

# DRUGS, DEPENDENCE AND THE WORKPLACE



## **A look at the role of employers – and benefits plans – in responding to the opioid crisis**

*By Sara Tatelman and Jann Lee*

**M**ore than 2,500 Canadians died from opioid-related overdoses in 2016, according to the Public Health Agency of Canada. The situation is particularly grave in the West. This year, British Columbia alone is on track to see 1,400 deaths due to opioids. The province declared a state of emergency in April 2016, and Alberta followed suit in May 2017. But the opioid crisis is affecting the entire country, with Ontario having committed \$222 million over three years to combat overdoses in August and Nova Scotia funding overdose kits through pharmacies since September.

While many addicts buy their fixes from street dealers, some users are getting opioid prescriptions from their physicians and claiming the drugs through their benefits plans. In a 2016 report on the City of Toronto's benefits plan, auditor general Beverly Romeo-Beehler found that, based on claims reimbursement data from 2013-15, 32 claimants had an equivalent of 19 months to 6.7 years' supply of fentanyl patches in at least one year. Romeo-Beehler has also raised concerns about doctors prescribing at least 800-milligram daily morphine equivalents of

fentanyl patches to non-cancer claimants, an amount she noted is almost nine times the recommended level requiring careful reassessment and monitoring.

Whether employees are getting high from fentanyl illegally imported from China or taking the OxyNeo their family doctor authorized, the issue has a number of implications for employers, especially if they're in a safety-sensitive industry such as construction or transportation.

Discussions about drugs and alcohol are a big concern for construction companies, says Keri Salvisburg Miller, vice-president of member services at the Progressive Contractors Association of Canada in Victoria.

"Safety is the No. 1 issue in construction, making sure that employees are fit for work," she says, noting that even employees who don't operate heavy equipment often work in confined spaces and near dangerous materials.

Under Canadian law, if someone causes an accident while on the job, an employer could be held liable.

"It can potentially be an occupational health and safety prosecution or an administrative penalty,

depending on what jurisdiction you're in," says Loretta Bouwmeester, a partner at Mathews Dinsdale & Clark LLP in Calgary.

"It can be a [workers' compensation] claim, depending on the circumstances. There can be civil liability . . . if public property or a member of the public or another contractor's equipment is damaged. And at its very worst, you could see a criminal prosecution under the Bill C-45 framework for criminal negligence."

### **Tweaking the plan**

Employers are well aware that some people, such as cancer patients and those with chronic pain, legitimately need opioids to function properly and come in to work, says Jean-Michel Lavoie, assistant vice-president of product development and group benefits at Sun Life Financial. "So most employers are concerned with that balance — making sure that the plan will provide the coverage for the ones who need [it] and provide the control for the misuse," he says.

Plan sponsors can tweak their offerings in several ways to reduce the risk of opioid abuse. For example, they can cap either the dollar or drug amount each patient can claim for opioids. Lavoie acknowledges that approach could leave legitimate prescriptions uncovered but he notes there are provisions for exceptions in such cases.

Because claimants can convert prescriptions of any narcotic to morphine equivalents, it makes more sense to cap dosages rather than dollar amounts, says Margaret Wurzer, director of benefit plan and product management at Alberta Blue Cross. The Michael G. DeGroote National Pain Centre at McMaster University suggests that for chronic non-cancer pain, dosages shouldn't exceed 90-milligram morphine equivalents.

Dollar limits on prescriptions are more difficult because there's so much variability in the cost of narcotics, Wurzer notes. To get a generic hydro-morphine dose equivalent to 180 milligrams of morphine — double the recommended maximum — a person would need nine tablets of four milligrams each. That works out to \$60 per month. For OxyNeo, a person would need two tablets of 60 milligrams, which would cost \$197 per month.

"If an insurer can't do the conversion to the morphine equivalent and all they could do was a dollar amount, you can see it's really tricky," says Wurzer. "If they set [the monthly limit] at \$200, someone who's using [generic] hydromorphone might be using

## WHEN ADDICTS HAVE ACCESS

Health care is another safety-sensitive industry when it comes to addiction issues. Doctors, nurses and allied health professionals need clear heads and steady hands when treating patients. But unlike construction workers and bus drivers, they're in close proximity to all kinds of medication, and hospitals must ensure appropriate use of the drugs.

"The way we do it at [the University Health Network] is we have a bio ID or fingerprint access for any narcotics . . .," says Jin Huh, senior director of pharmacy at the University Health Network in Toronto. Access is only available to those who actually dispense medication – so to nurses and pharmacy technicians, not to doctors – and to make theft even harder, the dispensing machines weigh more than 200 kilograms.

Every month, the organization looks at each staff member's use of the dispensing machines compared to the rest of the unit in question. The drugs they take out have to match their patients' conditions, and the pharmacy team watches out for variations beyond two to three times what's normal.

"Once that's triggered, we would work with the nurse manager to look at other factors: Was the person working? Were patients under her care? Did those patients experience dissatisfaction for poor pain control?" says Huh. Possible explanations for suspicious use include a nurse covering a colleague who called in sick or a patient struggling with pain control.

Signs a staff member is taking some of the hospital's opioids for personal use include hanging around the nursing station or dispensing machine when he or she doesn't need to be there or frequently signing off on colleagues' requests for more narcotics because of wastage.

If an employee does have an opioid addiction, whether or not he or she is stealing, the hospital's first response is to accommodate, says Jane Sloggett, senior director of occupational health and safety at the University Health Network.

"We do everything we can to support the recovery of people who are [addicted to any substance] because that really is what's going on," she says, noting one of the first steps is to relieve people of their duties and ensure patients are safe. "There's so much use and overdosing that it may be more important to ensure we have proper treatment facilities available for them. . . . With alcohol, we've done it many times to help them recover and bring them back [to work] when they've been through the program."

The hospital's benefits include disability leave, coverage for addiction drugs and time in a rehabilitation centres.

In terms of discipline, Sloggett notes the hospital would terminate an employee who committed an "egregious" theft of hospital drugs but she points out that there are often extenuating circumstances. "We would look at accommodation as opposed to discipline and give them opportunity to recover . . .," she says.

600 morphine equivalents before they hit that \$200 limit. Whereas someone using [OxyNeo], really, they're at 180 morphine equivalents and that's when they hit the limit."

Another option is to introduce or tweak a managed formulary, which traditionally puts limits around high-cost drugs. Lavoie notes that as of January 2017, Ontario's public drug programs have delisted high-dose fentanyl, and some private plans are following suit. Similarly, employers can require prior authorization for certain opioids. In that case, doctors would have to explain to the insurer or the pharmacy benefit manager why they're prescribing such a high level of narcotics.

"By requiring that sort of process on your plan . . . it provides an opportunity for the doctor to do a bit of a reassessment of [the] patient's pain," says Wurzer. "It provides an opportunity for that patient or that member to have some conversations with their doctor."

One of the most effective tools in catching opioid abuse is analyzing claims patterns. "If they identify potential claimants who may look to have higher-than-normal prescribing patterns . . . most insurers reach out to that patient," says Suzanne Nagy, national drug benefit lead at Mercer in Toronto. "They may also reach out to pharmacists and physicians, just to make sure everyone knows the claimant has higher-than-normal usage."

Fraud protection algorithms tied to members' drug benefit cards are particularly helpful, says Lavoie. If multiple doctors prescribe the same drug to one member, the system would flag it. "It could be even from the same family of drugs — so different doses or combinations of different opioids prescribed by different doctors and bought at different pharmacies," says Lavoie. Once a carrier flags a member for potential opioid abuse, an investigator would call the prescribing physicians to ensure the prescription was valid. The employer, however, wouldn't hear anything until the insurer confirmed the fraud.

### Support without stigma

Nevertheless, none of these tools will be useful if plan members are getting their fix from the street or their grandmother's medicine cabinet. "I'm not sure someone who intentionally wants to abuse and misuse opioids would actually claim it to their benefit plan," Lavoie notes, adding the majority of opioid claims his team sees are "legitimate and appropriate."

That's where human resources departments come in. "Employers want to support employees," says Nagy. "Not everyone is going to call their EAP and say, 'Hi, I'm abusing opioids.' It doesn't work that way."

A first step is creating non-stigmatizing workplaces. Prevention is "critical," says Julie Stich, associate vice-president of content at the International Foundation of Employee Benefit Plans. "One thing





that an employer can do is actually try to communicate with and educate their employees about this issue,” she says, suggesting awareness campaigns and conversations about substance abuse.

“Make the message pervasive throughout the workplace that this is a safe place and you can come to us,” she says.

That message can begin with something as basic as the choice of vocabulary and replacing talk about “substance abuse” with “substance-use disorder.” The term “disorder” seems more medicalized, Nagy notes, and thereby at a distance from the moralizing connotations of “abuse.”

“I think it will help people to reach out for assistance, if they know they have a disorder, as opposed to someone who thinks they’re just abusing something,” she says.

It’s also important to train managers on the early signs of opioid addiction — irritability, poor concentration and declining performance — so they can intervene before the situation deteriorates. But as Bouwmeester points out, they need to know their employees’ normal habits in order to pick up on differences. “When you take a step back and look at the big picture, it helps you identify what things seem to be off and put a bit of a process around it,” she says.


A first step in an opioid investigation is simply speaking with the employee. “We all want to be treated with respect and dignity,” says Andrea Furlan, a scientist at the Institute for Work and Health in Toronto.

Furlan notes some of the ways managers can approach the issue. “Bring the worker to an open and transparent conversation and say, ‘I noticed this. Are you going through some problems? Do you need help? We are here to help; we are not here to label.’”

Managers should also encourage staff to talk to their doctor and discuss available benefits, such as employee assistance programs and disability leave.

It’s also important for drug plans to cover treatment for addiction, such as suboxone and methadone, that can sate the cravings for opioids. Furthermore, employees dealing with addiction can also benefit from psychological support, although it’s important to cover a good number of sessions.

“They have a disease,” says Furlan.

“It’s not because they want to be addicted,” she adds. “It’s not because they’re a bad person.” 

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