — Part 1: The Evolution of a Crisis. *www.youtube.com/watch?v=XqOlAyEuqpQ.*

CDC's Opioids in Construction — Part 2: Impacting Lives. *www.youtube.com/watch?v=inQu1WqAPII.*

CDC's Opioids in Construction — Part 3: Pathways to Recovery. *www.youtube.com/watch?v=gsgbUQ2nKsE.*

Resources for Families Coping with Mental and Substance Use Disorders. *www.samhsa.gov/families.*

SAFE Project. *www.safeproject.us.*

SAMHSA's National Helpline. *www.samhsa.gov/find-help/national-helpline.*

Shatterproof. *www.shatterproof.org.*

Start Your Recovery. *startyourrecovery.org.*

Endnotes

1. "Addressing the Opioid Crisis." National Safety Council. *www.nsc.org/community-safety/safety-topics/opioids/prescription-drug-misuse.*
2. "Understanding the Epidemic." Centers for Disease Control and Prevention. March 17, 2021. *www.cdc.gov/opioids/basics/epidemic.html.*
3. "Drug Overdose Deaths in the United States, 1999–2020." Centers for Disease Control and Prevention. December 2021. *www.cdc.gov/nchs/products/databriefs/db428.htm.*
4. "National Census of Fatal Occupational Injuries in 2020." Bureau of Labor Statistics. U.S. Department of Labor. December 16, 2021. *www.bls.gov/news.release/pdf/cfoi.pdf.*
5. "Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015." Centers for Disease Control and Prevention. March 17, 2017. *www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm.*
6. "Opioid Overdose Crisis." National Institute on Drug Abuse. March 21, 2021. *www.drugabuse.gov/drug-topics/opioids/opioid-overdose-crisis.*
7. "Drug Overdose Deaths in the U.S. Top 100,000 Annually." Centers for Disease Control and Prevention. November 17, 2021. *www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.*
8. Mozes, Alan. "Did Pandemic Lockdowns Worsen the Epidemic of Opioid Abuse?" HealthDay. December 14, 2021. *consumer.healthday.com/12-14-did-pandemic-lockdowns-worsen-the-epidemic-of-opioid-abuse-2655959996.html.*
9. Dong, Xiuwen Sue; Brooks, Raina D.; & Brown, Samantha. "Musculoskeletal Disorders and Opioid Prescription Use among U.S. Construction Workers." The Center for Construction Research and Training. November 2020. *www.cpwr.com/wp-content/uploads/KF2020-MSDs-Opioids-US-workers.pdf.*
10. Thumula, Vennela & Liu, Te-Chun. "Correlates of Opioid Dispensing." Workers Compensation Research Institute. December 2018. *www.wcrinet.org/images/uploads/files/wcri8394.pdf.*
11. "Long-term opioid use significantly delays return to work, workers' comp study shows." Workers Compensation Research Institute. April 4, 2018. *www.wcrinet.org/news/in-the-news/long-term-opioid-use-significantly-delays-return-to-work-workers-comp-study.*
12. Wise, Carolyn. "Opioid Prescribing Across Industry Groups." National Council on Compensation Insurance. June 8, 2020. *www.ncci.com/Articles/Pages/Insights-Opioid-Prescribing.aspx.*
13. Ibid.
14. "How Opioids Impact Your Employees' Safety and Your Bottom Line." National Safety Council. 2019. *www.nsc.org/getmedia/f87adcf5-75fd-4348-86ba-88875c13b849/how-opioids-impact-employees-safety-and-bottom-line-infographic.pdf.aspx.*
15. "New Analysis: Employers Stand to Save an Average of $8,500 for Supporting Each Employee in Recovery from a Substance Use Disorder." PR Newswire. December 2, 2020. *www.prnewswire.com/news-releases/new-analysis-employers-stand-to-save-an-average-of-8-500-for-supporting-each-employee-in-recovery-from-a-substance-use-disorder-301183912.html.*
16. Dale, Ann Marie; Evanoff, Brad; Gage, Brian; Trout, Douglas; Novakovich, J'ette; Earnest, Scott; Garza, Elizabeth; & Chosewood, Casey L. "Addressing the Opioid Overdose Epidemic in Construction: Minimize Work Factors that Cause Injury and Pain." Centers for Disease Control and Prevention. September 14, 2021. *blogs.cdc.gov/niosh-science-blog/2021/09/14/opioids-in-construction.*
17. Dong, Xiuwen Sue; Brooks, Raina D.; & Brown, Samantha. "Musculoskeletal Disorders and Opioid Prescription Use among U.S. Construction Workers." The Center for Construction Research and Training. November 2020. *www.cpwr.com/wp-content/uploads/KF2020-MSDs-Opioids-US-workers.pdf.* Dale, Ann Marie; Evanoff, Brad; Gage, Brian; Trout, Douglas; Novakovich, J'ette; Earnest, Scott; Garza, Elizabeth; & Chosewood, Casey L. "Addressing the Opioid Overdose Epidemic in Construction: Minimize Work Factors that Cause Injury and Pain." Centers for Disease Control and Prevention. September 14, 2021. *blogs.cdc.gov/niosh-science-blog/2021/09/14/opioids-in-construction.*
18. Beyer, Calvin E. & Newland, Brand. "Optimizing Surgical Outcomes." *Insurance Thought Leadership.* October 10, 2021. *www.insurancethoughtleadership.com/optimizing-surgical-outcomes.*
19. "A Consumer Guide to Drug Formularies: Understanding the Fundamentals of Behavioral Health Medications." ParityTrack. *www.paritytrack.org/issue-briefs/a-consumer-guide-to-drug-formularies-understanding-the-fundamentals-of-behavioral-health-medications.*
20. "Opioids in the Workplace." Health Action Council. June 2020. *healthactioncouncil.org/getmedia/c7852988-bef9-4cf7-a0a1-556a606d3a0a/HAC-Opioids-in-the-Workplace.pdf.*
21. "Healthy Women, Healthy Pregnancies, Healthy Futures: Summary of the U.S. Department of Health and Human Services' Action Plan to Improve Material Health in America." U.S. Department of Health and Human Services. December 2020. *aspe.hhs.gov/sites/default/files/migrated_legacy_files/197501/hhs-maternal-health-action-plan-summary.pdf.*
22. "Trends in Pregnancy and Childbirth Complications in the U.S." BlueCross BlueShield. June 17, 2020. *www.bcbs.com/the-health-of-america/reports/trends-in-pregnancy-and-childbirth-complications-in-the-us.*
23. Peahl, Alex F.; Morgan, Daniel M.; Dalton, Vanessa K.; Zivin, Kara; Lai, Yen-Ling; Hu, Hsou Mei; Langen, Elizabeth; Low, Lisa Kane; Brummett, Chad M.; Waljee, Jennifer F.; & Bauer, Melissa E. "New persistent opioid use after acute opioid prescribing in pregnancy: a nationwide analysis." *American Journal of Obstetrics & Gynecology.* October 2020. *www.ajog.org/article/S0002-9378(20)30342-2/pdf.*
24. "PROTECT Initiative: Advancing Children's Medication Safety." Centers for Disease Control and Prevention. April 30, 2020. *www.cdc.gov/MedicationSafety/protect/protect_Initiative.html.*
25. "Exposing a Silent Gateway to Persistent Opioid Use: A Choices Matter Status Report." Pacira Biosciences. *https://www.planagainstpain.com/wp-content/uploads/2019/11/Pacira_2018report_102419b_FINAL.pdf.*
26. *apps2.deadiversion.usdoj.gov/pubdispsearch/spring/main;jsessionid=prZDTo5nuROuY4e_ElIlFmZRG8hkNhCZhnwaaKF6.web1?execution=e1s1.*

CAL BEYER, CWP, SCTPP, is Vice President of Workforce Risk and Worker Wellbeing at Holmes Murphy & Associates *(www.csdz.com/service/worker-wellbeing-and-suicide-prevention)* in Waukee, IA. Cal was instrumental in the launch of the Construction Industry Alliance for Suicide Prevention. He serves on the Executive Committee for the National Action Alliance for Suicide Prevention, the Expert Advisory Group for the Center for Workplace Mental Health, the Lived Experience Advisory Committee for the Suicide Prevention Resource Center, and the Advisory Board for Heritage CARES.

He is a past Secretary and Executive Committee member for CFMA and is a recipient of CFMA's Danny Parrish Outstanding Leadership Award in 2016 and its Chairman's Award in 2017. Cal can be reached at 651-307-7883 and *cbeyer@holmesmurphy.com*.

RICHARD JONES, MA, MBA, LCAS, CCS, CEAP, SAP, c-EMDR, is Executive Vice President and Executive Director for Heritage CARES, a division of Heritage Health Solutions *(www.heritagehealthsolutions.com)*, in Coppell, TX. Rich's focus is on building the clinical foundation for the Heritage CARES program. He is an experienced therapist, clinician, and health care entrepreneur operating primarily in the behavioral health space. He has wide-ranging professional experience across nearly all behavioral health domains, including mental health, substance use disorders, co-occurring disorders, and intellectual disabilities.

Rich has over 20 years of management experience and has been instrumental in launching and rebuilding multiple programs nationwide. He is passionate about providing quality care and supporting people in need. Rich can be reached at 864-764-8504, *rjones@heritagehealthsolutions.com*, and on Twitter @recoverycartel.

BRAND NEWLAND, PharmD, is the CEO and Co-Founder of Goldfinch Health *(www.goldfinchhealth.com)* in Austin, TX. Goldfinch Health optimizes the surgery and recovery experience for patients, saving companies and patients time, money, and addiction. Inspired by personal experiences with the pitfalls of surgery and a lack of proactive solutions to the opioid crisis, Brand helped to launch a vision toward a higher standard of care in surgery and recovery in 2018. He has over 15 years of experience in bringing new health care solutions to payers, employers, health care providers, and patients.

Brand received a Doctor of Pharmacy degree from the University of Iowa, his MBA at the University of Chicago Booth School of Business, and holds a certification in pain management. He can be reached at 319-594-4830 and *brand.newland@goldfinchhealth.com*.