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Editor's Corner

AHRMNY's Risk Management Journal (RMJ) is the official journal of The Association for Healthcare Risk Management of New York, Inc. (AHRMNY) and is published several times a year.

RMJ's Mission Statement: To enhance the quality of healthcare delivery through education, research, professional practice, and analysis specific to risk management issues.

This journal contains articles on a wide variety of subjects related to risk management, patient safety, insurance, quality improvement, medicine, healthcare law, government regulation, as well as other relevant information of interest to risk managers. The articles are usually written by AHRMNY members, so the journal serves as an opportunity for members to showcase their writing talents.

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Article Requirements: Maximum article length 3,500 words. Photos should be high-resolution JPEGs (at least 300 dpi); AHRMNY will not publish articles promoting products or services.

The information presented in AHRMNY RISK MANAGEMENT JOURNAL is for educational purposes only.

Questions or comments to editors may be sent to ahrmny@gmail.com

In this Edition . . .

3 President's Message
4 A Healthcare Orientated Approach to the Human Trafficking Problem
6 Webinar Summary: Safeguarding Controlled Substances/Drug Diversion
7 Tales from the Trenches
9 Understanding The CMS Five-Star Ratings
11 Member Spotlight
12 Addressing the Opioid Crisis in New York
17 Education Videos on Demand
18 Legalization of Marijuana: Considerations for Staffing Companies
20 2019 Sponsors
21 Article References
21 Upcoming Educational Programs

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President's Message

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Dear AHRMNY Members:

On behalf of the Board of Directors, it is my privilege and honor to serve people who never cease to amaze and impress. At AHRMNY, we are humbled to work with the inspirational women and men who give their time, determination and soul ensuring that each and every patient in New York gets the best medical outcome possible. The professionalism of our members rouses AHRMNY to work as hard on behalf of the New York Risk Management Community. Anyone plugged into the national ASHRM community knows that our Risk Management colleagues throughout the nation hold New York's Risk Management professionals in the highest esteem, on par with the special status given to New York's other famous institutions, such as the FDNY, Wall Street, the best pizza and bagels around and World Series championship baseball!

And that nationwide respect is well deserved. I follow in big shoes, Tiffany Wickes-DeMillio, CPHRM turned over the keys to a very successful organization. Our party at ASHRM Nashville was the best on Nashville's famous Broadway strip. We had three extremely successful educational seminars, culminated with another sold-out summer conference at the Andaz in downtown NYC. Our membership swelled to over 300 and continues to grow, and no wonder with innovative initiatives such as seasonal socials for membership to meet and mingle.

Despite all of that success, we are only getting started. Once again, we had one of the best parties during the ASHRM Conference in Baltimore on Monday, October 14, 2019 at the Hard Rock Cafe featuring local seafood and the best dang Jazz Band in Baltimore. 225 members and colleagues attended and it turned out to be a great party and networking opportunity.

We are glad to offer a fall Educational Event at the DeMattis Center at St. Francis Hospital on November 11, 2019. This is a special conference, as it falls on Veteran's Day. We are inviting local Veteran's to join us for breakfast, and all speakers this year have proudly served in the USA military. SERVICE is a special word not lost on myself, a volunteer firefighter, and all of our members who work ridiculously long hours and give so much to serve our community and ensure the best medical outcomes to patients and their loved ones who are so invested in the health of their family and friends. **Registration is now open for this educational program. Click here to to sign up.**

That is not all, we are also offering CPHRM training to our members for a small $35 fee on January 7-8, 2020 at Mount Sinai's Union Square East location. This is a rare opportunity and can frankly only be offered due to the unprecedented financial health of our organization. This event will sell out, and members are encouraged to sign up now so they do not lose this chance to learn and become CPHRM certified.

Click here to reserve your seat

I really want to thank our sponsors, who mean so much to us. Their generosity and the participation of many of our sponsors' employees form the backbone of our success. They make our educational conferences, webinars, events and social activities possible. As a result, I want to personally thank our 2019 Platinum Sponsors: Kaufman Borgeest & Ryan, Lewis Johs Avallone Aviles and Vigorito, Barker, Patterson, Nichols & Porter.

You are encouraged to view our Platinum Sponsor's websites, by clicking on their logos below, and see what they offer beyond their generosity.

My enthusiasm for AHRMNY and for the wonderful women and men I serve knows no bounds. I promise you, every time you are working late, missing your child's soccer game or family movie night to serve New York's patients -- that AHRMNY and myself are right behind you anxious to help. So, please get involved, contact me about joining a committee (914-495-4846 or d.braverman@vbpnplaw.com), contact Linda Foy (linda.foy@chsli.org) to submit an article to our award-winning journal, contact Mike Brendel (michael.brendel@sedgwick.com) about speaking at a conference or putting on a Webinar, and contact Lesli Giglio (lesli.giglio@chsli.org) to become a sponsor!

Most of all, if you need anything, and we can help, we will... just reach out to any AHRMNY member and you will not regret it. I will check in again during the Holidays to see how we are doing so far!

Very truly yours,

Dylan C. Braverman
AHRMNY President

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Patients in the Shadows: A Healthcare-Oriented Approach to the Human Trafficking Problem

By Hon. Ruth Bogatyrow Kraft, Mamie Stathatos-Fulgieri, and Krista Schlueck

"This is the third time she's been here this month," I thought to myself as I looked out at the woman sitting in the examination room. She was scantily clothed in a short, leopard print skirt and black lace shirt, hardly enough clothing to shield her from the bitter December cold. Somehow, she seemed to have lost even more weight since her last emergency department visit. Her legs were visibly bruised and the bump above her eye seemed to grow larger and darker with every passing minute. She couldn't have fallen down the stairs again; no one was that clumsy. "Can you tell me what happened?" I asked. The woman looked up with me with sad and nervous eyes, replying in a quiet voice, "I fell." "Can you tell me more about this fall?" She shuddered and quickly replied, "No, he'd kill me if I said any more."

This sort of scenario is frequently the unfortunate reality for human trafficking victims both in the United States and worldwide. Traffickers use violence, threats, deception, debt bondage, and other manipulative tactics to force people to engage in commercial sex or to provide labor or services against their will. According to the International Labor Organization, an estimated 40.3 million people are victims of human trafficking globally. In 2016, there were 5.4 victims of modern slavery for every thousand people in the world. Approximately 81% are trapped in forced labor, 25% of them are children, and 75% are females.[1] Although it is estimated that 14,000 to 15,000 people are trafficked into the United States annually, it is likely that these statistics underreport the reality of trafficking which, by its nature, is illegal and hidden.

Human Trafficking Defined

According to the United Nations, human trafficking is, "[t]he recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion or abduction, of fraud, of deception, of the abuse of power or a position of vulnerability, or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation."[2] Approximately 25 million people are forced into labor trafficking, a subset of which includes sex trafficking. These individuals are forced to work by private individuals and groups or by state authorities.[3] In many cases, the products they make and the services they provide include food and clothing and end up in legitimate commercial channels.

Most victims of forced labor are coerced in some manner by their employers or recruiters in order to prevent them from severing themselves from the situation. Coercive tactics include withholding or threats of non-payment of wages, threats and acts of violence against the individuals and their family members, and physical or sexual violence. Many victims of human trafficking often make voluntary, initial contact with the trafficker based on false promises of jobs, stability, educational opportunities, and loving relationships. Others, however, are involuntarily entrapped through kidnapping and violence.

Who is at Risk?

Victims of human trafficking do not fall into a unitary category and can be of any gender, nationality, level of education, or financial status. However, the one characteristic that victims tend to share is vulnerability; risk factors known to increase the likelihood of becoming a victim of human trafficking include runaway youth status, homelessness, domestic violence, sexual assault, child abuse, war or conflict, social discrimination, substance abuse; and financial stress. Marginalized populations including migrants, refugees, LGBT youth, and foreign nationals are among the most vulnerable.

Recognizing Victims

Sexually or labor trafficked victims may exhibit similar indicators that would lead to their identification as victims of human trafficking. Labor trafficking victims tend to owe large debts that they cannot possibly pay off, are not in control of their own identification documents, have been recruited under false pretenses and are grossly underpaid, if at all. In addition to the foregoing, Sex trafficking victims may exhibit signs of involvement in controlling or dominating relationships, physical or sexual abuse, drug or alcohol abuse, and inappropriate dress.

Medical Professional Involvement

Despite many challenges, medical professionals are in unique positions to assist victims of human trafficking. Warning signs and symptoms of human trafficking include evidence of neglect, sexually transmitted diseases, addiction disorders, pregnancy, evidence of physical trauma, self-inflicted injuries, chronic medical and dental conditions, along with the presence of a controlling individual. These indicia can be recognized during health care examinations which position medical professionals to identify and potentially assist victims.

Each human trafficking case is unique. Therefore, implementing a universal policy or approach to address trafficking cases may not be successful unless it can be nuanced to individual circumstances. It is important to understand the leading challenges presented by these cases when attempting to design human trafficking policies for health care institutions.

One initial challenge facing health care facilities is patient disclosure. Typically, patients are reluctant to disclose their situations in a clinical setting and rarely do so willingly. Institutional personnel must be thoughtful in engaging with these patients and should employ trauma-informed practices. It is critical to create a safe, non-judgmental space that will facilitate the identification of trafficking indicators in order to assist the patient. Policies should allow the patient to decide whether he or she would be more comfortable speaking with a male or female staff member; any such encounter should be held in a private, secure setting. Additionally, professionals should ensure that the individual understands confidentiality policies and practices as well as the laws surrounding mandatory reporting.

Implementing effective screening procedures will allow patients to feel more comfortable when discussing their circumstances with health care professionals. Separating patients from accompanying individuals is a priority. Healthcare providers should refrain from direct questioning with respect to trafficking or violence should that person refuse to leave. Initial interview questions should be direct and open-ended in order to alleviate the patient's fear of answering. During the physical examination, it is imperative to assess for signs of trauma or assault, regardless of the presenting complaint.

A second challenge is how to facilitate patient connections to support agencies. A multitude of non-profit organizations and public institutions are available to assist victims of human trafficking but, first, an individual must recognize that help is available and that the chains of trafficking can be broken. Many victims may simply refuse or may be too fearful to seek help. Patients who have acknowledged their status should be provided with information including the telephone number of the national human trafficking hotline as well as local resources, including safe centers. If the patient is in immediate, life-threatening danger, law enforcement should be contacted; to the extent possible, the patient should collaborate in the decision to involve law enforcement. Safety plans should be created to provide the patient with options for services and reporting.[4]

Rendering appropriate treatment is another challenge facing health care institutions. Medical and psychological professionals must consider each patient's individual circumstances. Treatment should be tailored to the patient's age, clinical situation, immediate needs, and stated priorities. Patient care should include primary care, mental health care, and, as indicated, screenings for cancer, substance abuse, sexually transmitted diseases as well as immunization, reproductive care, and dental care. Treatment of potential, as well as confirmed, victims would be incomplete in the absence of safety planning and a discussion of risk.

Mandatory reporting laws pose an additional quandary for health care facilities. In the United States, mandatory reporting is required for cases of child abuse, domestic violence, and knife and gunshot wounds. Mandatory reporting brings victims and survivors to the attention of social services and law enforcement agencies. However, it may simultaneously discourage trafficked individuals from seeking help based on distrust of the authorities and heightened fear of consequences from traffickers.

When dealing with children, medical staff members must be properly trained with respect to state laws as well as institutional guidelines. The minor should be informed of the legal mandates for reporting. It is critical for professionals to understand that, while healthcare workers are mandated reporters, they are not mandated interveners. Under certain circumstances, immediate removal from the situation may not be the safest option for the patient based upon the threat of retaliation or other harm.

The critical challenge at this time is how to educate and train hospital personnel. Mitigation of the adverse effects of human trafficking requires increasing awareness among health care providers, as well as support personnel, on how to identify and assist victims presenting for medical, dental or psychological care. It is vital that practitioners become educated on how to identity, screen and assess victims in order to provide trauma informed care in coordination with law enforcement and social services providers. Institutions, particularly those in high risk areas, should create and implement human trafficking training modules for all personnel involved in patient care.

Notably, New York is a high-risk state for human trafficking, ranking as fifth in overall incidence of human trafficking within the country. Recently, the state legislature has attempted to curb human trafficking by designing laws to attack both the supply and demand aspects of the trade. With respect to sex

trafficking, prosecutors are now able to bring charges against patrons as well as providers of "prostitution tourism." The penalty for patronizing a prostitute has increased from three months to a full year of imprisonment. Additionally, if convicted, sex traffickers now face up to twenty-five years of imprisonment; labor traffickers can be incarcerated for up to seven years.

In addition to increasing criminal penalties, New York has also employed a victim-based approach to combat human trafficking. A person who has been confirmed as a victim of human trafficking is eligible for access to social services, including healthcare and mental health services. This support is necessary to facilitate mental and physical healing as well as to provide victims with the confidence needed to enable them to testify against the traffickers. Their testimony is vital to prosecutorial success; without the victims' cooperation, it can be virtually impossible to obtain convictions.[5]

Conclusion

The prevalence of human trafficking is immensely disturbing. Reduction in this statistic is a challenge facing humanity on a worldwide scale. Healthcare practitioners must be vigilant in identifying and assisting victims by acknowledging their fears and providing safe, non-judgmental environments in which they can share their stories. The ultimate objective of all healthcare-oriented approaches should be to respect the human rights and dignity of all victims of trafficking, while aspiring to remove them from their threatening environments. Although the challenge is great, the healthcare profession is in a unique position to take the initial step toward bringing the victims of human trafficking out of shadows and into self-determined lives.

References on page 21

About the authors





Hon. Ruth Bogatyrow Kraft, Mamie Stathatos-Fulgieri, Esq. are partners of Vigorito, Barker, Patterson, Nichols & Porter, LLP. Krista Schlueck, Esq. is an associate of the firm. Ruth is the chair of the firm's employment law practice and Mamie is the chair of the compliance practice. They have spoken on human trafficking at both the 2018 and, in more depth, the 2019 ASHRM annual meeting and lecture nationally on this compelling subject matter.

Webinar Summary

The Association for Healthcare Risk Management of New York (AHRMNY) hosted experts from the New York One & Only Campaign/New York State Department of Health (NYSDOH) in an informative webinar on healthcare provider drug diversion and substitution on January 24, 2019.

The dual presentation by a NYSDOH infection preventionist and an investigator for the NYSDOH Bureau of Narcotic Enforcement was entitled: "Safeguarding Controlled Substances/Infectious Risks of Drug Diversion". The webinar highlighted both the patient safety risks of healthcare provider drug diversion and substitution (where a provider steals medication intended for patients, tampers with the medication vial, then replaces the contaminated vial for subsequent patient use), and also outlined the legal and liability risks diversion poses to any healthcare facility.

Positive reactions came in participants' comments to a post-webinar survey where they were asked if anything they heard on the webinar would make them change their current practices or share the information with their organization. They included:

- "Yes, I did not realize how common diversion is. I was happy to hear about some of the signs to look for. It was very informative."
- Our hospital system has a drug diversion task force. I am going to bring the information I learned today to our task force!"
- There is so much important information here that we will use as we create more awareness, and move this initiative forward in our organization.

If you were not able to listen to the "live" webinar, a copy of the video recording is available to order

TALES FROM THE TRENCHES . . .



Allison Lamardo

This month we begin publishing successful initiatives of our members for the benefit of their colleagues in AHRMNY. In choosing, the Publication Committee will review submissions for organizational impact, execution, results, potential for replication and innovation and creativity. Please submit a summary of your initiative to ahrmny@gmail.com.

Improving Safety in a Community Hospital Using High Reliability Techniques

An initial review of our historic incident reports yielded an alarming result. There were several serious patient harms events, some including death, that could have been mitigated or avoided had there been a system in place to detect any deviations in generally accepted practice. This was our impetus to act. An organization-wide training was initiated focusing on error prevention and reporting. Managers also underwent "Just Culture" training to ensure that they had the tools available to create a supportive environment conducive to organizational learning. This was reinforced with weekly executive leadership rounds and department elected Safety Coaches. The vision of this project is to be a "Zero Harm" organization. In the interim, our focus is on increasing the engagement and psychological safety of our staff and as a result, creating better channels for communication for the transfer of knowledge from the front-line to leadership.

Actionable Take Aways

- The transfer of information from frontline staff to their manager is imperative to the advancement of a continuous learning organization. The work of our frontline staff is what ultimately determines customer value, therefore the only way to improve value is through engaged employees.
- Traditional performance improvement focuses on improving the steps in a process, and often forgets to take into account the individual's commitment. This commitment can only be embedded when there is a shared governance in the decision making.
- Culture cannot be "pushed" down to the front-lines. Universal enrollment starts with leadership. When staff see engaged leaders, they will pull the organization's mission into their work.

Situation/Challenge

The hospital with support from the healthcare system recognized the need for high reliability after an analysis of events revealed 34 preventable deaths and 116 serious safety events over a 3-year period. This meant every 8 days a patient in our healthcare system was harmed.



Strategy and Approach

In June of 2016, a multidisciplinary team consisting of leadership from medicine, nursing,

risk management and clinical operations was formed to assess the adverse events that were reported in our electronic risk management system over the past three years (2013-2016). The goal was to draft a plan to reduce the number of serious safety events by 80%, aligning with our systems larger strategic plan. The review proved to be invaluable, as it was realized that there was a gross underreporting of events. Furthermore, many of the events could have been prevented had the system been more resilient. It was decided that an increased focus on error prevention and error reporting was necessary. In September of 2016, leadership began taking classes on error prevention and in November, underwent private coaching with professional trainers so that they could deliver the message to our frontline staff in an effective and engaging manner. Training of frontline staff began in April of 2017 and in July, managers underwent another course titled "Just Culture". As employees were encouraged to report errors, we had to be sure that our managers were adept at handling these reports in a positive and constructive manner. In order for any of this to be successful, frontline staff needed to be able to trust their managers. In December of 2017, Safety Coaches were nominated by members of their department to serve as role models and as a resource for reinforcement of the safety principles. All of the Safety Coaches reconvene monthly and share what they're witnessing in the facility. Additionally, Leadership Rounds occur every Wednesday for approximately two hours, where Executive Leadership round on each unit and meet with the staff. This is an opportunity for front-line staff to transfer knowledge to the leadership team. In 2018 alone, this exchange removed nearly 100 barriers and scaled 14 projects from unit-based to hospital-wide.

Barriers Overcome

One of the first issues we encountered when creating the organizational training; was special accommodations for certain sub-groups undermined the notion of unity and our efforts to reduce power distance. When our organization rolled out the Error Prevention Training all staff members, except physicians, were required to receive the 4 hour training on-site. A special accommodation was made for our physicians; an online version of the class was created with test questions to be completed at a time convenient for them. Many staff members realized physicians were not present at the on-site training and some perceived that physicians were not receiving Error Prevention Training. Concerns were raised, especially by the nursing staff that they did not feel comfortable using the safety behaviors and language since physicians weren't trained accordingly. We used our Leadership Rounds to correct this perception and relay to staff that physicians have been trained to use these safety behaviors and language.

A second barrier the organization had to overcome was not capturing the full scope of safety events that occurred. Approximately a year into our high reliability journey, we recognized an opportunity for improvement to capture more safety events. The system had given us guidance material on events which narrowed our focus on the scope of safety events scored. In an effort to correct this and capture more events, we reviewed all incident reports for the last year. Any incident report that had GAPS were taken to our Safety Scoring Committee to score. Going forward we have ensured that we capture our incident reports in scoring.

Measurable Outcomes

- There was a 44.7% increase in the number of events reported (1000 to 1447). In addition, the frequency of "good catch" events increased from 1 per 20.2 days to 1 per 9.98 days (103% increase), indicating we are recognizing potential harm events before they reach our patients.
- The frequency of serious safety events decreased from 56% in 2017 to 20% in 2018.
- Year-on-year improvements were noticed in all twelve categories in the AHRQ Culture of Safety survey. In addition, all categories rose above the New York Partnership for Patients (NYSPFP) mean and 8 of 12 above the national mean. The improvements ranged from 5 percentage points (7.7%) to 13 percentage points (32.5%).

Innovative or Creative Aspects

As Peter Drucker said, "Culture eats strategy for breakfast." All too frequently in healthcare, we are

foolishly surprised when our incremental process change yields incremental outcome improvement. To become a high performing organization you need three components: a deep sharing of the mission and vision of the organization, a continuous realignment of processes to ensure that the mission and vision is achievable and the universal enrollment of every staff member. This program solidified across the organization it's vision for zero harm (deep sharing), created an avenue for the bi-directional passage of knowledge (continuous realignment) and is shifting us in the direction of shared governance (universal enrollment). We are currently undertaking a new initiative regarding strategies for Patient Experience and for the first time, our union President and a few delegates have requested to become trainers. This is very exciting for us as it bookmarks a chapter in the history of the organization that will be looked upon as pivotal in the years to come.

In addition, an analysis of staffing patterns revealed that there was not a significant change in staffing from 2017 to 2018, yet according to the AHRQ Culture of Safety Survey results staffing scores increased by 8 percentage points (17%). A major focus of high reliability training is supporting team members. This means looking out for each other in order to catch mistakes while also building a greater sense of accountability. It helps each individual perform at their best but also helps the team reach higher levels of performance.

About the Author

Allison Lamardo is the Quality and Risk Analyst at St. Joseph Hospital in Bethpage. As a certified Error Prevention Trainer, Allison plays an integral role in the organization's journey to high reliability and zero patient harm. In May of 2019, she earned her Master's Degree from George Washington University in Healthcare Quality. Allison is a member of AHRMY and ASHRM.

Star Crossed: Understanding The CMS Five-Star Ratings

By Mario C. Giannettino

The Centers for Medicare & Medicaid Services (CMS) publicly reports performance measures for both hospitals (Hospital Compare website) and skilled nursing facilities (Nursing Home Compare website). CMS's aspiration is to provide healthcare consumers – patients, caregivers and families - with resources to make informed health care decisions and promote provider transparency as to their performance. To that end, the Five-Star system provides a snapshot of facilities by grading certain areas and assigning a rating between 1 and 5 stars. Those with five stars are considered to have above-average care quality and those with 1 star are considered to have below-average care quality.

While the Five-Star rating system can be a valuable tool, it has been criticized for relying on methodology that is not particularly consumer friendly or digestible. The central problem is how to accurately measure "good care".

To address this dilemma, providers must understand how star ratings are generated by CMS. For hospitals, CMS gathers data points spanning 57 different performance areas, including but not limited to: mortality, patient safety, patient experience, effectiveness of care, timeliness of care and efficient use of medical imaging. This data is then analyzed using a statistical formula called latent variable modeling (LVM). In essence, LMV weighs three outcome groups—readmissions, safety and mortality at 22% each, which is higher than the other outcome groups. When the LMV model was first introduced many hospitals experienced significant changes in their Star-ratings because of the disproportionate weighting system. For example, specialty and community hospitals that treated healthier patients with less complex conditions received higher stars than rural hospitals. Lower volume surgical hospitals also saw decreased ratings compared to hospitals that performed a higher volume of surgeries. Equally problematic was the fact that if a hospital performed below average on any of the heavily weighted groups like safety and mortality, they had to perform above average in other groups to obtain the coveted four or five star status.

Concerns about the LMV model are not just theoretical. CMS data published in January 2019 showed that the most common rating was three stars with just over 27% of hospitals receiving that score. A nationwide survey of 4,500 hospitals conducted this year demonstrated that only 293 hospitals received a Five-Star rating. Most hospitals (1,264) scored three stars and over 1,000 scored one or two stars. In New York State alone a single hospital obtained five stars while forty-eight received one star. These ratings created uproar in the health care industry and advocates demanded that CMS rethink the scoring system. In response CMS had no choice but to admit to the flaws inherent in the Five Star system and requested public comment on how its methodology can be fixed for the next anticipated relaunch slated to take place in 2022.

Nursing Home Compare is equally problematic. In April 2019 CMS made several key changes that to the rating system. The most concerning is the modification to the staffing component. In the past, CMS previously demoted nursing homes to one star if they went seven or more days without a registered nurse on site. The new standard is that if a facility does not have a registered nurse on site for four days or more the facility will be automatically downgraded to one star.

This modification may not seem significant. However, as a result of the staffing component change, 36% of skilled nursing facilities saw an overnight decline in their overall Five-Star ratings. Thus, 36% of SNFs were suddenly deemed "understaffed despite" no evidence of a proportional decline in resident care or outcomes.

While no one should doubt the critical role that registered nurses play in delivering care, they are not the only caregivers interacting with residents. Yet CMS's methodology does not take into account therapists, who provide a host of valuable cares to residents; private duty nurses directly reimbursed by a resident or his/her family; hospice staff; or physicians performing primary care activities. Staffing levels, which were previously self-reported by facilities, are now determined by payroll based data submitted to CMS. This data, while auditable, only accounts for the hours each staff member is paid to deliver services. By way of example, if a salaried employee worked 10 hours a day but was only paid for 8 hours, only 8 hours would be reported.

Moreover, payroll based reporting is based on the employee's primary role and official title/designation. In the SNF setting, staff often wear many hats and perform non-primary duties throughout the day (e.g., helping out others when needed). Some staff may completely shift primary roles during the work day. For example, a nurse may spend the first half of her shift as a floor nurse and then the last half as a unit manager. However, facilities typically only report the total hours of the employee based on their primary role. So again, the question is whether Five-Star is accurately portraying what transpires at the facility level.

The reality of health care in the hospital and skilled nursing setting is that it is highly complex and nuanced. While the Five-Star rating provides a glimpse of a provider's operations, assessing the actual measure of efficacy at treating patients and residents should not rely around raw data that may not tell an accurate picture and often is not understood by the public. The foregoing is especially true as claims of improper staffing are traditional features of healthcare litigation. It is conceivable that a provider that is downgraded to one or two stars may find itself the target of a lawsuit simply because of a poor rating and not because of any actual proof of deficient care. Also, choosing a hospital (in the absence of an emergency situation) or skilled nursing facility is based on many considerations including the extent of which specialty care is provided and proximity of the facility to loved ones. Five-Star does not take the foregoing into account.

In closing, the danger of the Five-Star system is largely one of unanticipated consequences. By creating a public reporting system, the risk is that the public may make the incorrect assumption that the lower the number of stars, the worse the quality of care. To address this possible data flaw it is critical that the public understand that that Five Star is a metric, not an endorsement of any health care providers' practices. While Five-Star has value, one should proceed with caution when compartmentalizing overall quality into composite scores which at their heart overly simplify complex data into a rating that may not be truly representative of a provider's skill in delivering care.

About the Author



Mario Giannettino is a partner with Kaufman Borgeest & Ryan, LLP and specializes in the defense Medical Malpractice, Nursing Home and Long-Term Care and General Litigation matters from inception through trial. Mario regularly publishes and speaks nationally on matters relating to all aspects of health care defense.

MEMBER SPOTLIGHT

Join us in congratulating the following AHRMNY members for volunteering to share their achievements featured in this edition's MEMBER Spotlight

Eileen M. Clinton, CPCU, ALCM, CEA, AIC, REPA - Brown and Brown of Empire State



Eileen M. Clinton, Senior Vice President of Risk Management at Brown and Brown of Empire State, recently became a member of the McNeil Academy Advisory Board at the Madden School of Business, LeMoyne College. The McNeil Academy was formed to provide Insurance and Risk Management studies to students of LeMoyne. The Advisory board will guide the course curriculum in the areas of Risk Management and Insurance. Eileen is also currently an instructor with the National Alliance of Insurance and a past CPCU instructor.

Carol S. Doty, BSN, JD, Esq., CIPP/US, CPHRM - Kaufman Borgeest & Ryan, LLP



Carol Doty, is an attorney and partner at Kaufman Borgeest & Ryan LLP, in their Stamford, Connecticut office, with over 20 years of experience defending healthcare facilities and providers. Prior to becoming an attorney, Carol practiced as a Certified Critical Care Registered Nurse. Carol is proud to be an avid supporter of ASHRM, AHRMNY and Past-President of CSHRM and honored to have achieved the designation of Certified Professional in Healthcare Risk Management (CPHRM) in September, 2019.

Ruth Nayko, RN, MBA, CPHQ, CPHRM, CPPS, FASHRM - MCIC Vermont



Ruth assumed the role of Director of Patient Safety and Loss Prevention at MCIC Vermont in April, 2019. MCIC is A Risk Retention Group which provides medical professional and general liability insurance and risk management services to its academic health system subscribers. Ruth works primarily with the Johns Hopkins Health System in Baltimore.

Addressing the Opioid Crisis in New York through Prescription Monitoring, Provider and Patient Education, and Targeted Intervention at a Major Outpatient Academic Medical Center


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Abstract

Weill Cornell Medicine (WCM), a major academic medical center in New York City, formalized its strategy to reduce high-risk opioid prescribing behaviors among its providers. In recognition of the connection between opioid prescribing and opioid overdose deaths, the WCM division of Quality & Patient Safety launched an initiative to collect data on outpatient opioid prescribing. The division assessed changes in opioid prescribing patterns in response to potential influences, such as the launch of the NYS Prescription Drug Monitoring Program (I-Stop) and the WCM official opioid prescribing policy. Furthermore, the division created educational resources for providers and patients, including an Opioid Prescribing Toolkit, a Top 10 Tenets of Opioid Prescribing campaign, and a patient-focused Opioid Safety and Pain Management brochure. Over the next 6 months, the division will continue monitoring opioid prescribing patterns to measure the effectiveness of the interventions.

Introduction

The United States is facing a prescription opioid misuse and overdose epidemic. Between 1999 and 2016, opioid overdoses killed more than 350,000 people. In 2016 alone, more than 42,000 people died from opioids. Since 1999, the number of opioid overdose deaths has increased 5-fold. These opioid overdose deaths involve a prescription opioid 40% of the time[1]. The burden of opioid-related deaths is especially high among young adults, with opioid overdoses responsible for one in five deaths of individuals aged 24 to 35[2].

Increased opioid prescriptions parallel the surge in opioid abuse and overdose deaths. From 1999-2016, the amount of opioids prescribed by medical professionals increased 4-fold. In 2016, over 61 million patients filled at least one opioid prescription, amounting to over 214 million opioid prescriptions and 193 billion morphine milligram equivalents (MME) dispensed by pharmacies[3]. Of patients prescribed opioids for chronic pain, approximately 25% misuse them and 10% develop an opioid use disorder[4].

The opioid crisis has caused significant harm in New York State (NYS) and New York City (NYC), the location of Weill Cornell Medicine. The rate of all opioid overdose deaths per 100,000 NYS residents doubled between 2010 and 2015. In 2015, more than two-thousand NYS residents died from opioid overdoses, while over eight-thousand visited the emergency room and three-thousand were hospitalized[5]. In NYC, every 7 hours someone dies of a drug overdose[6]. More than eight in ten of these drug overdoses involved opioids, totaling 1,127 opioid overdose deaths in 2016 in NYC[7].

Weill Cornell Medicine (WCM) accounts for approximately 1.4 million patient visits per year in 125 locations throughout the five boroughs of New York City. Approximately 36% of patients are covered by Medicare and 32% are commercially insured, with only 10% of patients covered by Medicaid. The remainder of patients are self-pay. In recognition of the relationship between opioid prescribing and opioid overdose deaths, misuse, and use disorder, WCM launched an initiative led by the division of Quality & Patient Safety (QPS) to collect data on outpatient opioid

prescribing by medical departments and providers associated with the Weill Cornell Physician Organization, which is the faculty practice of the Weill Medical College of Cornell University. We assessed changes in opioid prescribing patterns in response to possible influences that occurred during the measurement period. These influences included launching the NYS Prescription Drug Monitoring Program (I-Stop), initiating mandatory electronic prescribing at WCM, creating the official WCM opioid prescribing policy, changing the selection for initial short-acting opioid prescriptions to 3 days, and mandating 3 hours of state-required opioid prescribing training.

Our objective is to describe the comprehensive assortment of opioid prescribing interventions we developed, explain the iterative nature of this quality improvement initiative, and report preliminatry results showing association with opioid prescribing patterns at our academic medical center. The interventions included developing educational resource tools for providers and patients to improve opioid safety and resetting electronic prescription software defaults to 'nudge' providers to choose lower doses and durations for short-acting opioids. We believe that describing our efforts to change physician behavior around opioid prescribing and sharing lessons learned will be instructive to other health care delivery systems seeking to reduce opioid prescribing risk.

Methods

In 2018, WCM decided to formalize its strategy for reducing high-risk opioid prescribing behaviors among its providers. Although state mandates (prescription drug monitoring program (I-Stop), e-prescribing and 3 hours of opioid education) had been adopted and followed, we believed that a more formal, comprehensive approach would have the greatest impact. In order to measure impact, the first step was to develop metrics.

Working with our colleagues in Physician Organization Information Systems (POIS), we developed automated reports to pull opioid-related data from the electronic medical record. These reports were then shared with selected practices (those identified as having a higher percentage of high risk prescribing behaviors). High-risk prescribing behaviors include prescribing >90 MME/day, co-prescribing a benzodiazepine, and prescribing opioids for 3 consecutive months. Concurrently, a comprehensive opioid prescribing policy was developed and implemented in July 2017. This policy included guidelines for checking I-Stop, urine toxicology screenings for patients on chronic opioid therapy (>30 days) and the signing of a contract at the onset of long term opioid therapy. In September of 2017, the NYS Department of Health sent letters to providers identified as practicing one or more of the aforementioned high-risk opioid prescribing behaviors.

In the summer of 2018, an audit performed by the Division of Quality and Patient Safety of the 5 patients in each department receiving the highest number of morphine milligram equivalents (MME) revealed several opportunities for improvement. In some cases, opioids were prescribed for non-clinically indicated conditions, such as fibromyalgia, low back pain and headache- for which clinical guidelines suggest that more effective non-opioid treatments exist. Chart reviews revealed several opportunities to improve opioid prescribing practices including: documentation of a signed opioid contract and appropriate urine drug screening for patients on chronic opioid therapy; concurrent prescribing of benzodiazepines; documentation of an I-Stop encounter number; and prescribing naloxone rescue kits for those at high risk of overdose. It became clear that the existence of a comprehensive opioid prescribing policy was only a first step to reducing high-risk opioid prescribing.

Development of the Toolkit and Resources

After initial conversations informing certain physicians of their opportunities to lower risk associated with opioid prescribing, many providers questioned how to reduce prescribing risk. In response, the QPS division developed a collection of resources for both physicians and patients. For physicians, we developed a comprehensive Opioid Prescribing Toolkit, a Top 10 Tenets of Opioid Prescribing campaign (**Figure 1**), and an Opioid Prescribing Best Practices Qualtrics quiz. The Qualtrics quiz, which is smartphone-accessible, was utilized to share teaching points with prescribers and allowed us to track prescriber engagement. For patients, we designed an Opioid Safety and Pain Management brochure (**Figure 2**). These resources sought to bring providers and patients together to reduce the risks of prescribing and using opioids.

The Opioid Prescribing Toolkit highlighted strategies for non-opioid pain management, low-risk opioid prescribing, and locally available addiction treatment. In particular, the toolkit offered suggestions on non-opioid medications and non-pharmacologic options for managing pain, best practices for discharge prescribing such as multi-modal analgesic regimens and abuse-deterrent formulations, pharmacy locations where patients could receive naloxone rescue kits or dispose of excess opioids, and medical practices offering medication assisted treatment and behavioral therapy. The Top 10 Tenets of Opioid Prescribing flyer distilled the toolkit into 10 essential recommendations, including setting realistic expectations on pain with patients, prescribing opioids as a last resort, ordering urine drug screens, and learning the indications for buprenorphine. To reinforce knowledge, the Qualtrics quiz

encouraged physicians to demonstrate understanding of the WCM Opioid Prescribing Policy and the options for implementation made available in the Opioid Prescribing Toolkit and Top 10 Tenets flyer. The patient-facing Opioid Safety and Pain Management brochure complemented the physician resources by sharing information about pain management and safe use of opioids, QR codes showing which pharmacies offered naloxone rescue kits without a prescription and drop-boxes for excess opioids, and local treatment options for opioid misuse and abuse.

To develop these resources, the QPS team interviewed, strategized, and collaborated with physicians, nurses, and administrators. We understood that changing prescribing behavior would require physician involvement throughout the development process. At the start, we identified WCM providers interested in lowering opioid-related risks for patients, in particular physicians from Addiction Psychiatry, Interventional Pain Management, Obstetrics, and Otolaryngology. We solicited their recommendations for risk-reduction best practices and featured their guidance in "Ask an Expert" sections in the Opioid Prescribing Toolkit. Many of these physicians initiated research projects on opioid prescribing, such as comparing pain levels and opioid prescribing after cesarean delivery (Obstetrics) and sinus surgery (Otolaryngology). When drafting the resources, physicians across multiple departments reviewed and edited the documents before their publication. Prior to distribution, we reviewed the resources with department chairs for feedback, participation, and buy-in to help implement our recommendations into clinical practice.

Electronic Prescribing 'Nudge'

In a concurrent project, we implemented a "nudge" intervention in the ambulatory electronic prescribing system. Starting in March 2018, new orders for short-acting opioids were auto-completed with the minimum dose and duration for new prescriptions recommended in the CDC Opioid Guideline (generally, 12 tablets/pills administered every 6 hours for a 3-day supply)[8]. This default dosage could be easily overridden by typing over the default or selecting a different choice.

Results

A subsequent review of the opioid data from the POIS reports in the Summer of 2018 revealed valuable insights to direct our intervention. From Q1 of 2017 to Q2 of 2018, the number of patients with opioid prescriptions received from providers in the Weill Cornell Physician Organization declined 18% (**Figure 3**). During the same time period, the number of opioid prescriptions written by clinicians in the Physician Organization decreased 19% (**Figure 4).** The total morphine milligram equivalents (MME) prescribed during the same time period fell 30% (**Figure 5**). When comparing MME prescribed by specialty, providers in the top 3 prescribing specialties accounted for 43% of total MME prescribed by clinicians in the Physician Organization.

Discussion

The opioid crisis continues to vex providers and patients at all levels of the healthcare system. As a major academic medical center in New York City, we believed we had a responsibility to try to impact high-risk opioid prescribing behaviors among our large network of providers. We launched an intensive and multipronged quality improvement intervention, which was iterative in nature with repeated checks of prescribing practices followed by novel strategies.

Initial interventions (electronic prescribing, development of policy and development of monthly reports) in conjunction with state-mandated initiatives (I-Stop, mandatory education, letters to high-risk prescribers) correlated with a downward trend in the high-risk prescribing behaviors across the Physician Organization as shown in Figures 3-5. Although encouraging, these initial findings still left room for improvement, particularly for providers and departments identified as outliers in prescribing behaviors. The development and rollout of the Opioid Prescribing Toolkit, The Top 10 Tenets of Opioid Prescribing flyer and the patient-focused brochure intended to augment ongoing efforts. Next steps will include one-on-one meetings with high prescribers to further support them in identifying and reducing their high-risk prescribing behavior. We will continue to monitor opioid prescribing data and report on prescribing trends every 6 months.

A few published studies have investigated opioid prescribing in response to certain interventions. Bohnert et al. measured opioid prescribing practices following release of the CDC *Guideline for Prescribing Opioids for Chronic Pain* in March 2016. The study found that the release of the guideline was associated with a decline in high-risk opioid prescribing practices[9]. Chiu et al. found that lowering the default number of pills presented when prescribing opioids in an EMR system correlated with a decrease in the median number of opioid pills prescribed[10]. A case study report by Ramar et al. describes institutional efforts at the Mayo Clinic to use administrative data sources to understand prescribing patterns by departments according to specific opioid and doses prescribed[11]. Similarly, a case report by Rishikesh P. Dalal, MD, MPH details an institutional process to identify high-risk prescription patterns undertaken by the NewYork-Presbyterian (NYP) Medical Groups. Though affiliated with

NewYork-Presbyterian Hospital, Weill Cornell Medicine providers in our study practice separately from NYP Medical Group providers. Dalal reports significant decreases in MME prescribed per patient and concomitant opioid and benzodiazepine prescriptions as a result of identifying and distributing clinical standards and developing a decision aid to identify high-risk prescriptions[12]. These findings in addition to our reporting suggest that reducing opioid prescribing risk requires a multipronged intervention approaching the challenge from many angles.

Our study conclusions are restricted by certain limitations. The results describe outpatient opioid prescription patterns from a single academic medical center. Physicians practicing in such a setting may be more receptive and inclined to prescribe medications according to evidence-based guidelines. The interventions launched to reduce prescribing risk were implemented in an iterative manner. Therefore, it is difficult to pinpoint the corresponding decrease in opioid prescribing associated with each intervention. Because we performed an observational, retrospective analysis, the study does not contain a comparator group, limiting results to descriptive trends rather than an exhaustive statistical analysis. Therefore, the impact of the intervention could be attributed to external confounding factors. For example, the nation's mounting awareness of the opioid crisis could have contributed to decreases in prescribing. As such, the declines in opioid prescribing must be viewed through the lens of decreasing opioid prescriptions nationwide.

Conclusion

The introduction of comprehensive opioid resources for providers has been well-received by the organization, with important feedback coming from some of the highest-prescribing departments. We will utilize this feedback to hone our metrics to make them more meaningful for providers. We have shared these resources with our hospital affiliate and will continue to collaborate with both hospital and community-based leaders in order to maintain and sustain the progress we have made to this point and ensure that patients remain the focus of our efforts.

The Author(s) declare(s) that there is no conflict of interest.

References on page 21

Figure 1: Top 10 Tenets of Opioid Prescribing at Weill Cornell Medicine



Figure 2: Opioid Safety and Pain Management for Patients



Figure 3: Number of Patients w/Opioid Prescriptions by Quarter

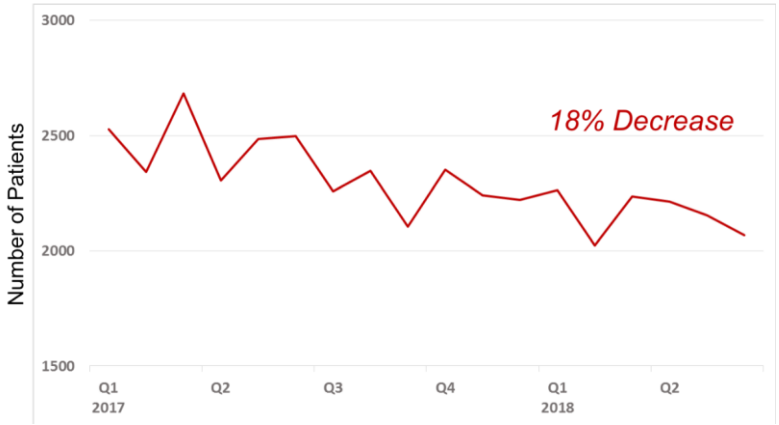


Figure 4: Number of Opioid Prescriptions by Quarter

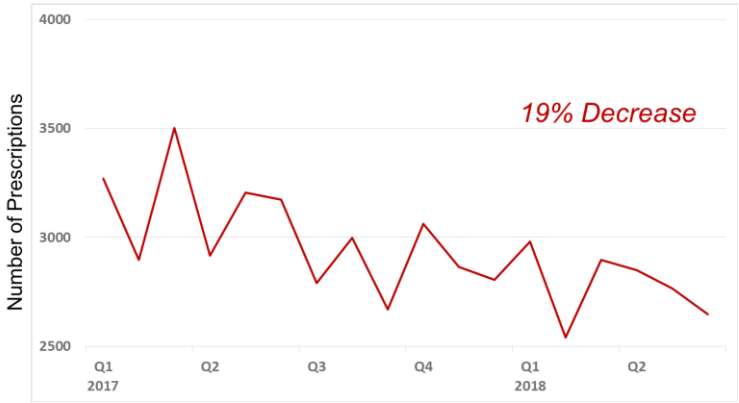


Figure 5: Total Morphine Milligram Equivalents by Quarter



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Legalization of Marijuana: Considerations for Staffing Companies

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The legalization of marijuana, whether for medical or recreational uses, is causing anxiety among many U.S. businesses. Staffing companies have the added complications of hiring employees for their own firm and then placing them with another – straddling the sometimes conflicting needs of employees and client companies. If there are wide disparities between your firm's drug policy and those of your client companies, you could open yourself up to risks in several areas.

Keeping up with marijuana laws is difficult, particularly if you're placing employees in multiple jurisdictions. Therefore, you should seek the advice of a qualified legal advisor when reviewing your drug policy to ensure it doesn't violate labor laws or make you vulnerable to civil litigation. Still, a basic understanding of how the laws are changing, what those changes mean to employers' drug policies, and how you can strengthen your own practices in response to the new laws will help you in hiring, placing and retaining employees while keeping the bonds of your client relationships strong.

Regardless of how the laws change, it's clear that employers in every sector will need to broaden their understanding of how marijuana is used medically, and when it does and doesn't impair judgement or physical activity. Yet, as with alcohol, we all know that legalization doesn't mean anyone should be under the influence at work. Your organization should have a clearly defined, communicated and enforced drug policy created and maintained with the help of a qualified legal advisor.

Legalization Trends at the Federal and State Levels

At the federal level, marijuana is still under Schedule I drugs in the Controlled Substances Act, meaning the federal government views marijuana as having "no currently accepted medical use and a high potential for abuse."[1] However, the federal government's stance could soften as public opinion becomes more supportive of medical marijuana. One major concern with reclassification is the impact full legalization of medical marijuana would have on drug-free workplaces. Once it is accepted as having medicinal value, it would be treated like other prescription medications and employers in all states would be forced to move from zero tolerance to allowing it unless it causes impairment (such as with alcohol). Without a legally defined level for impairment and an easy test for measurement, a law change of this nature would prove challenging in the workplace.

While it would be difficult to stay on top of the legal status of marijuana in every state, you should know the laws of your



own jurisdiction and those where you have a client base. The majority of states have laws legalizing marijuana in some form, while only a handful allow its sale for recreational use.[2] But even though most states allow for limited use of medical marijuana under certain circumstances, some laws are broader than others.

Some allow only for cannabis-infused products, such as oil or pills. Others allow it only for certain rare illnesses.[3]

How legalization affects workplace drug policies

Most states with laws legalizing some aspect of marijuana use allow employers to regulate the use of marijuana at their facilities even though its use may be legal in the employer's jurisdiction. In some states where marijuana is legal for recreational use, the courts have ruled in favor of employers following the federal law and prohibiting its use for any purpose.[4] Others, such as Massachusetts and Rhode Island, have said employers need to follow an interactive process to accommodate those who need to use medical marijuana.[5]

Companies may have greater latitude in setting zero tolerance policies in safety-sensitive positions.[6]

Examples of safety-sensitive positions include those with job duties that involve:

- Driving motorized vehicles, including highway and off-road (i.e., industrial forklifts and construction equipment)
- Working with heavy machinery
- Exposure to machinery where there is risks of entanglement or entrapment hazards

- Working at heights
- Working with hazardous chemicals/materials or hazardous processes.

Job descriptions should clearly define these types of characteristics. Many office jobs may be difficult to classify as safety-sensitive unless driving a vehicle for business is required. If you're placing employees in companies with federal government contracts, they will almost certainly have zero tolerance for marijuana use. Jobs in the healthcare sector are also almost certain to take a hardline stance in order to protect patients.

Reviewing your Workplace Drug Policy in Light of Changing Marijuana Laws

In addition to reviewing your own workplace drug policy, you should review those of your client companies. Even if you have a zero tolerance policy that is strictly enforced, a more lax policy at the client company could put your employee at risk or lead to other types of exposure. Drug policies fall under the categories of "zero tolerance" or "impaired."

A quick comparison shows some key differences:

Zero Tolerance	Impaired
More testing options (blood, urine, hair, saliva)	Testing options limited to blood test due to inaccuracy of other tests
Greater protection for the employer since there is no "gray area"	THC levels open to interpretation in terms of what is considered "impaired"
Easier to administer and enforce	Supervisors and employees must be trained for signs and symptoms of impairment

Whether your business' policy or a client company's policy is zero tolerance or impaired, the written drug policy should consider the following:

- A statement that drugs and alcohol testing is required and that you conduct this testing
- A statement of when this testing will occur (see below)
- A signed statement from the employee that he or she understands the policy
- All workplace drug policies should specify when testing can be conducted. Commonly they would take place:
  - Pre-employment (any attempt by the applicant to put this off for several days should be a "red flag")
  - Randomly, as long as they are done fairly and equitably
  - In the event of "reasonable suspicion" of impairment
  - After an incident that involves property damage or injury

Hot Issues to Watch in Marijuana Laws

As you monitor what's going on in your state and around the country with regards to marijuana laws, here are some issues to keep an eye on:

- Where the federal government goes in terms of taking marijuana off the Controlled Substances Act list
- Whether the Supreme Courts in your state are ruling in favor of employers who choose to comply with the federal law versus the state law (as in a recent Colorado case)[7]
- More advanced testing for marijuana becoming available, as well as a clearer definition of what is "impaired"
- Cases where unemployment compensation is disputed when an employee is fired for marijuana use in a state where it's legal
- Employees using the American's with Disabilities Act as an avenue to force employers to accommodate medical marijuana use

References on page 21

The information in this publication was compiled from sources believed to be reliable for informational purposes only. All sample policies and procedures herein should serve as a guideline, which you can use to create your own policies and procedures. We trust that you will customize these samples to reflect your own operations and believe that these samples may serve as a helpful platform for this endeavor. Any and all information contained herein is not intended to constitute advice (particularly not legal advice). Accordingly, persons requiring advice should consult independent advisors when developing programs and policies. We do not guarantee the accuracy of this information or any results and further assume no liability in connection with this publication and sample policies and procedures, including any information, methods or safety suggestions contained herein. We undertake no obligation to publicly update or revise any of this information, whether to reflect new information, future developments, events or circumstances or otherwise. Moreover, Zurich reminds you that this cannot be assumed to contain every acceptable safety and compliance procedure or that additional procedures might not be appropriate under the circumstances. The subject matter of this publication is not tied to any specific insurance product nor will adopting these policies and procedures ensure coverage under any insurance policy. Risk engineering services are provided by The Zurich Services Corporation.

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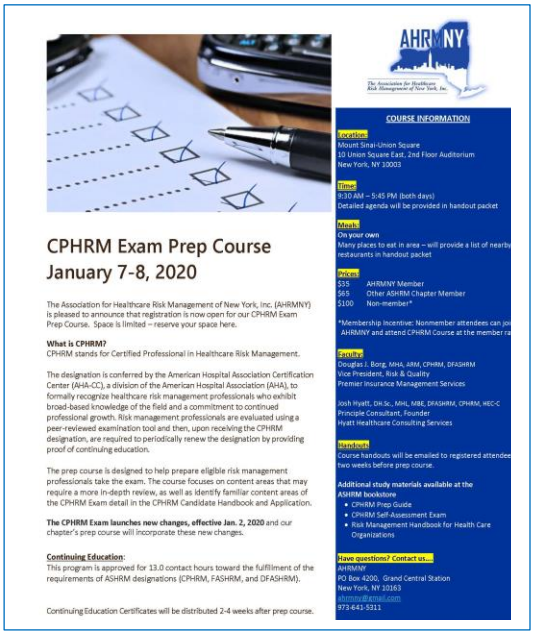
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