

List of Common Objections and Potential Responses

Instructions

While there is generally broad support for health plan actions addressing the opioid crisis, you may encounter objections from internal and external stakeholders when launching a new opioid safety initiative. Below are common objections and evidence-based responses you can use when faced with such objections. As discussed in the motivational interviewing guide, it is important to give weight to everyone's opinions and listen to ensure you understand their points of view.

Objection	Evidence-based Responses
Moral Hazard Availability of naloxone increases risky drug use.	<ul style="list-style-type: none">• Communities with increased access to overdose prevention education and naloxone have seen greater reductions in opioid-related overdose mortality.¹• Naloxone distribution is cost effective, particularly when distributed to individuals who use heroin.²• Increased access to naloxone has been shown to reduce mortality and has not been associated with increased drug use.³
The Use of Medications for Addiction Treatment Aren't you replacing one addiction with another?	<ul style="list-style-type: none">• Medications that treat opioid use disorder such as buprenorphine and methadone have been shown to reduce overdose deaths, reduce illicit drug use, and increase retention in treatment. Injectable extended-release naltrexone has been shown to reduce illicit drug use and increase retention in treatment.⁴• Evidence suggests that medication-assisted treatment (MAT) results in significant reductions in overdose deaths, illicit drug use, criminal activity, and improvements in health.⁵• Retention rates in MAT in controlled studies range from 70% to 90%, which is superior to other treatment modalities.• Individuals with OUD who receive treatment with medications have lower health care costs compared to those receiving OUD treatment without medication.⁶
Overburdened Primary Care Primary care practices aren't well equipped for the clinical and social complexities of SUD treatment.	<ul style="list-style-type: none">• Health plans can help fill the gap by connecting primary care providers with training and mentoring resources:<ul style="list-style-type: none">○ Telementoring resources (e.g., UC Davis's Project ECHO) are available to provide support for primary care physicians.

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	<ul style="list-style-type: none"> ○ The Substance Use Warmline (855.300.3595) is available 6 AM–5 PM Monday–Friday for free consultation with addiction specialists. ○ The Providers Clinical Support System provides training and mentorship. ● France dropped overdose death rates by 80% by requiring health plans to pay “chronic disease care” payments to primary care providers for managing SUD, and by decreasing restrictions on buprenorphine prescribing.⁷
<p>Return on Investment Carve out and other factors make return on investment unlikely.</p>	<ul style="list-style-type: none"> ● Plans have a strong business case for building better access to addiction treatment whether or not substance use disorders are the financial responsibility of the plan. ● Streamlining access to MAT has been shown to lower emergency department (ED) and hospitalization costs, lower hepatitis C and HIV rates, and decrease overdose deaths.⁸ ● While substance use treatment services are carved out of Medi-Cal managed care plan contracts, some local Medi-Cal managed care plans launched MAT expansion projects in their networks, recognizing that promotion of MAT is a way to improve health and safety in their membership while lowering ED and inpatient services associated with untreated addiction. Examples include sponsoring buprenorphine waiver trainings, pay-for-performance programs that incentivize physicians to become waived and to accept new patients, and fee-for-service payments on top of capitation.⁹
<p>Fraud and Abuse Buprenorphine can be diverted for nonmedical use.</p>	<ul style="list-style-type: none"> ● Most individuals who take buprenorphine that is not prescribed are taking it for its intended purposes (withdrawal management, detoxification or relapse prevention.)¹⁰ ● Buprenorphine diversion is indicative of a lack of sufficient treatment access.¹¹
<p>Fraud and Abuse Easy access to physical therapy will result in overuse and fraud.</p>	<ul style="list-style-type: none"> ● Seeing a physical therapist before a physician for low back pain used fewer opioids, had fewer imaging studies and lower ED visits.¹² ● Use of a PT bundle for low back pain (single copay) lowered ED and primary care visits.¹³

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Overburdened Emergency Departments (EDs) Starting buprenorphine in the ED is burdensome and will result in a flood of patients.	<ul style="list-style-type: none"> Starting buprenorphine in the ED does require some level of system intervention. Buprenorphine in the ED results in greater retention in treatment.¹⁴ Use of buprenorphine in the ED results in a decrease in return-rate visit to the same ED by >50%.¹⁵ Experiences from EDs that actively recruit patients for buprenorphine starts shows no evidence of being overburdened.¹⁶
Futility Addiction is not a treatable disease.	<ul style="list-style-type: none"> Relapse is part of the illness. This leads to patient-provider misalignment. Data show that outcomes for addiction treatment are as good as the treatment for other chronic conditions such as diabetes and COPD.¹⁷

¹ Alexander Y. Walley et al., "Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution in Massachusetts: Interrupted Time Series Analysis," *BMJ* 346, no. 7894 (Jan. 31, 2013): f174, doi:1136/bmj.f174.

² Phillip O. Coffin and Sean D. Sullivan, "Cost-Effectiveness of Distributing Naloxone to Heroin Users for Lay Overdose Reversal," *Annals of Internal Medicine* 158, no. 1 (Jan. 1, 2013): 1–9, doi:10.7326/0003-4819-158-1-201301010-00003.

³ Chandler McClellan et al., "Opioid-Overdose Laws Association with Opioid Use and Overdose Mortality," *Addictive Behaviors* 86 (Nov. 2018): 90–95, doi:10.1016/j.addbeh.2018.03.014.

⁴ TIP 63: Medications for Opioid Use Disorder, Substance Abuse and Mental Health Services Administration, February 2018, <https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Documents-Including-Executive-Summary-and-Parts-1-5-/SMA18-5063FULLDOC>. (need to pull original references) <--NOT SURE WHAT THIS MEANS. -JV

⁵ Julia Elitzer and Margaret Tatar, *Why Health Plans Should Go to the "MAT" in the Fight Against Opioid Addiction*, September 26, 2017, www.chcf.org/publication/why-health-plans-should-go-to-the-mat-in-the-fight-against-opioid-addiction/.

⁶ Onur Baser et al., "Cost and Utilization Outcomes of Opioid-Dependence Treatments," *Amer. Journal of Managed Care* 17 (June 11, 2011): S235–48, www.ajmc.com/journals/supplement/2011/a369_june11/a369_11jun_alcohol_s235to48.

⁷ Maria Patrizia Carrieri et al., "Buprenorphine Use: The International Experience," *Clinical Infectious Diseases* 43, Suppl. 4 (Dec. 15, 2006): S197–215, doi:10.1086/508184.

⁸ Joseph Tkacz et al., "Relationship Between Buprenorphine Adherence and Health Service Utilization and Costs Among Opioid Dependent Patients," *Journal of Substance Abuse Treatment* 46, no. 4 (April 2014): 456–62, doi:10.1016/j.jsat.2013.10.014.

⁹ Elitzer and Tatar, *Why*.

¹⁰ Michelle R. Lofwall and Sharon L. Walsh, "A Review of Buprenorphine Diversion and Misuse: The Current Evidence Base and Experiences from Around the World," *Journal of Addiction Medicine* 8, no. 5 (Sep.–Oct. 2014): 315–26, doi:10.1097/ADM.0000000000000045.

¹¹ Lofwall and Walsh, "Review."

¹² Bianca K. Frogner et al., "Physical Therapy as the First Point of Care to Treat Low Back Pain: An Instrumental Variables Approach to Estimate Impact on Opioid Prescription, Health Care Utilization, and Costs," *Health Services Research* 53, no. 6 (Dec. 2018): 4629–46, doi:10.1111/1475-6773.12984.

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¹³ Daniel D Maeng, “Impact of a Value-Based Insurance Design for Physical Therapy to Treat Back Pain on Care Utilization and Cost,” *Journal of Pain Research* 10 (May 31, 2017): 1337–46, doi:10.2147/JPR.S135813.

¹⁴ Gail D’Onofrio et al., “Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized Clinical Trial,” *JAMA* 313, no. 16 (Apr. 28, 2015): 1636–44, doi:10.1001/jama.2015.3474.

¹⁵ M. L. Berg et al., “Evaluation of the Use of Buprenorphine for Opioid Withdrawal in an Emergency Department,” *Drug and Alcohol Dependence* 86 (Jan. 12, 2007): 239–44, doi:10.1016/j.drugalcdep.2006.06.014.

¹⁶ Based on Highland Hospital experience.

¹⁷ A. Thomas McLellan et al., “Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation,” *JAMA* 284, no. 13 (Oct. 4, 2000): 1689–95, doi:10.1001/jama.284.13.1689.