New York State NURSES ASSOCIATION One strong, united voice for nurses and patients

Continuing Nursing Education Take Home Packet

The New York State Nurses Association (NYSNA) is accredited by the International Association for Continuing Education and Training (IACET) and is authorized to issue the IACET CEU.

The New York State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's (ANCC) Commission on Accreditation.

By completing the courses in this packet, participants will be eligible to receive up to 5.5 CH/.5 CEUs. Each module includes a complete list of goals and objectives and notifies the participant of the number of ANCC contact hours and IACET CEUs that will be conferred upon completion of the program.

In order to receive contact hours **for each module**, participants must read the course material, complete and return the post-test answer sheet with a score of 80% or better, and submit the completed evaluation for the course. The completed post-test answer sheet and evaluation must be returned to NYSNA no later than the date listed in the module.

NYSNA wishes to disclose that no commercial support or sponsorship was received. NYSNA Program Planners and Presenters declare that they have no conflict of interest. Declaration of Vested Interests: None.

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Nurses medical missions to Puerto Rico and US Virgin Islands: What nurses need to know and do next.

NYSNA Continuing Education

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This course has been awarded 1.0 contact hours and 0.1 CEU and is intended for RN's and other healthcare providers. In order to receive contact hours/CEU participants must read the course material, complete and return the post-test answer sheet with a score of 80% or better, and submit the completed evaluation for this course. Contact hours/CEUs will be awarded for this take-home course until March 25, 2021.

All American Nurses Credentialing Center (ANCC) accredited organizations' contact hours are recognized by all other ANCC accredited organizations. Most states with mandatory continuing education requirements recognize the ANCC accreditation/approval system. Questions about the acceptance of ANCC contact hours to meet mandatory regulations should be directed to the professional licensing board within that state.

NYSNA wishes to disclose that no commercial support was received.

NYSNA's program planners and presenters disclose no conflict of interest.

Introduction

The US territories of Puerto Rico and the US Virgin Islands have experienced unprecedented and wide spread damage from Hurricanes Irma and Maria unlike any other natural or man-made disasters that have occurred in the US. First missions to these territories have revealed that the residents living there are experiencing collective, territory-wide hardships and those experiencing the hardships are predominately racial/ethnic minorities who are already experiencing high levels of poverty and health care needs. This program is intended for nurses and other health care professionals who want to learn post-disaster risks, health care needs, and how to best promote resilience among individuals, families, and communities in these territories.

Course Objectives:

At the conclusion of this program, the learner will be able to:

- Recognize health care needs and psychosocial stressors in Puerto Rico and the US Virgin Islands post hurricane;
- Describe examples of coping strategies that nurses can use while working with patients that can promote resilience in those patients;
- Explore possibilities of what nurses can do next in the recovery of theses Territories.

About the Author

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Carol Lynn Esposito, EdD, JD, MS, RN-BC, NPD, is the Director, Nursing Education and Practice for the New York State Nurses Association (NYSNA) and an attorney with over 15 years' experience in organizing and educating unionized nurses on how to develop leadership skills, build power in their workplaces, and make real improvements in their living and working conditions.

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Dr. Esposito and NYSNA's nursing and practice education team design, develop, implement and evaluate the association's nursing practice and occupational health and safety law continuing education programs. Dr. Esposito has been adjunct faculty at Adelphi University, Hofstra University, and Excelsior College where she has taught courses on Contemporary Legal Issues in Healthcare, Collective Bargaining, Health Care Management, Ethics, Policy and Politics in Nursing, Communications in Nursing, and Violence in the Healthcare Setting. She has also taught courses in Introduction to Law, Civil Litigation, Risk Management, Medical Malpractice, and Birth Injuries. An attorney with over 25 years' experience in the trial of medical and nursing malpractice cases, Dr. Esposito has worked for several medical malpractice and personal injury firms, and for the United States Attorney's Office in their civil litigation department.

Dr. Esposito has been an honorarium and keynote speaker for various schools of nursing and professional organizations. She has authored articles on Informed Consent, Malpractice Insurance, Transcultural Nursing, Patient Satisfaction, Medical Missions, and Nursing Ethics and has developed course and text materials for the New York State Nurses Association, Adelphi University, Hofstra University, Excelsior College, and the National Center of Professional Development.

The author declares she has no vested interest or conflict of interest in this program. No commercial support was received for this program.

PUBLIC HEALTH IN PUERTO RICO AND THE US VIRGIN ISLANDS

At the heart of all successful public health initiatives are the workers and health care practitioners who promote and protect the public's health and safety. In addition to addressing everyday public health needs, the public health work forces face a number of emerging and complex health issues such as the increase in obesity and long-term chronic conditions, managing vaccine supplies, disparities in health outcomes, and emergency preparedness. Compounding these issues, practitioners also face workforce challenges, including large numbers of employees who are retiring, shortages of key professionals, and the need for ongoing training and education to ensure that professionals can effectively address all of the emerging public health issues.

For all types of public health hazards, nurses play a major role in responding to disasters, managing their victims, and ensuring the best possible outcomes. However, despite the attention in the literature to emergency preparedness over the past six years, most schools of nursing don't adequately cover this topic, if at all. Few address even such basics as disaster triage, decontamination, and proper personal protective equipment. Before competency in disaster response, nurses need to be versed with the knowledge and skills to manage disaster events and to participate safely.

ASSESSING LARGE POPULATIONS POST DISASTER

Large population of patients affected by a natural or man-made disaster may be assessed and then categorized according to three major categories, according to their risk status.

- The **high risk group**, which generally represents 5% of the total population, has at least one complex illness and multiple comorbidities and psychosocial problems. These are the patients who end up needing hospitalization.
    - High risk patients should have a one-on-one care manager who is familiar with the management of the condition. The focus of care is to provide the patient with a comprehensive, proactive care to prevent acute exacerbation and re-hospitalization.
- The **rising risk group**, which generally comprises 20% of the population has multiple risk factors that could easily push them into the high risk group.
    - The rising risk patients are best managed in an enhanced primary care setting where they can be cared for by a team of providers. Who they see on their visits would depend upon the need to be addressed at that time. Patients need to be engaged in their care. They should be taught how to manage their chronic illness to prevent complications that would place them into the high risk category.
- The **low risk group** is the generally the majority of the population. They tend to be younger, more health conscious, generally healthy or if they have a chronic condition it is well managed and controlled.
    - Low risk patients are best managed in a primary care setting or enhanced primary care setting. The aim of their care is to keep them healthy through health maintenance and prompt treatment of medical problems.

COMMUNITY HEALTH WORKERS

Community health workers (CHW) are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status and life experiences

with the community members they serve. They have been identified by many titles such as community health advisors, lay health advocates, "promotores(as)", outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening. Some examples of these practitioners are Community Health Aides or Practitioners established under 25 USC 1616 (l) under HHS, Indian Health Service, Public Health Service.

Community Health Workers are active in all three risk groups noted above and help ensure equity in health at grassroots levels and contribute to efforts to ensure health care for all, particularly the poor, underserved and underprivileged. The CHW is responsible for helping patients and their families to navigate and access community services, other resources, and adopt healthy behaviors. As a priority, activities will promote, maintain, and improve the health of patients and their family. CHWs apply their unique understanding of the experience, language, and/or culture of the populations they serve in order to carry out one or more of the following:

- Provide culturally appropriate health education, information and outreach in community-based settings, such as homes, clinics, schools, shelters, local businesses, and community centers;
- Bridge and mediate between individuals, communities and health and human services, including actively building individual and community capacity;
- Assure that people access the coverage and services they need;
- Provide direct services, such as informal counseling, social support, care coordination and health screenings;
- Advocate for individual and community needs.

Role of the Community Health Worker

Delivering immediate response

To save lives in emergencies, time is of the essence. Community health workers are more often than not the closest to hand when people are in need of first aid, triage and other essential health care, assisting in search and rescue operations and providing emergency relief items.

Assessing, monitoring risks

As key members of the community, grassroots health workers are generally well placed to assess risks to their own towns and villages. They can identify vulnerable groups, such as children, women and the elderly, detect trends in disease patterns and provide early warning for rapid response to emergencies.

Mobilizing communities to respond

Mobilizing grassroots health action by people is a basic function of community health workers and professionals. This way, they empower people and different sectors to protect public health by detecting disease outbreaks, preventing malnutrition, promoting healthy behavior and avoiding hazards.

Treating common illnesses

Treating people with common illnesses is one role of community health workers.

Pneumonia, for example, is a leading killer of children worldwide, including in humanitarian settings where people are displaced that community health workers in many vulnerable countries treat, including in people's homes.

Promoting good health

Health workers and professionals operating in communities help identify priority health concerns and promote good primary health practices. These include early home visits for newborns which help communities improve child survival, growth and development in emergency settings.

Risk reduction, emergency preparedness

Training local health workers and professionals to be able to identify hazards to communities, help make towns and villages less vulnerable and increase the capacity of people to respond to emergencies is a powerful way to protect public health.

Recovering from disasters

The work of community health workers and professionals in acute crises helps devastated health systems recover and be more resilient in the future. The skills and knowledge of such workers provides the base on which local health services have built back better in many countries.

STATUS OF PUERTO RICO BEFORE THE HURRICANE

The Commonwealth of Puerto Rico is a U.S. territory located in the Caribbean, with a population of approximately 3.41 million residents as of July 2016. Puerto Ricans are U.S. citizens by birth. Prior to Hurricane Maria, Puerto Rico faced a number of economic and public health challenges. The island was already in the midst of a debt crisis, following years of economic recession, and in May of this year filed for bankruptcy relief. Close to half of Puerto Rico's residents lived at or below the federal poverty level in 2016 (43.5%), compared to just 12.7% in the U.S. overall. The median household income in Puerto Rico over 2011-2015 was $19,350, almost one-third the median household income in the US overall ($53,889). The unemployment rate was estimated at 10.1%, a figure more than two times higher than that for US overall (4.1%).

The health care system also faced challenges. Puerto Ricans were much less likely to have employer sponsored health insurance compared to rest of the U.S. (35% compared to 60%) and more likely to rely on Medicaid (49% compared to 20%), though a smaller proportion were uninsured (6% compared to 9%). Unlike the 50 US states and Washington, DC, Medicaid spending in Puerto Rico has been subject to a statutory cap, which means that under normal circumstances once federal funds are exhausted, the island no longer receives financial support for its Medicaid program for that fiscal year. Many residents of Puerto Rico access primary health care services through community health centers (CHCs), which rely heavily on federal Medicaid funding; there were 93 CHCs in Puerto Rico before the storm serving over 350,000 residents on the island, primarily in rural areas.

In one indicator of basic health care access, the Health Resources and Services Administration (HRSA) estimated that at the end of 2016, there were just over 19,000 people living in primary "healthcare provider shortage areas" (HPSAs) with just 32% of the need for physicians in these areas being met. Basic health statistics in Puerto Rico also indicate that the island faced significant health concerns even before the storm. Puerto Ricans were much more

likely to report having fair or poor general health compared to the U.S. overall (34% compared to 18%). The percentage of people living with a disability (estimated for 2011-2015) was 15.4% compared to 8.6% in the U.S. overall. Puerto Rico had a higher percentage of low-birthweight infants and a higher infant mortality rate compared to the US overall. The prevalence of diabetes was 50% higher in Puerto Rico compared to the rest of the U.S., including a death rate due to diabetes that was more than three times higher. The HIV death rate in Puerto Rico was nearly four times higher than that of the U.S. overall, and second highest of any state, territory, or federal district in the country (after Washington D.C.) in 2014. The number of people living with HIV in Puerto Rico in 2014 was estimated at 17,072, which represented one of the highest rates of people living with HIV per 100,000 in the U.S. Puerto Rico has also seen outbreaks of mosquito-borne viral diseases over the last several years, including dengue, chikungunya, and Zika.

Zika was first detected on the island in December 2015, and since that time Puerto Rico has reported the vast majority (84%) of all U.S. Zika cases. In 2016, the island experienced almost 35,000 symptomatic cases of Zika infection, compared with 6,218 cases in the rest of the U.S. and territories. So far in 2017 there have been far fewer Zika cases in Puerto Rico; 476 infections were reported through October (433 cases were reported in the rest of the U.S./territories). Some public health experts believe the decline in cases stems from the fact that a large proportion of the population was infected earlier and is now immune, creating a level of “herd immunity.” Still, the potential for further Zika outbreaks does exist. Other endemic infectious diseases of concern in Puerto Rico include leptospirosis, a serious, sometimes fatal bacterial infection usually transmitted via exposure to contaminated surface water.

POST-HURRICANE PUBLIC HEALTH STATUS IN PUERTO RICO

Hurricane Maria has significantly damaged key transportation, communication, and electricity infrastructures across the island which in turn have exacerbated already challenged health conditions. Immediately after the hurricane, there was virtually no electricity, available water, or transportation access on the island. On October 12, three weeks after the hurricane struck, only 392 miles of Puerto Rico's 5,073 miles of roads were open according to the Federal Emergency Management Agency; it is unclear how many of the islands’ roads remain impassible now. Damage to cell towers and antennae, still being repaired, has left a reported 28% of people without telecommunication access as of November 8. While access to electricity has been increasing, it stood at 43% on November 16 (by comparison, the percent of population with access to electricity at the global level is over 80%; the country with the lowest access in the world, Papua New Guinea, has 40%); the remainder rely on generators or go without power. The ongoing power outage on the island has been named the “largest blackout in American history”. On November 9 and again on November 14, major power outages following power line failures and technical issues at the main power plant left 80% of the island without power, underscoring systemic weaknesses in the power grid. The goal of the Puerto Rico government is to be able to restore power to 50 percent of the population by the end of November, and power to all by spring or summer 2018. With these broader issues in mind, major public health concerns on Puerto Rico post-hurricane include the following:

Mortality

The official death toll on Puerto Rico from Hurricane Maria, as of November 4, stood at 55, primarily from more immediate impacts, but this is widely understood to be an underestimate. Officials have stated that there were 472 additional deaths in

September 2017 compared to September 2016, though the cause of many of these excess deaths or their potential link to the hurricane has not been certified. Barriers to an accurate and updated accounting of deaths include insufficient resources and challenges in transportation, communication, and organization in confirming and certifying causes of death. The official count of the number of deaths caused by the Hurricane is likely to increase over time as more deaths and their causes are counted and confirmed and longer term health complications set in.

Food, Water and Sanitation

Many island residents have had difficulties accessing groceries and fresh food, relying on meals provided by FEMA, the Red Cross, World Central Kitchen, and other entities. According to Puerto Rico officials, emergency responders are still providing 1 million meals per day on the island as of the first week of November. Lack of access to adequate food results in malnutrition, which can cause and exacerbate other health issues.

Right after the storm, access to water was minimal, with water treatment and pumping stations knocked out by the storm. Even by October 1, almost two weeks later, it was still at less than 50%. Since that time, access has increased slowly. As of November 16, Puerto Rico's water authority reports that 91% of the population had access to water, leaving about 9% (about 300,000 people) still without access.

While the percentage with access in Puerto Rico has been improving over time, it is still variable across the territory. San Juan metro region has the highest percentage with access to potable water (97%), while the West region has the lowest (86%). While the water authority reports the water is safe to drink, the Puerto Rico health department is still recommending residents boil or otherwise disinfect all water before drinking or cooking.

Some of those without access to safe water have been using natural fresh water sources such as ponds, lakes, and streams. Ingesting or other exposure to untreated fresh surface water is potentially dangerous due to possible contamination with disease-causing microbes.

While no official case numbers are available, there are many reports in the media, from health care providers on the island, and from government officials that there has been an increase in conditions related to unclean water, ranging from vomiting and diarrhea to conjunctivitis (pink eye), scabies and asthma. In addition, by the end of October Puerto Rico had already reported 121 cases and 4 confirmed deaths from leptospirosis since the hurricane (compared to about 60 cases in total in a regular year). One difficulty in diagnosing infectious diseases is that public health laboratory testing on the island has been interrupted due to damage from the storm.

Another concern is the leaching of raw sewage or other contamination into drinking water sources. A reported 20 of the island's 51 sewage treatment plants were out of service as of October 17, due mainly to lack of power. As a result, sewage has been identified as contaminating sources people are using for drinking water. In addition, the water authority briefly distributed water taken from a well at an EPA-designated groundwater contamination ("Superfund") site, but this is no longer the case. Authorities

have barred residents from accessing water at other groundwater wells with potentially dangerous levels of chemical or other contamination.

Health Care Infrastructure

Hospitals and other health care infrastructure suffered extensive damage from the storm, and most hospitals were left without electricity and with limited access to generators with fuel. Only three major hospitals were functioning on the island three days after the hurricane, but repair has progressed since then. At this point, while all hospitals tracked by the Puerto Rico government are open and functioning, 26 of the 65 hospitals (40%) with available information were still running on generators rather than regular electric power as of November 8. This means power may be available on an intermittent or limited basis (especially when generators fail or run out of fuel), which can result in the need to rely on alternative light sources such as flashlights when conducting surgery or providing other medical care. Community Health Centers (CHCs) have also been affected by the storm, with 10 of the 93 (11%) CHC sites reported closed as of October 20 (four weeks after the hurricane); it is unclear how many remain closed currently.

Given the high burden of diabetes on Puerto Rico, dialysis centers are an important part of the health care system. Almost all of the island's 47 dialysis centers lost power after the Hurricane, though most of these centers have now re-opened. Still, many dialysis centers do not have regular electrical power and must rely on generators. Generator power has failed at some dialysis centers, and patients have been transported to other areas (including some to the continental U.S.) for treatment.

In another indicator of the challenges faced by Puerto Ricans in accessing health care on the island, the latest estimates from HRSA indicate that 1,689,212 people – almost half of the population –lived in HPSAs as of November 7, with less than 2% of the need for physicians being met.

As a result, across Puerto Rico, community-based groups have transformed into de facto relief brigades, setting aside their missions to meet the most immediate needs of their communities, whether it's food, water, shelter, medicine, disinfectants or other life-and-death necessities.

Proyecto Enlace Del Caño Martin Peña is an alliance of community groups comprising eight neighborhoods along the channel. The group focuses on environmental restoration, anti-gentrification and poverty reduction. But these days they're patrolling the streets and helping wherever they're needed.

Whether it's because of poor planning by central authorities, the obliteration of telecommunication infrastructure at a time when it's most needed, or a bogged down response by government entities, community groups in Puerto Rico are turning to each other and coordinating help for communities in need.

Other Infectious Diseases

As mentioned above, Puerto Rico faces a number of endemic mosquito-borne diseases such as Zika, dengue, and chikungunya. Although it is common for mosquito populations to increase in the weeks after major rain events, raising the potential risk for mosquito-borne disease outbreaks, at this time there is no evidence that the island is experiencing any large-scale outbreaks of these diseases.

Likewise, Puerto Rico faced a significant public health challenge from HIV prior to the hurricane, so there is increased concern about people living with HIV, and their access to medicines and other support services. While HIV program authorities on the island continue to face intermittent communication and power challenges, thus far no major interruptions in services have been reported or are evident and all Ryan White HIV/AIDS Program funded clinics are open.

Mental Health

Media reports, statements from public health officials, and NY RNs who have participated in medical missions on the island indicate that many Puerto Ricans are struggling with mental health issues in the wake of the hurricane. Thirty-two suicides have been reported and demand for mental health services has increased sharply in the nearly two months since the storm struck. Anxiety, PTSD, and depression are frequently reported, even by those who never experienced these issues before.

An ongoing concern is lack of access to drug treatment and mental health services for those who need them. Mental health concerns may even increase over the coming months and years as people move beyond the immediate crisis and attempt to return to a normal life. Studies of those affected by Hurricane Katrina, for example, found that rates of mental illness remained elevated for more than a year after that disaster.

STATUS OF THE US VIRGIN ISLANDS BEFORE THE HURRICANE

In the USVI, 507 public health workers are employed by the U.S. Virgin Islands Department of Health (USVI-DOH), including those assigned to the local health agencies. According to its website, the USVI-DOH includes 3 health care facilities, 2 district offices and field offices, as well as the central office, located on St. Thomas. The current Commissioner of Health is Dr. Michelle Davis, PhD. The USVI public health workforce functions as an allied health workforce, providing health care services in addition to public health services.

Some 28 health concerns and disparities in the USVI have been identified. The leading health concerns in the USVI centered on issues of access to quality health services for 1) heart disease and stroke, 2) cancer, 3) diabetes, and 4) HIV infection.

Heart Disease and Stroke

As with the mainland U.S., cardiovascular diseases are the leading causes of death in the USVI. According to the V.I. Bureau of Vital Statistics, cardiovascular diseases accounts for approximately 34 percent of all deaths in the Virgin Islands, a rate of 191.5 deaths per 100,000 population (USVI Department of Health, 2003).

Risk factors for cardiovascular diseases are widespread in the USVI. Although most of the major risk factors for heart disease and stroke are modifiable or entirely preventable (Chyun, Amend, Newlin, Langerman, & Melkus, 2003), over 80 percent of Virgin Islanders report having at least one major risk factor for heart disease (USVI Department of Health, 2003). These include tobacco use, physical inactivity, poor diet, and high blood pressure, high blood cholesterol, obesity, and diabetes. Several studies have reported racial, ethnic and socioeconomic disparities in the clustering of cardiovascular disease risk factors (Graham-Garcia, Raines, Andrews, & Mensah, 2001; Sharma, Malarcher, Giles, & Myers, 2004).

Cancer

Cancer is the second leading cause of death in both the mainland U.S. and the USVI. The Cancer Facts and Figures 2003 from the American Cancer Society reports that about one-fifth of all deaths in the U.S. stem from cancer, and that cancer will eventually inflict one in every three Americans alive today. The mortality data in the USVI mirror national trends, with breast and prostate cancers being the most common for female and male cancer deaths respectively (USVI Department of Health, 2003).

Diabetes

According to the results of the Behavioral Risk Factor Survey 2009, 8 percent of Virgin Islanders have been told they have diabetes. Diabetes in the USVI affects more Black and Hispanic residents and is more common among older adults and persons with lower education and income levels (USVI Department of Health, 2003). These data show a need for healthier nutrition practices and more physical activity.

HIV Infection

At the end of 2007, there were 31.4 people per 100,000 residents living with AIDS in the USVI, compared to 12.5 in the U.S. as a whole (Centers for Disease Control, 2010). Because of the lack of information about risk and transmission of the disease, and sexual mores, there is a high rate of other STDs as well, which increases the risk of HIV transmission. HIV infection is a stigmatized disease in the Territory, leading many to avoid testing for HIV, so that by the time they present for care, many patients have severe immuno-suppression, or AIDS. The most common risk factor for HIV infection in the USVI is unprotected heterosexual sex, and the number of men and women who have the disease is nearly equal. Substance abuse is also an important factor in transmission.

Persons of Afro-Caribbean descent make up 68 percent of those diagnosed with HIV, similar to their representation on the overall USVI population. On the other hand, approximately 28 percent of those diagnosed with HIV are Hispanic, a proportion that is double their proportion in the population. An estimated 55 percent of those patients were infected through heterosexual transmission, and women make up 43 percent of the patients in care.

POST HURRICANE PUBLIC HEALTH STATUS IN US VIRGIN ISLANDS

The members of IDSA and HIVMA are deeply concerned that the US Virgin Islands will face worsening public health crises in the wake of Hurricanes Maria and Irma.

Providing Health Services after the Storm in US Virgin Islands

A whole community effort is in full force to maintain medical care and public health support for survivors across the territory. Hundreds of healthcare professionals from the U.S. Department of Health and Human Services (HHS) and Department of Defense (DOD) have supported and augmented local medical staff who were working steady 12-hour shifts in the weeks since the hurricanes. Many continued to care for patients despite damage to their own homes and the need to evacuate their families.

What's more, the three major hospitals throughout the territory were battered by severe winds and flooding. In response, the military's 575th and 602nd Area Support Medical

Companies (ASMC) established mobile medical units outside of St. Croix's Gov. Juan Luis Hospital and Medical Center as well as St. Thomas's Schneider Medical Center to offer backup support for patients needing medical care.

Personnel from the National Disaster Medical System (NDMS), part of HHS, provided medical care at St. John's Myra Keating Smith Clinic before relocating to the Morris F. deCastro Clinic. NDMS staff also provided basic medical services at the fire station in Coral Bay, St. John. HHS and DOD workers provided basic healthcare services, such as triage and emergency medicine.

The U.S. Army Corps of Engineers is also contributing to the effort to ensure ongoing patient care. It will be setting up interim soft-walled durable structures or modular units at damaged hospitals on all the islands and at DOH facilities. These units can expand to capacity and allow additional space for surgery and post-op patient recovery. Among its many efforts on behalf of Virgin Islanders, DOH is providing recurring walk-in clinical services from a mobile medical van. The health department is also providing infant-toddler kits, prescription medicine and family planning services.

HHS and DOD continue to evacuate patients who need critical care. So far, more than 300 patients with critical care needs have been evacuated to the mainland for additional medical attention. HHS and DOD are following up with medical centers and local organizations in Atlanta and Columbia, S.C. for their care.

Because flooding offers a breeding ground for mosquitoes spreading waterborne viruses, staff from the Centers for Disease Control and Prevention (CDC) have been working with DOH on vector control issues. U.S. Public Health Service Commissioned Corps personnel have performed environmental health assessments at shelters, childcare, healthcare and educational facilities. Infectious disease risks in the wake of these hurricanes include exposures to waterborne pathogens, the spread of infections in crowded shelters, food-borne illnesses, mosquito-borne infections and mold-related illnesses.

Reliable access to medicines for patients with HIV and tuberculosis is also critical to preventing treatment disruptions that increase patients' risks of serious illness, disease progression, and to avoid the emergence of drug-resistance or transmission of these infections. Health workers in the affected areas struggle with shortages of antibiotics and hydration solutions, and they are bracing for potential infectious disease outbreaks. Ensuring that basic needs are met including access to clean water, safe food and sanitation is essential for infection control.

CDC is also supporting DOH in getting health and safety information to communities about post-hurricane risks. Health advice focuses on promoting mental health in the storms' aftermath, staying safe while cleaning mold, preventing carbon monoxide poisoning and more.

FEMA and Federal Partners Continue to Support Life-Saving and Life-Sustaining Efforts As of September 12, 2017, 9 a.m.

- FEMA is coordinating closely with the governor's office in the Virgin Islands, its Emergency Management Agency and its federal partners to support life-saving and life-sustaining operations on the islands.
- The priority is to support efforts by territorial, local, private sector and voluntary agency partners to help meet the needs of Hurricane Irma survivors and begin to restore basic services and communications capabilities.

- As of September 11th, FEMA had sent nearly 146,700 liters of water, 443,000 meals, and 56 rolls of blue tarp, 13 infant/toddler kits to St. Thomas and St. John for the response effort.

Federal Family Response

- The federal family -- including the Departments of Defense, Energy and Health and Human Services – is on the ground and strongly supporting response and recovery efforts in the Virgin Islands.
- A FEMA Urban Search and Rescue Incident Support Team-Advance element and Virginia Task Force Two (VA-TF2), Virginia Task Force One (VA-TF1), both as a NIMS type 1 task force, are on the ground in the U.S. Virgin Islands conducting operations. FEMA deployed additional US&R support including Canine Search and Logistics teams.
- The U.S. National Guard Bureau is conducting medical evacuations and moving critical disaster personnel and equipment to the U.S. Virgin Islands.
- Mobile Emergency Response Support (MERS) personnel continue to deploy to support communication needs for the U.S. Virgin Islands. A 20- person team with communications equipment and vehicles are present in St. Thomas.
- FEMA National Radio System is operable in St. John and St. Thomas to help provide essential emergency communication.
- Three Department of Energy (DOE) responders are on the ground in St. Thomas and St. Croix, for electricity restoration tracking and technical assistance. DOE responders are also working with the U.S. Army Corps of Engineers to coordinate emergency power generation in St. Thomas and St. John.
- The Corps of Engineers also has technical experts on the ground to assess requirements for debris cleanup, assess damages at critical facilities and assist in identifying power restoration and generator requirements, including for the power plant in St. Thomas. Corps subject matter experts are also identifying requirements for temporary roofing solutions.
- UACE has received a FEMA mission assignment to provide coordination and execution of debris removal for St. Thomas.
- The U.S. Coast Guard (USCG) is conducting search and rescue operations in the U.S. Virgin Islands. Additionally, USCG is conducting damage assessment overflights and port reconstitution efforts are underway.
- Coast Guard cutter crews have been arriving to support Hurricane Irma relief efforts in the U.S Virgin Islands. The Coast Guard cutter fleet from Sector San Juan, along with other Coast Guard cutters are supporting Hurricane Irma relief efforts in the U.S. Virgin Islands by providing maritime security, assisting with port assessments, as well as transporting supplies, equipment, Coast Guard teams and other government agency responders to St. John and St. Thomas.
- U.S. Northern Command (USNORTHCOM) is providing search and rescue capabilities to the U.S. Virgin Islands (USVI) to assist with lifesaving and life-sustaining efforts.
- The USS Wasp located near the USVI is conducting medical evacuations for critical care patients from St. Thomas to St. Croix and performing damage assessments in support of the local government.
- The Department of Health and Human Services (HHS) has medical teams providing care at a hospital emergency department on St. Thomas, and is sending personnel to St. John.
- Personnel from HHS and DOD are evacuating dialysis patients from St. Thomas, U.S. Virgin Islands, to San Juan, Puerto Rico, due to the extensive damage to the health care infrastructure on St. Thomas.

- ❖ Approximately 100 HHS medical personnel are deployed to Puerto Rico and the U.S. Virgin Islands to aid in patient evacuation and to assist USVI doctors and nurses in providing medical care in a hospital emergency department in St. Thomas.
- ❖ U.S. Customs and Border Protection (CBP) coordinated with the Coast Guard to deploy a 67-person Disaster Assistance Recovery Team (DART) for response and recovery in St. Thomas. CBP is supporting relief and recovery efforts in USVI.
- ❖ DOD Civil Authorities Information Support (CAIS) forward team and capabilities arrived Tuesday, September 12 on St. Thomas. Coordination efforts are underway to locate staging area. CAIS teams will coordinate with FEMA on broadcast and loudspeaker messaging in St. John and St. Thomas.
- ❖ The Department of Health and Human Services (HHS) has three medical teams that are providing care at a hospital emergency department on St. Thomas, U.S. Virgin Islands, and are helping evacuate dialysis patients. HHS Secretary Tom Price, M.D., signed public health emergencies declarations for Puerto Rico, U.S. Virgin Islands, Florida, Georgia and South Carolina, and the Centers for Medicare and Medicaid Services has made subsequent waivers available.
- ❖ The U.S. Coast Guard (USCG) is conducting search and rescue operations in the U.S. Virgin Islands. Additionally, USCG is conducting damage assessment overflights and port reconstitution efforts are underway.
- ❖ U.S. Northern Command (USNORTHCOM) is providing search and rescue capabilities to the U.S. Virgin Islands (USVI) to assist with lifesaving and life-sustaining efforts. The USS Wasp located near the USVI is conducting medical evacuations for critical care patients from St. Thomas to St. Croix and performing damage assessments in support of the local government.
- ❖ Three Department of Energy (DOE) responders are on the ground in St. Thomas, and St. Croix, for electricity restoration tracking and technical assistance.

SOCIAL DETERMINANTS OF HEALTH

Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health.

Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships.

Social determinants of health include:

- ✓ Availability of resources to meet daily needs (e.g., safe housing and local food markets)
- ✓ Access to educational, economic, and job opportunities
- ✓ Access to health care services
- ✓ Quality of education and job training
- ✓ Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities
- ✓ Transportation options
- ✓ Public safety

- ✓ Social support
- ✓ Social norms and attitudes (e.g., discrimination, racism, and distrust of government)
- ✓ Exposure to crime, violence, and social disorder (e.g., presence of trash and lack of cooperation in a community)
- ✓ Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it)
- ✓ Residential segregation
- ✓ Language/Literacy
- ✓ Access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media)
- ✓ Culture

Physical determinants of health include:

- ✓ Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change)
- ✓ Built environment, such as buildings, sidewalks, bike lanes, and roads
- ✓ Worksites, schools, and recreational settings
- ✓ Housing and community design
- ✓ Exposure to toxic substances and other physical hazards
- ✓ Physical barriers, especially for people with disabilities
- ✓ Aesthetic elements (e.g., good lighting, trees, and benches)

Health Care Problems in Puerto Rico

The six most important health issues identified in Puerto Rico, and seen by NY RNs on medical missions, were Heart Disease, Diabetes, Malignant Neoplasms, Arthritis, Asthma, and Alzheimer's.

Perceived Barriers to good health and good health care in Puerto Rico

There was concern for the health of women, overall, in Puerto Rico. Heart disease is greater in women whose household incomes were less than $15,000/year. Diabetes is prevalent in 1 out of 3 women over the age of 65 where household incomes were less than $15,000/year. Malignant neoplasms, arthritis, and Alzheimer's disease is more prevalent in women over the age of 65 where household incomes were less than $15,000/year. Lastly, asthma is more prevalent in younger women where household incomes were less than $15,000/year. Also noted were patient dissatisfaction with the cultural competence of care given, low literacy levels, poor self-care, stress, anxiety and depression, and poor access to care.

Health Care Problems in the US Virgin Islands

The five most important health issues identified in the US Virgin Islands, and seen by RNs on medical missions, were Diabetes, Heart Disease, HIV/AIDS, Asthma, and Hypertension. The majority of participants expressed concerns about limited resources and high costs, such as the Medicare gap, high cost of insurance and co-pay, large number of uninsured residents, and the overall cost of services.

Perceived Barriers to good health and good health care in US Virgin Islands

There was concern that health care providers from the U.S. mainland were not culturally competent, and about significant provider-patient communication obstacles based on patients' use of language that providers may misunderstand. Second, some barriers to good health can be addressed by more rigorous enforcement of existing policies concerning patient

confidentiality and privacy. Overall, trust and confidence in the health system is markedly low; concern for confidentiality is high. Third, some barriers could be addressed by better coordination, planning, and/or financing. Included here is confusion about where best to go to receive specific health services and doubt about the range and limits of services provided by the Department of Health. Some participants did not know which problems were best treated in local clinics or physicians' offices vs. hospital emergency rooms.

NURSES ON MEDICAL MISSIONS CAN MAKE A DIFFERENCE

Nurses on medical missions can help to make a difference to address Common Chronic Diseases and post-hurricane public health issues in the Puerto Rican and US Virgin Islander population. The following actions are recommended post-hurricane:

- All flood-dampened surfaces should be cleaned, disinfected and dried as soon as possible. Follow these tips to ensure a safe and effective cleanup:
- Open windows for ventilation and wear rubber gloves and eye protection when cleaning. Consider using a mask rated N-95 or higher if heavy concentrations of mold are present.
- Use a non-ammonia soap or detergent to clean all areas and washable items that came in contact with floodwaters.
- Mix 1-1/2 cups of household bleach in one gallon of water and thoroughly rinse and disinfect the area. Never mix bleach with ammonia as the fumes are toxic.
- Cleaned areas can take several days to dry thoroughly. The use of heat, fans and dehumidifiers can speed up the drying process.
- Check out all odors. It's possible for mold to hide in the walls or behind wall coverings. Find all mold sources and clean them properly.
- Remove and discard all materials that can't be cleaned, such as wallboard, carpets and furniture, fiberglass and cellulose areas. Then clean the wall studs where wallboard has been removed, and allow the area to dry thoroughly.
- Assess clients for wounds, illnesses, nutritional status, mental status, etc. and provide first aid relief and immunizations. Make referrals when appropriate. Provide teaching when appropriate, such as importance for food hygiene, boiling water, creating a dedicated toileting area, etc.
- Provide equipment, supplies, and medicines to operate temporary clinics that come from donations through partnerships with pharmaceutical and medical supply companies, hospitals, and other health and development organizations, as well as donations from private supporters.
- Promote resilience in patients by incorporating cultural dance, exercise, yoga and meditation, listening to music, reading, or photography, support groups, and journaling to improve coping skills. These programs should also be organized in institutions in the following months and patients and their caretakers should be encourage to attend them.

Major concerns of health care providers when going on medical missions include issues related to food, water, septic issues and water waste, home damage including flooding and how to clean it up and repair it, no electricity or heat, coping with the traumatic event, lack of medical supplies (medication, oxygen, equipment), and illness and injury prevention.

The following actions are provided by RNs on medical missions:

- Assisting with basic medical tasks such as first aid or administering vaccines;

- Taking vitals and building patient histories;
- Performing day-to-day activities such as sterilizing instruments, completing paperwork, or readying clinics for intake;
- Observing local medical staff to learn healthcare practices in developing countries or communities;
- Conducting home visits and surveys to understand the most common or priority medical needs facing the community;
- Educating individuals, families, and communities about hygiene, family planning, and other healthcare issues;
- Arranging for support groups where clients can clearly express their problems, feelings and thoughts, share experiences with the other community members experiencing similar problems and develop common methods to solve the problems.

Working with an ethical organization is one of the most important parts of mission work. Questions nurses should ask before deploying include:

- Does the organization have an ongoing relationship with a hospital, agency, or clinic on the ground?
- Who provides follow-up care when we leave?
- Why does a commitment to the community matter to the coordinating organization? Is it for humanitarian, self-fulfilling, or profit-making purposes?
- How skilled are the people I will be traveling with? Will the care being delivered be substandard?
- Will I likely be asked to do things that exceed my scope of practice in my home country? How do I feel about that?
- Are the supplies I am traveling with appropriate for the illnesses I am likely to encounter, or is the bag thrown together with medications and supplies that are likely to be useless in the communities I will be serving?
- Will I feel comfortable if I am asked to participate in religious or cultural activities? Will I feel comfortable working outside of my comfort zone and while learning new things, both in the nursing/medical field and also culturally?
- Will the organization support the nursing concept of non-interference in cultural matters (imposition of Western values in developing nations)?
- Will the coordinating organization respect and maintain the local customs and beliefs that clashed with their own values?
- Does the coordinating organization provide me with safe food, clean drinking water, a place to stay, a translator, and a guide? Will I be left on my own or traveling with a group?
- What is the structure of the medical team? What are the team responsibilities?
- Will the organization facilitate psychological support for clients and aid workers during and post complex emergencies?
- Will the organization provide for debriefing sessions so that there is an opportunity to discuss feelings such as lack of achievement regarding self and mission?
- Will quality assurance and outcomes documentation be preserved and passed along to agencies for follow up care?

FOLLOW UP CARE

- Involvement in decisions and respect for preferences

- Clear, comprehensible information and support for self-care
- Emotional support, empathy and respect that is ongoing
- Fast access to reliable health advice
- Effective treatment, including treatment for PTSD
- Attention to physical and environmental needs
- Involvement of, and support for, family and caretakers
- Continuity of care and smooth transitions

Summary

The experience of providing humanitarian aid in countries following a natural and/or man-made disaster is culminated by recognizing the need to change one's practice to align with the priorities, values, and resources within the local community. This often means accepting a focus on survival, for example, rather than providing for nutritional needs such as dieting. It also means feeling anxious and concerned about extending one's practice beyond the scope and parameters previously practiced at home. Significantly, it is an experience of feeling rewarded in ways not previously imagined. The nurse's practice is less constrained than in his/her own country, and this release of potential is not only what draws nurses to return, but also facilitates thoughts of what true independent practice looks like and feels like.

In conclusion, short-term medical missions currently fill an important niche in addressing the global health burden. They also provide opportunities for students and other providers to develop greater appreciation of the health care beliefs and practices of different cultures. Next steps in short-term medical missions include formulating alliances so that the health concerns that have been assessed by RNs on medical mission will continue once the medical mission team returns home.

Nurses medical missions to Puerto Rico and US Virgin Islands: What nurses need to know and do next.

Course Activity Exam

Instructions: Complete the exam questions below by marking your answers on the answer sheet provided. Be sure to complete the evaluation form on the back of the answer sheet.

1. All of the following are focuses of public health EXCEPT:
    A. Health promotion.
    B. Epidemics.
    C. Health insurance.
    D. Reducing environmental hazards.

2. The populations that public health focuses on includes all of the following except:
    A. Rising risk group.
    B. Emergent risk group.
    C. Low risk group.
    D. High risk group.

3. All of the following health conditions pre-existed Hurricane Maria in Puerto Rico and the US Virgin Islands EXCEPT:
    A. Conjunctivitis.
    B. Zika.
    C. HIV.
    D. Low birth weight infants.

4. Social determinants of health include all of the following EXCEPT:
    A. Language, literacy and quality of education and job training.
    B. Transportation options and social norms and attitudes.
    C. Resources to meet daily needs, safe housing, local food markets.
    D. Mass media, emergency technologies, and motor vehicular laws.

5. Physical determinants of health include all of the following EXCEPT:
    A. Physical barriers for people with disabilities.
    B. Aesthetic lighting and roads.
    C. Community artwork.
    D. Housing, community designs, and green spaces (grass, trees).

6. TRUE or FALSE. Community health workers can be a positive link by actively working in the community to help address common chronic diseases in Puerto Rico and the U.S. Virgin Islands, such as obesity, hypertension, asthma, cancer, and diabetes.

    A. True
    B. False

7. All of the following reflect deficiencies in chronic care delivery, EXCEPT:
    A. Lack of care coordination and active follow-up to insure the best outcomes for patients.
    B. Patients are unable to manage their illnesses because they are inadequately trained and have high health literacy.
    C. Practitioners feeling rushed, or a lack of time to follow established guidelines to provide care.
    D. Practitioners do not address the mental and/or PTSD issues in their patients.

8. Some strategies to improve communication and provide culturally competent care include all of the following EXCEPT:
    A. Tailoring care plans to include patient's needs and preferences.
    B. Only asking the patient to be involved in any aspect of decision making.
    C. Utilizing a patient centered care approach.
    D. Making sure patient's understand medical instructions by engaging patients in teach-backs.

9. TRUE or FALSE. Limited health literacy is a condition that makes itself easily visible for nurses to see when doing an assessment.

    A. True
    B. False

10. TRUE or FALSE. The nurse, when teaching the Community Health Worker, needs emphasize techniques so the Community Health Worker will be able to help clients examine their current habits, values, and future goals.

    A. True
    B. False

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Nurses medical missions to Puerto Rico and US Virgin Islands: What nurses need to know and do next.

Answer Sheet

Please print legibly and verify that all information is correct.

First Name: _____ **MI:** _____ **Last Name:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Daytime Phone Number (include area code): _____

E-mail: _____

Facility: _____ **NYSNA Member #:** _____

Please print your answers in the spaces provided below. **There is only one answer for each question.** All answers are located within the course content.

1. _____

2. _____

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10. _____

Please complete the course evaluation on the back.

Nurses medical missions to Puerto Rico and US Virgin Islands: What nurses need to know and do next.

Course Evaluation

Please use the following scale to rate statements 1-7 below:	Poor	Fair	Good	Very Good	Excellent
1. The content fulfills the overall purpose of the course.	○	○	○	○	○
2. The content fulfills each of the course objectives.	○	○	○	○	○
3. The course subject matter is current and accurate.	○	○	○	○	○
4. The material presented is clear and understandable.	○	○	○	○	○
5. The teaching/learning method is effective.	○	○	○	○	○
6. The test is clear and the answers are appropriately covered in the course.	○	○	○	○	○
7. How would you rate this course overall?	○	○	○	○	○
8. Was this course fair, balanced, and free of commercial bias?				Yes / No (Circle One)	

9. Comments _____

_____

10. Do you have any suggestions on how to improve the program? _____

_____

_____

_____

Thank You!

Safe Staffing in Hospitals: Improved Outcomes for Patients, Nurses and Hospitals

NYSNA Continuing Education

The New York State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This course has been awarded 1.0. contact hours and is intended for RN's and other healthcare providers. In order to receive contact hours participants must read the course material, complete and return the post-test answer sheet with a score of 80% or better, and submit the completed evaluation for this course. The completed post-test answer sheet and evaluation must be returned to NYSNA no later than April 13, 2019.

All American Nurses Credentialing Center (ANCC) accredited organizations' contact hours are recognized by all other ANCC accredited organizations. Most states with mandatory continuing education requirements recognize the ANCC accreditation/approval system. Questions about the acceptance of ANCC contact hours to meet mandatory regulations should be directed to the professional licensing board within that state.

NYSNA wishes to disclose that no commercial support was received.

Introduction

Patients and their families are increasingly aware that hospitals do not have enough RNs to provide the life-saving treatment, medication and support that they need, especially since the average acuity of hospital patients is higher than ever. So it is more important than ever for RNs and other healthcare professionals to review the latest evidence-based research on the impact on patients, RNs and hospitals of safe staffing and of unsafe staffing.

Purpose Statement: Hospital patients are sicker, on average, and require constant monitoring by qualified licensed professionals. Therefore, staffing in hospitals is more important now than ever. Patient acuity is on the rise, length of stay is shortened, and patients are discharged more quickly. These are added reasons for legislated nurse-to-patient ratios. This program is intended for registered professional nurses and other licensed healthcare professionals who want to be versed in the literature surrounding safe staffing and patient outcomes and the economic benefits of safe staffing.

Course Objectives

At the completion of this learning activity the learner will be able to:

- Examine how safe staffing saves lives and is an economically beneficial way to improve patient outcomes

About the Author

Desma Holcomb, MA

Desma Holcomb, the Director of Labor Education for the New York State Nurses Association (NYSNA), has 37 years' experience in the labor movement, primarily in strategic research and labor education. During the last few years of organizational transformation at NYSNA, she has overseen research on trends in healthcare economics, hospital finance, healthcare delivery by nurses, labor issues and safe staffing impact and policy. She developed and leads the Member Leader Training and Union Leadership Education initiatives to teach hundreds of union nurses to effectively advocate for themselves and their patients.

She received her Master's degree in Economics from the New School for Social Research in New York City and her Bachelor's degree from Princeton University. She has taught "Union Organizing Strategies" at the Joseph S. Murphy Institute for Worker Education and Labor Studies/City University of NY Graduate Center in New York City.

Ms. Holcomb and NYSNA's Labor Education team design, develop, implement and evaluate labor education programs. Together, they educate unionized RNs and healthcare professionals on hospital and healthcare economics, healthcare disparities, Safe Staffing advocacy and union member leadership skills.

Please read the New York case study report “Safe Staffing in Hospitals: Improved Outcomes for Patients, Nurses and Hospitals,” by the New York Campaign for Patient Safety, and then complete the Quiz for 1.0 CH.

Safe Staffing in Hospitals: Improved Outcomes for Patients, Nurses and Hospitals

Course Activity Exam

Instructions: Complete the exam questions below by marking your answers on the answer sheet provided. Be sure to complete the evaluation form on the back of the answer sheet. **For those members wishing to earn CHs for these courses, please return completed evaluation form and answer sheets to NYSNA no later than April 13, 2019.**

1. In a 2015 survey, what percentage of New Yorkers said that New York hospitals do not have enough nurses?

    A. 50%
    B. 67%
    C. 86%
    D. None of the above.

2. Two comprehensive reviews of existing research concluded that adding one full-time RN per patient day was associated with:

    A. A 6% reduction in the odds of death for medical patients.
    B. A 9% reduction in the odds of death for ICU patients.
    C. Neither.
    D. Both.

3. Which of these statements are False?
    i. Peer-reviewed research found that Black patients are largely concentrated in a small number of hospitals, which have lower nurse staffing than hospitals with fewer Black patients.
    ii. A 2012 study of the impact on safety-net hospitals of the Safe Staffing law found that the legislation increased nurse staffing "in those hospitals in which an improvement in staffing has historically been most difficult and most improvement was needed."

    A. (i)
    B. (ii)
    C. Neither.
    D. Both.

4. According to data from the Centers for Medicare & Medicaid Services (CMS), New York's hospital performance on hospital readmissions, compared to other states is:

    A. Worse than every other state.
    B. About average.
    C. Better than average.
    D. None of the above.

5. Medicare now financially penalizes hospitals with high rates of potentially avoidable infections and complications such as blood clots, bedsores and falls—outcomes that can be reduced with improved RN staffing. Medicare is lowering 2016 payments by 1% for how many New York hospitals?

    A. 26
    B. 46
    C. 86
    D. None.

6. Peer-reviewed research has found that increases in hospital nurse staffing levels improved quality and reduced length of stay

    A. But at a substantial additional cost
    B. With no additional cost
    C. With a much lower cost
    D. None of the above

7. The 2004 Safe Staffing law in California had which outcome(s)?

    A. Raised RN staffing levels
    B. Improved patient outcomes
    C. Maintained ancillary staffing levels
    D. All of the above

8. When comparing the cost per life saved, how does decreasing the number of patients per RN from 7 to 6 compare to pharmaceutical thrombolytic therapy for acute myocardial infarction (heart attack):

    A. Safe staffing costs more per life saved than thrombolytic therapy
    B. Safe staffing costs the same per life saved as thrombolytic therapy
    C. Safe staffing costs less per life saved than thrombolytic therapy

9. How did the operating profit margin change for California hospitals from 2003—before the Safe Staffing law ratios took effect—to 2010—after the ratios had taken effect?

    A. Decreased from 3.1% to 2.1%
    B. Decreased from 3.1% to 0%
    C. Stayed the same
    D. Increased from 1% to 3.1%

10. In a 2015 survey, what percentage of New Yorkers said that they would support a minimum number of nurses on duty per patient at any given time?
    A. 86%
    B. 67%
    C. 50%
    D. None of the above

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Safe Staffing in Hospitals: Improved Outcomes for Patients, Nurses and Hospitals

Answer Sheet

CODE:

Please print legibly and verify that all information is correct.

First Name: _____ **MI:** _____ **Last Name:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Daytime Phone Number (include area code): _____

E-mail: _____

Facility: _____ **NYSNA Member #:** _____

For those members wishing to earn CHs for these courses, please return completed evaluation form and answer sheets to NYSNA no later than APRIL 13, 2019. Please print your answers in the spaces provided below. **There is only one answer for each question.** All answers are located within the course content.

1. _____

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9. _____

10. _____

Please complete the course evaluation on the back.

Safe Staffing in Hospitals: Improved Outcomes for Patients, Nurses and Hospitals: Evaluation

Please use the following scale to rate statements 1-7 below:	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
1. The content fulfills the overall purpose of the course.	○	○	○	○	○
2. The content fulfills each of the course objectives.	○	○	○	○	○
3. The course subject matter is current and accurate.	○	○	○	○	○
4. The material presented is clear and understandable.	○	○	○	○	○
5. The teaching/learning method is effective.	○	○	○	○	○
6. The test is clear and the answers are appropriately covered in the course.	○	○	○	○	○
7. How would you rate this course overall?	○	○	○	○	○
8. Was this course fair, balanced, and free of commercial bias?				Yes / No (Circle One)	

9. Comments: _____

_____

10. Do you have any suggestions about how we can improve this course? _____

_____

_____

_____

Thank You!

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Executive Director

Working Families Party
Bill Lipton
Executive Director

Make the Road NY
Deborah Axt
Co-Executive Director

New York Communities for Change
Jonathan Westin
Executive Director

Metro New York Healthcare for All
Mark Hannay
Director

Committee of Interns and Residents / SEIU Healthcare
Tim Foley
Policy Director

SAFE STAFFING IN HOSPITALS:

Improved Outcomes for Patients, Nurses and Hospitals

FEBRUARY 2016

the NEW YORK CAMPAIGN for PATIENT SAFETY

the NEW YORK CAMPAIGN for PATIENT SAFETY

SAFE STAFFING IN HOSPITALS:

Improved Outcomes for Patients, Nurses and Hospitals

campaignforpatientsafety.org

Executive Summary

Patients and their families count on our hospitals to care for their loved ones when they are sick or injured. Nurses are a vital part of safe, successful hospitals. They care for patients around the clock, providing life-saving treatment, medication and support. A safe staffing ratio of nurses to patients is critical to ensuring every patient is properly cared for.

The research is clear: Safe staffing ratios save lives and improve patient outcomes. Safe staffing ratios also reduce emergency room wait times, and lower costs for hospitals and the health system as a whole.

Conversely, research shows that short-staffing can harm patients, as nurses must leave tasks undone to take on an increased workload.

Safe staffing is more important now than ever. On average, hospital patients are sicker, increasing demands on staff and increasing workloads. Nurses report that understaffing leads to patient deaths and complications,[1] and most New Yorkers say that the state's hospitals do not have enough nurses.[2] Meanwhile, hospitals in New York State perform worse than hospitals nationally on key indicators of quality and patient safety.[3, 4]

Overwhelming evidence shows that:

- **Safe staffing saves lives.** Peer-reviewed research finds that higher nurse staffing is associated with lower mortality rates. For example, adding one RN per patient day was associated with a 16 percent decrease in failure to rescue in surgical patients.[5]

- **Safe staffing improves patient outcomes.** Studies have shown increased RN staffing lowers the risk of a number of specific patient outcomes and safety measures, including hospital-acquired infections, hospital-acquired pneumonia and cardiac arrest.[6] Higher nurse staffing also reduces hospital readmissions[7] and emergency room wait times.[8]

- **Safe staffing is cost-effective.** A 2009 analysis found that the savings associated with lives saved per thousand hospitalized patients were greater than the increased cost of one additional RN per patient day in intensive care, surgical and medical units.[9]

- **Safe staffing reduces nurse burnout, turnover and injuries.** Adding even one patient per nurse increased burnout by 23 percent and job dissatisfaction by 15 percent in one study.[10] Safe staffing ratios in California were associated with an occupational injury and illness rate 31.6 percent lower than what would have been expected without the law.[11]

California's experience has shown safe staffing laws work and that hospitals can thrive with safe staffing in place.

- Since California's law was implemented, **nurses in California care for fewer patients,** on average, than they did prior to the legislation and fewer patients than nurses in other states.[12] **Legislation also increased nurse staffing in safety-net hospitals** "in which an improvement in staffing has historically been most difficult and most improvement was needed."[13]

- **Despite predictions, no hospitals closed in California** following the implementation of minimum nurse ratios there,[14] and **hospital margins have actually improved** since implementation.[15] **Nor did hospitals decrease ancillary staffing.[16]** As reimbursements shift to a value-based model, the improved outcomes safe nurse staffing can provide will directly translate into financial benefit for hospitals.

Despite the benefits of safe staffing for patients and hospitals, patients in New York State currently have no legal protection against inadequate nurse staffing. The state legislature's previous efforts to make hospital staffing levels transparent have not succeeded, and even if information were available in a transparent fashion, many patients would not be able to choose a hospital based on adequate nurse staffing due to geographical, insurance or financial limitations.

Through the Safe Staffing and Quality Care Act, lawmakers can improve the quality of New York hospitals, keep pace with changing health care needs, and create safe and equitable standards for patients across New York State.

INTRODUCTION

A Solution to the Crisis in Patient Care

Nurses in our hospitals provide essential patient care: monitoring patients for changes in their condition, responding to requests for help, administering medications, and facilitating communication between patients and the rest of the care team. It is no surprise, then, that research shows that safe nurse staffing ratios can save lives, improve patient outcomes, reduce emergency room wait times, and reduce costs for hospitals and the overall health system. Research also shows that safe staffing is an economical way to improve patient outcomes, compared to other strategies. Conversely, short staffing is associated with nurses having to leave specific care tasks undone and worse patient outcomes.

As hospital patients are sicker, on average, and require constant monitoring by qualified, licensed professionals, staffing in hospitals is more important now than ever. Patient acuity (a measure of the intensity of care required by patients) is on the rise as lengths of stay are shortened and patients discharged more quickly to post-acute care like skilled nursing facilities and home health care. This means only the sickest patients remain in the hospital.[17] Additionally, higher patient turnover—due to shorter hospital stays—generates more work for nurses, who must help transition patients in and out of the hospital. In an intensive care unit (ICU), nurses report that the administrative work of admitting or discharging a single patient can take two hours—nearly 20 percent of a 12-hour shift.

"New York [ranks] thirty-fourth in the nation in hospital safety."

Despite rising levels of acuity and the documented benefits of safe staffing, nurses and patients report that worsening understaffing is hurting patients. In a 2015 survey of nurses in Massachusetts, one in four nurses reported patient deaths directly attributable to having too many patients to care for at one time, and 61 percent reported complications for patients due to unsafe patient assignments.[18] Similarly, in a 2013 national survey, 66 percent of registered nurses (RNs) surveyed say limited coverage and clinical support mean nurses have to divide their time between more patients.[19]

New Yorkers agree. In a 2015 survey, 67 percent of New Yorkers said that New York hospitals do not have enough nurses, and 86 percent support a minimum number of nurses on duty per patient at any given time.[20]

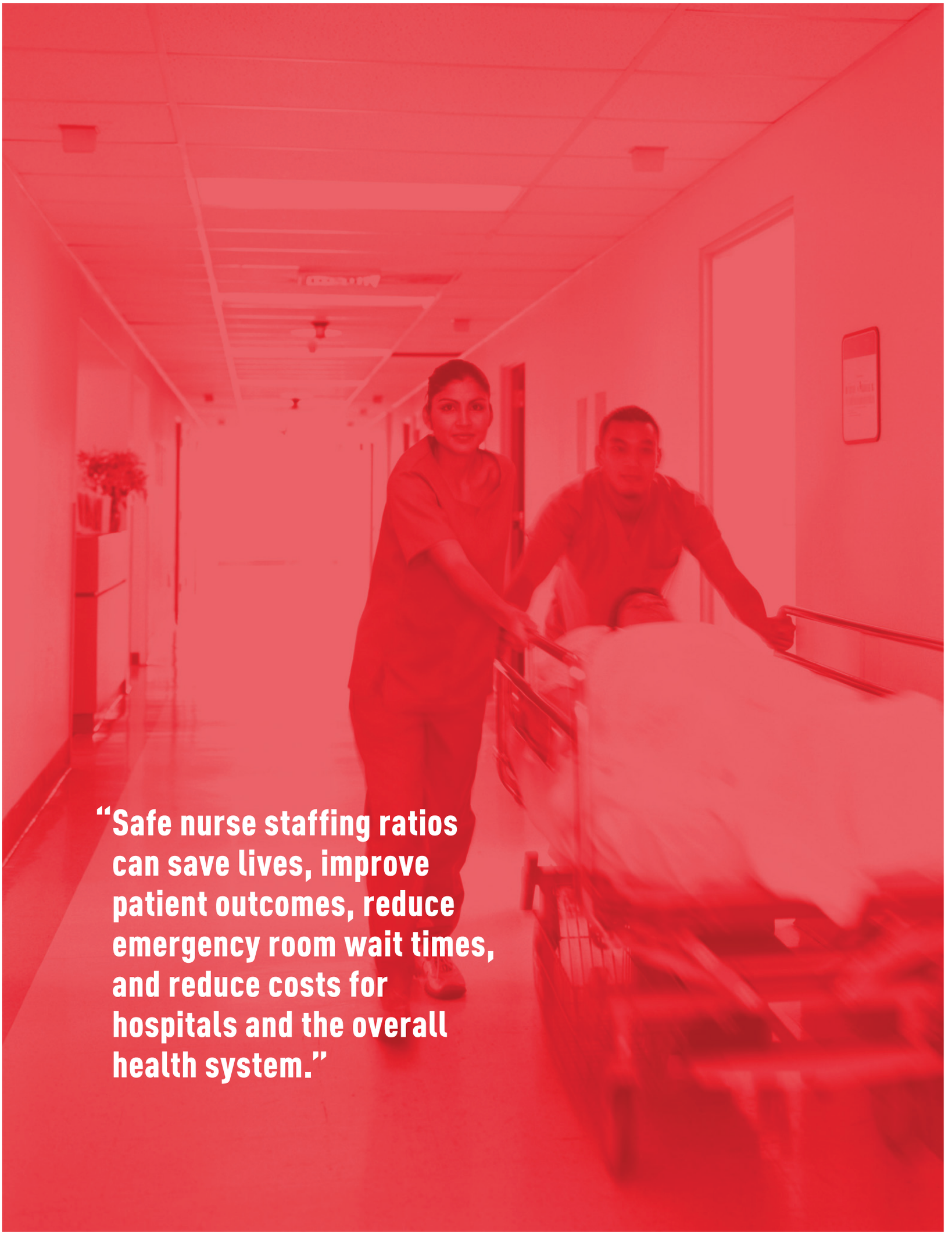
New York hospitals lag in quality, patients left unprotected

Currently, patients in New York State have no legal protection against inadequate nurse staffing. The state legislature's previous effort to at least make hospital staffing levels transparent, by requiring hospitals to provide ratio information upon request, has failed because hospitals do not provide meaningful, comprehensible data in a timely fashion. Hospitals are allowed to use self-reported data that is averaged over three to 12 months. This renders the staffing information meaningless in terms of any particular patient's experience, even though every short-staffed shift increases the likelihood of death or adverse outcomes and makes it difficult to compare across institutions.

Additionally, hospitals are not required to post the information online and have 30 days to respond to requests for staffing data, which is hardly timely for patients and their families. A 2015 study by New Yorkers for Patient and Family Empowerment found that of four hospitals from which ratio information was requested, not one provided all the information requested within 30 days.[21] Even if a patient were able to get access to accurate, comparable ratio data in a timely fashion, many patients cannot afford to choose a hospital based on its staffing, due to geography, insurance or cost.

Meanwhile, New York hospitals perform worse than hospitals nationally on key indicators of quality and patient safety. The Leapfrog Group, using data from federal agencies, its own survey and the American Hospital Association, ranks New York 34th in the nation in hospital safety.[22] According to data from the Centers for Medicare and Medicaid Services (CMS), New York performs worse than every other state in the country on hospital readmissions. One in three New York hospitals measured has a rate of readmissions worse than the national average—more than any other state in both proportion of hospitals and raw numbers.[23]

The Safe Staffing and Quality Care Act (A08580-A/S782) protects patients through minimum staffing requirements in our state's hospitals and nursing homes. Similar legislation implemented in California in 2004 has succeeded in raising RN staffing levels, maintaining ancillary staffing levels and improving patient outcomes, all while hospitals improved their operating margins. Through the proposed legislation, lawmakers can improve the quality of New York hospitals, keep pace with changing health care needs, and create safe and equitable standards for patients across New York State.



"Safe nurse staffing ratios can save lives, improve patient outcomes, reduce emergency room wait times, and reduce costs for hospitals and the overall health system."

SECTION ONE:

Safe staffing saves lives and improves patient outcomes

Peer-reviewed studies consistently report that higher RN staffing is related to lower hospital-related mortality.[24]

- **Higher RN staffing saves lives**, according to two comprehensive reviews of existing research. **Adding one full-time RN per patient day was associated with a 6 percent reduction in odds of death for medical patients and a 9 percent reduction for ICU patients**, in a 2007 analysis combining data from 28 studies.[25] A 2011 analysis of 17 studies—10 of which were not included in the 2007 study—concluded that 14 out of 17 studies found a statistically significant relationship between higher nurse staffing and lower mortality rates.[26]

- **Adding one RN is associated with a 16 percent decrease in failure to rescue in surgical patients**.[27] Failure to rescue refers to a death after a treatable complication and is an important measure of patient safety. For example, a patient may develop a bedsore that, if unnoticed or untreated, could develop into a life-threatening sepsis infection.

Increased RN staffing lowers the risk of a number of specific patient outcomes and safety measures, including hospital-acquired infections, hospital-acquired pneumonia and cardiac arrest, according to multiple studies.[28]

- **An increase of 1 percent in RN staffing reduced adverse events by 3.4 percent, and a 5 percent increase in RN staffing reduced adverse events by 15.8 percent,** according to a two-year study covering nearly 35,000 patients in 11 medical-surgical units across four hospitals.[29]

- **Higher RN staffing was associated with fewer bloodstream infections in children,** according to a study of seven children's hospitals.[30]

- **Higher nurse staffing also reduces hospital readmissions.** Increasing RN staffing by 0.75 hours per patient day was linked with a 4.4 percentage point drop in probability of readmission in a study of nearly 3,000 hospitals.[31]

- **Safe staffing standards can be particularly important as patient acuity rises.** One study noted that, as acuity rose in California, the state's safe nursing ratio law may have prevented patient outcomes from worsening.[32]

Meanwhile, lower nurse staffing is associated with higher risk of death and worse patient outcomes:

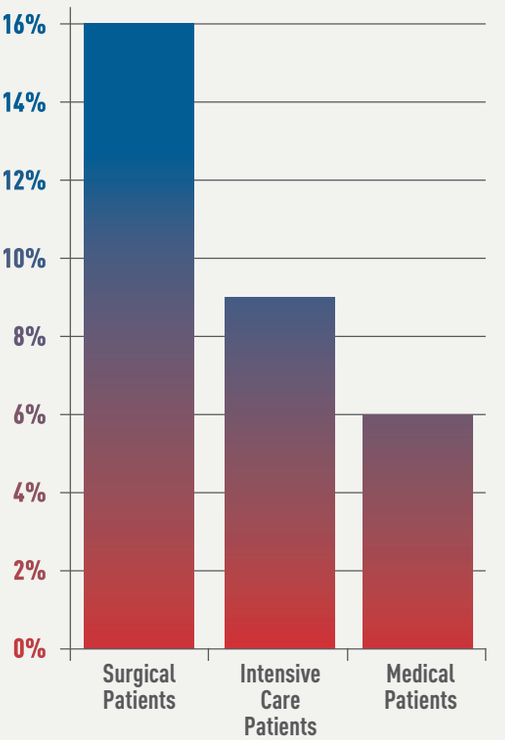
- **A patient's risk of death increased by 2 percent for every below-target, or short-staffed, shift to which he or she was exposed**, according to a four-year study of over 190,000 admissions to a hospital. The study estimated that the risk was even higher for patients exposed to short-staffing in the first five days of hospitalization.[33]

- **Adding even one patient per nurse is associated with a 7 percent increase in the likelihood of patient death within 30 days of admission and a 7 percent increase in the failure to rescue**, according to a study of 168 hospitals in Pennsylvania.[34]

- **Understaffing in neonatal intensive care units is associated with hospital-acquired infections among infants with very low birth weights**.[35]

More Nurses, More Survivors

Increased Likelihood of Patient Survival with One Additional RN per Patient Day



Patient days are the number of census days that admitted inpatients spend in the hospital. Findings of an analysis combining results from 28 studies of the impact of nurse staffing on patient outcomes. R. Kane, et al, "The Association of Registered Nurse Staffing Levels and Patient Outcomes: Systemic Review and Meta-Analysis," Med Care 2007;45:1195-1204.

Improved nurse staffing improves patient outcomes by ensuring that nurses are able to complete all necessary nursing tasks for each patient and adhere to best practices that benefit all patients. For example, lower nurse staffing hours are associated with nurses missing specific care tasks (such as providing ambulation).[36] Understaffing can also limit time for communication with patients and their families, which could result in inadequate education on post-hospital care.

Although less research is available on the impacts of Licensed Practical Nurse (LPN) and Certified Nurse Assistant (CNA) staffing in hospitals, a 2011 study found that total hours of nursing care (including care from RNs, LPNs and assistants) was associated with lower rates of congestive heart failure, mortality and failure to rescue.[37] This underlines the importance of maintaining LPN and nurse assistant staffing. After the passage of safe staffing standards in California, most nurses reported that LPN and nurse assistant staffing were maintained or increased, and this may have contributed to improved patient outcomes observed there.[38]

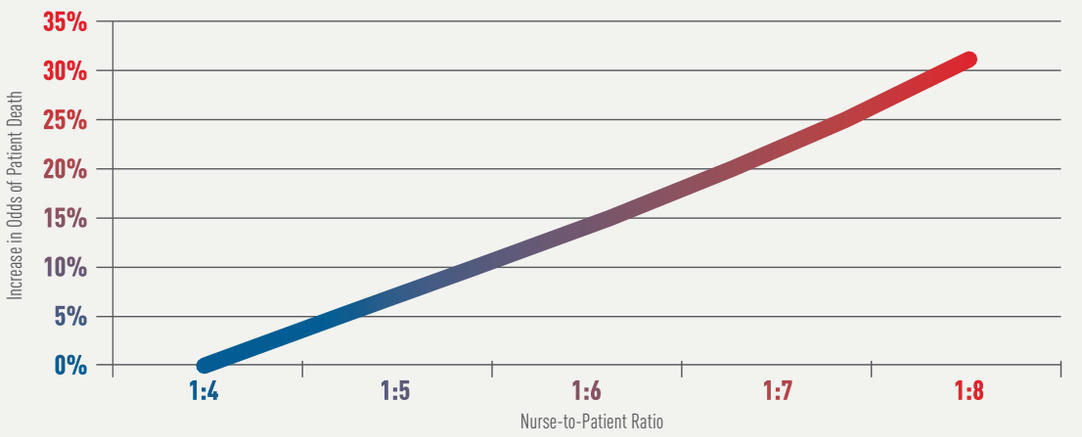
Safe staffing can improve outcomes for poor patients and patients of color

While 92 percent of New Yorkers say there should be consistent staffing levels at all New York hospitals,[39] it appears that staffing varies widely. A 2012 study of over 3,000 U.S. hospitals found that hospitals with the best staffing had more than twice the nursing staff as hospitals with the worst staffing (9.7 nurses per 1,000 patient days versus 4.6 nurses per 1,000 patient days).[40]

In general, safety-net hospitals have worse staffing levels and serve sicker, poorer patients.[41] This can contribute to health disparities. While affluent families can afford to hire private nurses to augment inadequate staffing, most patients at public hospitals cannot.

There is also evidence that inadequate staffing disproportionately affects outcomes for patients of color. Research has shown that black patients are largely concentrated in a small number of hospitals and that these hospitals have lower nurse staffing than hospitals caring for fewer black patients.[42] Additionally, a study of more than half a million patients over 65 having general, orthopedic or vascular surgery found that, controlling for location, black patients experienced higher odds of death with each additional patient per nurse compared to white patients.[43] This suggests that safe staffing standards could contribute to better outcomes for patients of color.

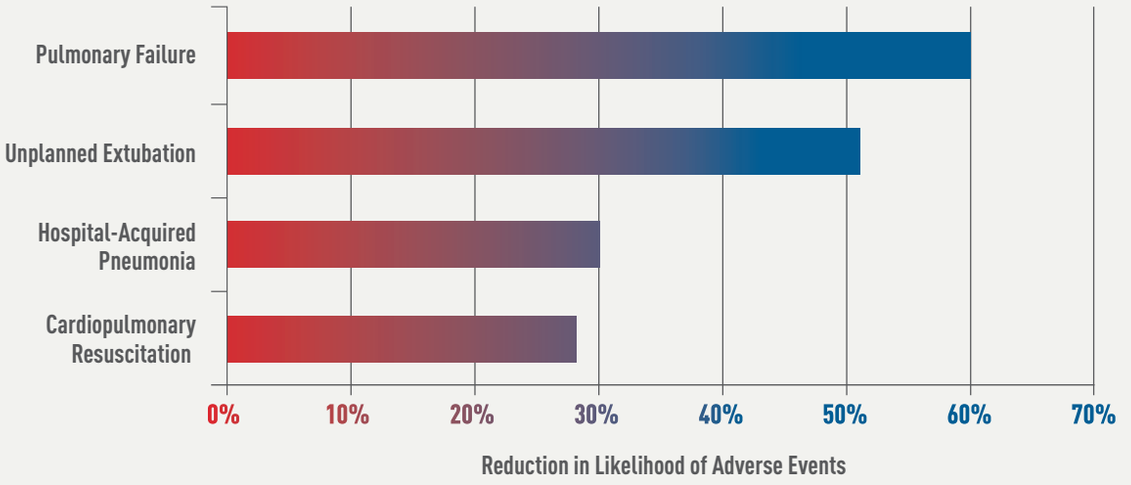
Safe staffing laws have been shown to improve staffing at safety-net hospitals. A 2012 study of the impact of California's safe staffing law found that the legislation increased nurse staffing "in those hospitals in which an improvement in staffing has historically been most difficult and most improvement was needed."[44]



Study found that odds of patient mortality increased by a factor of 1.07 with the addition of one patient per nurse over the average ratio of one nurse to four patients, by a factor of 1.14 with the addition of two patients per nurse, 1.22 with the addition of three patients per nurse and 1.31 with the addition of four patients per nurse. L. Aiken, et al, "Hospital Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," JAMA 2002;288(16)1987-93.

In the ICU: More Nurses, Safer Patients

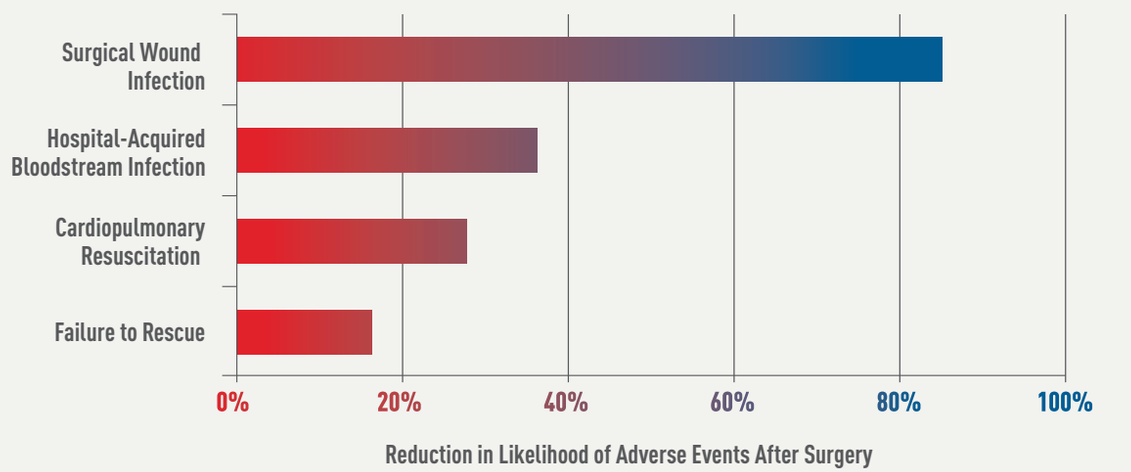
Decreased Likelihood of Adverse Events for ICU Patients with One Additional RN per Patient Day



Patient days are the number of census days that admitted inpatients spend in the hospital. Findings of an analysis combining results from 28 studies of the impact of nurse staffing on patient outcomes. R. Kane, et al, "The Association of Registered Nurse Staffing Levels and Patient Outcomes: Systemic Review and Meta-Analysis," Med Care 2007;45:1195-1204.

After Surgery: More Nurses, Safer Patients

Decreased Likelihood of Adverse Events for Surgical Patients with One Additional RN per Patient Day



Patient days are the number of census days that admitted inpatients spend in the hospital. Findings of an analysis combining results from 28 studies of the impact of nurse staffing on patient outcomes. R. Kane, et al, "The Association of Registered Nurse Staffing Levels and Patient Outcomes: Systemic Review and Meta-Analysis," Med Care 2007;45:1195-1204.

SECTION TWO:

Safe staffing ratios will save money as well as lives

New York's hospitals need to improve care to reduce readmissions and improve outcomes for patients, and research shows that safe staffing is an economical way to make those improvements. There is significant evidence that improved nurse staffing can save money for hospitals, and the health system overall, by improving patient outcomes, especially those that are increasingly tied to hospital reimbursements, and reducing costly nurse turnover and injuries.

Safe staffing is a cost-effective way to improve patient outcomes

- **Increases in hospital nurse staffing levels improved quality and reduced length of stay at no additional cost** in one four-year study. Researchers also found that increasing the number of registered nurses reduced costs.[45]

- **The money saved when patient lives are saved outpaces the cost of increased staffing.** A 2009 study found that the value of lives saved per 1,000 hospitalized patients was 2.5 times higher than the increased cost of one additional RN per patient day in ICUs; 1.8 times higher in surgical units; and 1.3 times in medical units.[46]

- In another study, decreasing the number of patients per nurse from seven to six cost $63,900 per life saved—while other measures cost far more. By way of comparison, it noted that thrombolytic therapy (the breakdown of blood clots by pharmacological means) in a case of acute myocardial infarction (heart attack) costs $182,000 per life.[47]

Safe staffing is common sense in light of new reimbursement rules

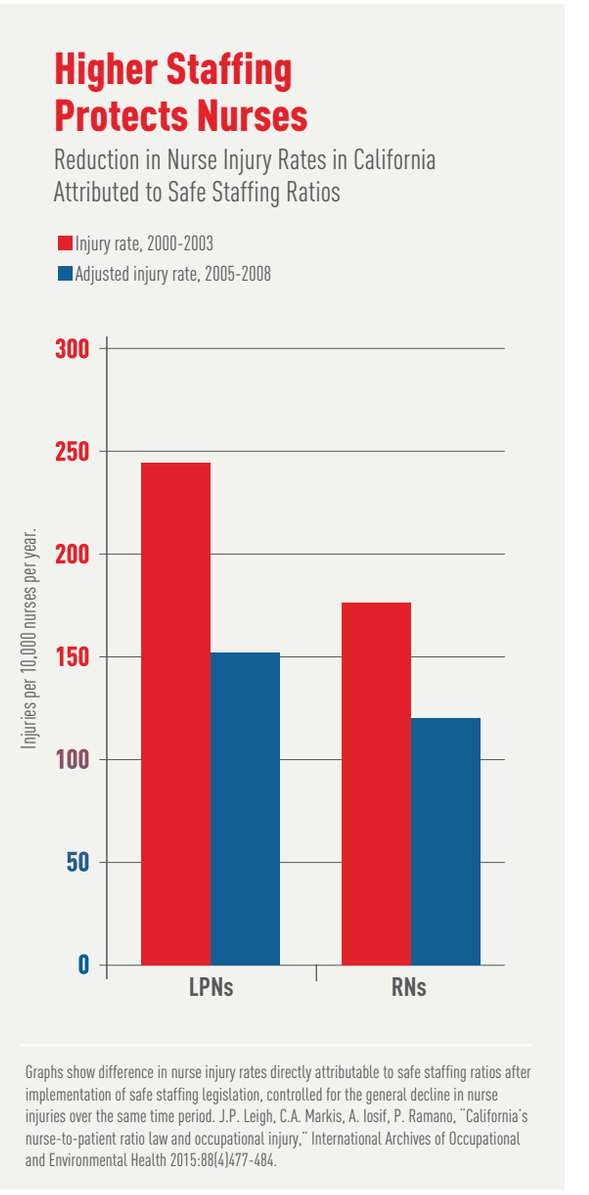
Improved nurse staffing makes even greater economic sense in the context of changing Medicare reimbursement processes under the Affordable Care Act (ACA). Medicare's Value-Based Purchasing programs reward hospitals that provide quality care by tying reimbursements to rates of hospital readmissions, hospital-acquired infections and patient outcomes.[48]

As noted above, the quality measures Medicare considers in its reimbursements are improved by safe nurse staffing. A 2013 study found that under the Affordable Care Act's Hospital Readmissions Reduction Program (HRRP), hospitals with higher nurse staffing had 25 percent lower odds of being penalized for excessive readmissions compared to otherwise similar hospitals with lower staffing.[49] Researchers noted that investment in nursing is a potential system-level intervention to reduce readmissions that policymakers and hospital administrators should consider in the new regulatory environment.

New York hospitals are already being penalized for high rates of potentially avoidable infections and complications such as blood clots, bedsores and falls. In December 2015, Medicare announced it would lower 2016 payments by 1 percent for 46 New York hospitals—approximately one out of four hospitals in the state. More than half of these facilities were also penalized in 2015.[50]

Nurse turnover and burnout are costly

The high cost of nurse turnover is well documented, with studies putting the cost of turnover between $22,000 and over $64,000 per nurse.[51] PricewaterhouseCoopers estimated in



Graphs show difference in nurse injury rates directly attributable to safe staffing ratios after implementation of safe staffing legislation, controlled for the general decline in nurse injuries over the same time period. J.P. Leigh, C.A. Markis, A. Iosif, P. Ramano, "California's nurse-to-patient ratio law and occupational injury," International Archives of Occupational and Environmental Health 2015:88(4)477-484.

2007 that hospitals with low nurse retention rates spend, on average, $3.6 million more per year than hospitals with high retention rates, and that every percent increase in nurse turnover costs an average hospital about $300,000 annually.[52]

Despite this, nurse turnover is on the rise. In a 2014 survey of 141 facilities, covering nearly half a million health care workers and over 100,000 RNs, facilities reported a turnover rate for bedside RNs of 16.4 percent—up from 11.2 percent in 2011. Even higher rates of turnover are seen in behavioral health (49.2 percent), emergency services (21.7 percent), medical/surgical (20.7 percent), and step down (18.5 percent). Researchers report that without intervention, these areas will turn over their RN staff every two to 5.4 years.[53]

Turnover is largely driven by burnout and workload, suggesting that improved safe staffing will keep experienced nurses on the job. Burnout is the frustration, loss of interest, decreased productivity, and fatigue caused by overwork and prolonged stress. A study in Pennsylvania found that an increase of one patient per nurse increased burnout by 23 percent and job dissatisfaction by 15 percent. In turn, 43 percent of nurses who reported high burnout and were dissatisfied with their job intended to leave in the next year, while only 11 percent of those who were not dissatisfied intended to leave.[54]

"The money saved when patient lives are saved outpaces the cost of increased staffing."

Safe staffing can also reduce injuries that cause nurses to be away from work. The Occupational Safety and Health Administration reports that RNs and nurse aides suffer more injuries than almost any other occupation nationwide, and more injuries that keep them away from work.[55] A 2014 study of the impact of California's ratio law on occupational injury found that the ratios were associated with 55.57 fewer occupational injuries and illnesses per 10,000 RNs per year, which is 31.6 percent lower than the number of injuries otherwise expected based on a comparison with national averages.[56]

The Government Accountability Office has found that job dissatisfaction, driven by inadequate staffing, heavy workloads, and increased use of overtime, is a major obstacle to increasing the supply of nurses into the workforce.[57] Safe staffing standards can improve these conditions and bring nurses back to the bedside.

CASE STUDY:
California Hospitals Thrived Under Safe Staffing Legislation

In 2004, California became the first state to implement statewide minimum nurse-to-patient staffing requirements. Prior to the adoption of these standards, there was considerable concern that safe staffing legislation would cause hospitals to close, hurt hospitals' bottom line, gut support staff and not improve patient outcomes.[58]

Those concerns are being echoed by New York hospital management in their lobbying campaign to kill safe staffing legislation in Albany. **But these fears have been shown to be unfounded—research in California has demonstrated that patients have benefited and hospitals have thrived since safe staffing legislation was enacted.**

Nurses in California now care for fewer patients, on average, than they did prior to the legislation—and fewer patients than nurses in other states. The greatest improvements were found in hospitals with the lowest and the highest pre-mandate staffing ratios.[59]

The lower ratios required by the California staffing law resulted in improved patient outcomes—despite increasing acuity.[60]

- **Failure-to-rescue rates improved significantly more** in California hospitals than in comparable hospitals in other states. Hospitals that were the most understaffed prior to regulatory implementation saw a significant decrease in pulmonary embolism/deep vein thrombosis.[61]

- **Emergency room wait times fell** after the new requirements went into effect,[62] and fewer patients left emergency departments without being seen, according to other studies.[63]

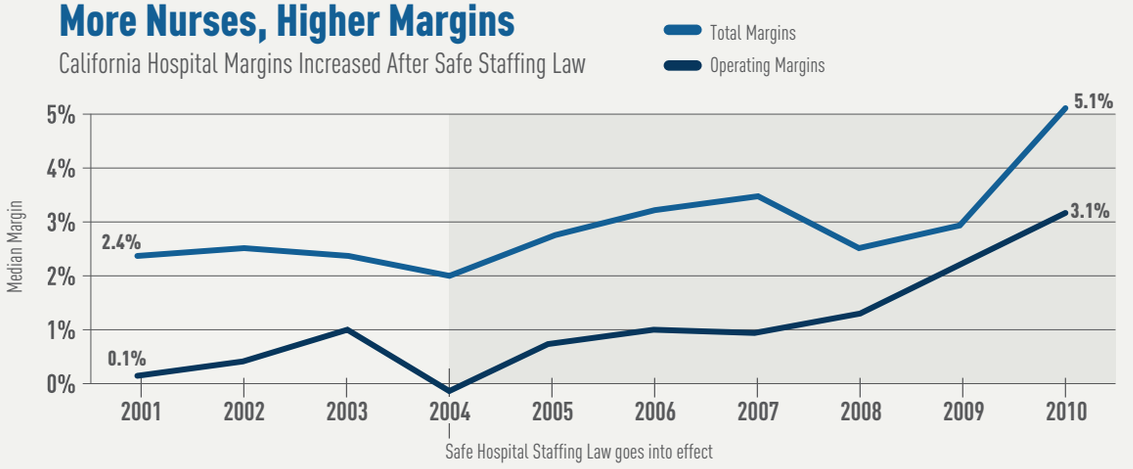
Critically important to the New York debate over staffing legislation, the implementation of the California law did not negatively affect hospital financial performance.

- **No hospitals have closed in California** due to the implementation of its safe staffing law.[64]

- **Staffing requirements had at most a marginal impact on hospital financial stability,** according to a California Healthcare Foundation study five years after the ratios were implemented.[65] The median operating margin for California hospitals tripled from 1 percent in 2003, the year before the ratios went into effect, to 3.1 percent in 2010.[66]

More Nurses, Higher Margins

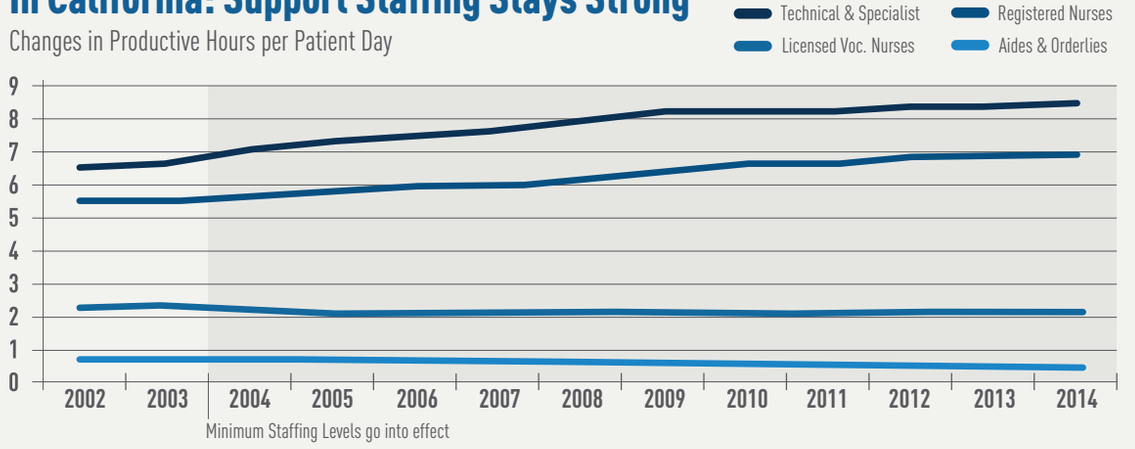
California Hospital Margins Increased After Safe Staffing Law



The operating margin is the percentage of operating revenue that remains as income after operating expenses have been deducted. The total margin is the percentage of all revenue that remains as income after all expenses have been deducted. Source: California Healthcare Foundation, "California Hospitals: Buildings, Beds, and Business," January 2013. Based on OSHPD Hospital Annual Financial Data, 2001-2010.

In California: Support Staffing Stays Strong

Changes in Productive Hours per Patient Day



Productive hours are total hours actually worked. Adjusted days are patient days adjusted for outpatient utilization. Source: California Office of Statewide Health Planning and Development, Hospital Annual Financial Data Pivot Profiles, 2002-2014. Productive hours per adjusted days.

- **Increasing RN staffing does not have a significant impact on hospital profits,** according to academic research.[67]

Nor was ancillary staffing reduced as a result of improved nurse staffing.

- **Employment of licensed vocation nurses (LVNs) and aides has remained stable under the new law.**[68]
- There was **little change overall in LVN, nurse aide or clerical staffing** between 2000 and 2006, after the California law was implemented, according to a 2012 study. Data on staffing levels through 2014 demonstrates that LVN and nurse aide staffing levels have continued to be relatively steady in California hospitals.[69]
- The same study documented an **increase in diagnostic radiology and respiratory therapy staffing.**[70]
- In a survey, **73 percent of nurses reported that levels of support staff either stayed the same or increased after the law** was implemented.
- Additionally, **66 percent of respondents reported that the levels of unlicensed assistive personnel, such as nursing assistants, increased or stayed the same.**[70]

CONCLUSION:
Safe staffing benefits patients, nurses and hospitals

Hospitals and patients face significant challenges, nationally and in New York State. Patients are sicker, nurses report "burnout" and are more likely to leave the profession, and hospital finances are increasingly tied to patient outcomes. New York hospitals are ranked below the national average in key measures of quality patient safety, and most New Yorkers say that hospitals do not have enough nurses.

Safe staffing will address these challenges. Overwhelming evidence shows that higher nurse staffing saves lives, improves patient outcomes and reduces hospital readmissions. The California experience shows legislation establishing safe staffing ratios is an effective way to improve staffing, even in those hospitals that traditionally have the worst staffing and treat the poorest, sickest patients, making safe staffing a matter of health care equity. Nor did the California law reduce essential ancillary staffing.

"Hospitals can thrive by improving staffing."

Hospitals can thrive by improving staffing. There is also ample evidence that the savings associated with saved patient lives and improved outcomes from additional nurse staffing significantly outpace the costs of that staffing. As reimbursements shift to a value-based model, the improved outcomes resulting from safe nurse staffing will directly translate into financial benefit for hospitals. Even before the widespread introduction of outcome-based reimbursements, the California example showed hospitals succeeding with safe staffing. No hospitals closed in California following the implementation of minimum nurse ratios there, and hospital margins have actually improved since the years prior to implementation.

New Yorkers deserve the protection of minimum staffing standards in our hospitals, for ourselves and our loved ones.

ENDNOTES

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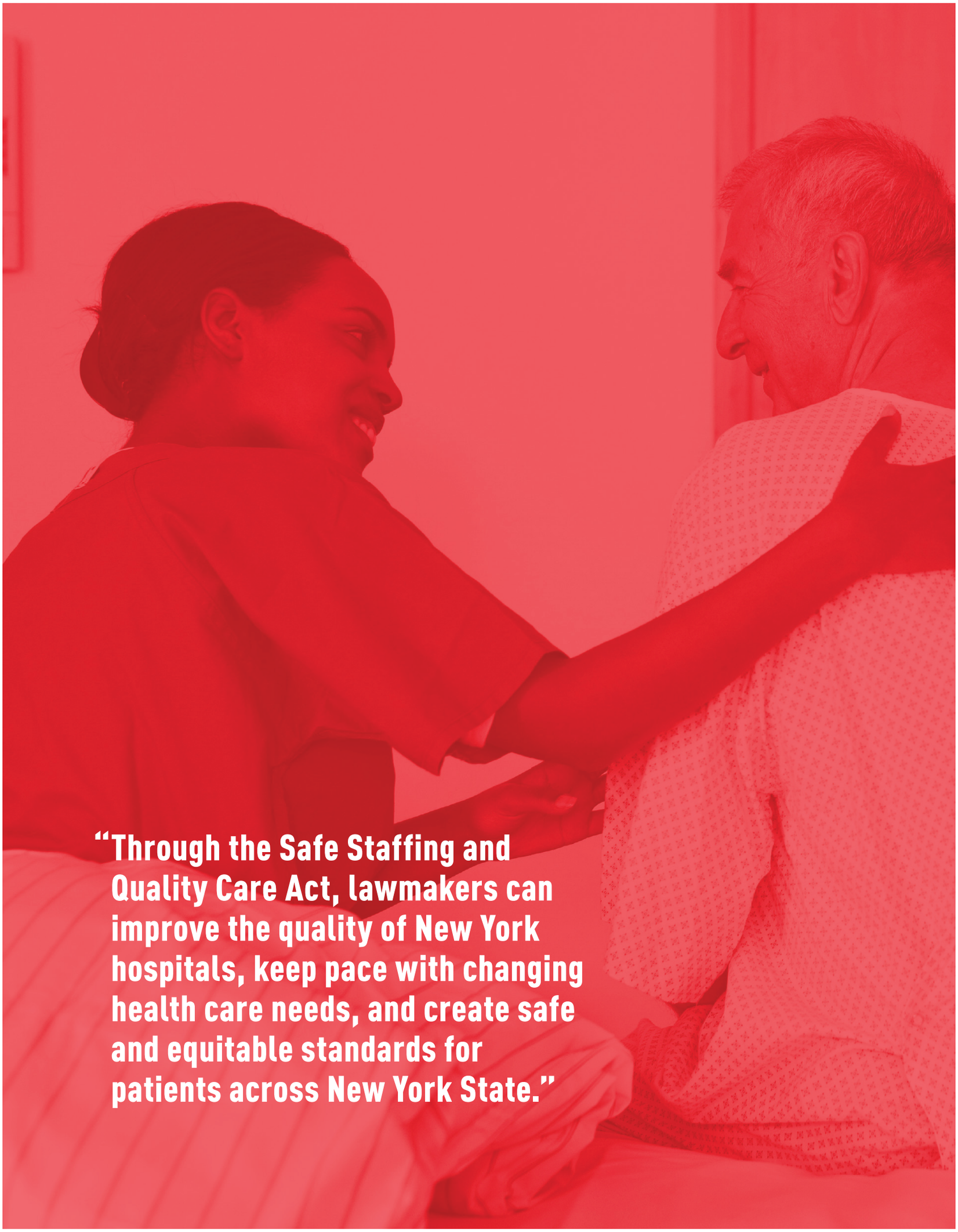

“Through the Safe Staffing and Quality Care Act, lawmakers can improve the quality of New York hospitals, keep pace with changing health care needs, and create safe and equitable standards for patients across New York State.”

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Responding to the Opioid Crisis: The RN's Role (1.0 CH/0.1 CEU)

NYSNA Continuing Education

The New York State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. NYSNA is accredited by the International Association for Continuing Education and Training (IACET) and is authorized to issue the IACET CEU.

This course has been awarded 1.0 contact hours and 0.1 CEU and is intended for RNs and other healthcare providers. In order to receive contact hours/CEU participants must read the course material, complete and return the post-test answer sheet with a score of 80% or better, and submit the completed evaluation for this course. The completed post-test answer sheet and evaluation must be returned to NYSNA at the conclusion of the program.

NYSNA wishes to disclose that no commercial support was received.

Introduction

The US Department of Health and Human Services has identified Opioid abuse as a serious public health issue. Drug overdose deaths are the leading cause of injury and death in the United States. Prevention, treatment, research, and effective responses to rapidly reverse opioid overdoses are critical to fighting the epidemic. Nurses as patient defenders and the most trusted professionals, are committed to help treat and prevent opioid dependence and overdoses which have grown to epidemic proportions. This NY case study will review the role of an RN in responding to this public health crisis.

Course Objective

At the completion of this learning activity the learner will be able to:

- Recognize the NY State Law requirements of registered nurses in regards to medical protocols of drug treatment.
- List two of the indicators of when an opioid overdose can occur and two of the signs of opioid overdose.
- Identify two of the actions nurses working as community advocates, educator and providers of critical public health services can take to address the opioid epidemic.

About the Author

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Mary Lewis is a Labor Educator for the New York State Nurses Association (NYSNA) and has 45 years' experience in the labor movement and community organizing. In her role, she has created, presented and evaluated workshops for nurses and healthcare professional practitioners on various topics of interest related to labor and employment law, leadership skills, internal organizing and conflict resolution.

As a member of NYSNA's Labor Education Team, her current focus is on hospital and healthcare economics, healthcare disparities, safe staffing advocacy, climate change and union member leadership skills.

Ms Lewis received her Master of Arts Degree from Farleigh Dickinson University and her Bachelor of Arts Degree from Rutgers University. She holds certification as a consultant and trainer from the UAW-GM Center for Human Resources. She also holds certification as a health and safety trainer from the International Chemical Workers Union Center (ICWUC).

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The Online Journal of Issues in Nursing
A Scholarly Journal of the American Nurses Association

Legislative: Responding to the Fatal Opioid Overdose Epidemic: A Call to Nurses

Angela Clark, MSN, RN

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People who weren't familiar with the opioid overdose epidemic were shocked by the tragic death of Philip Seymour Hoffman. Many of my friends and co-workers (who know I work with clients suffering from opioid dependence) asked me what I thought of his death. I took this opportunity to explain to them that Mr. Hoffman's death was in no way a solitary event. Drug poisoning (overdose) has now surpassed motor vehicle accidents as the leading cause of accidental-injury death in the United States (US); approximately 41 people die every day of a drug overdose involving prescription painkillers (CDC, 2012; Paulozzi, 2012). In the state of Ohio, approximately five people per day fall victim to fatal, opioid-related overdoses; and in my county in Ohio, we lose an average of one person every other day (Ohio Department of Health, 2013).

Opioid overdoses affect individuals, families, friends, and communities. The societal costs of opioid overdoses exceed 20 billion dollars annually; everyone is affected in some capacity (Inocencio, Carroll, Read, & Holdfored, 2013). Nurses have a social responsibility for the holistic welfare of all individuals. Given the widespread and multifaceted reach of care delivery, nurses are uniquely positioned to combat the opioid overdose epidemic on many fronts. This column will discuss how nurses are well positioned both to address the opioid epidemic and support the use of naloxone to reverse opioid-related overdoses and also to promote legislation to increase access to naloxone and decrease fatal opioid overdoses.

Nurses are encouraged to become active in the prevention of opioid-related overdoses and to incorporate overdose prevention into their daily practice. Both prescription and illicit opioids, including heroin, morphine, codeine, methadone, hydrocodone, oxycodone, hydromorphone, and fentanyl, contribute to the fatal opioid overdose epidemic. When someone is experiencing an opioid overdose, a potentially fatal cyanotic cascade of events ensues: breathing slows, oxygen levels in the blood decrease, and oxygenation to vital organs decreases. Within minutes unconsciousness, brain damage, coma, and death may follow (Harm Reduction Coalition, 2013). Respiratory depression is the hallmark symptom of an opioid overdose. Overdoses, in which a person has not ingested opioids, cause respiratory depression infrequently. Opioid overdoses are rarely immediate; and there is usually of window of time to intervene. Naloxone hydrochloride, brand name Narcan®, is a Food and Drug

Administration-approved medication which, if administered in time, has the potential to effectually reverse opioid overdoses, allowing victims to receive the treatment they need (Boyer, 2012).

In 1996, community-based opioid overdose prevention programs (OOPPs) began distributing naloxone to individuals who are at high risk for witnessing an opioid overdose. Naloxone distribution has now reached over 50,000 individuals; over 10,000 overdose reversals have been reported (Wheeler, Davidson, Jones, & Irwin, 2012). Opioid overdose programs aim to teach those people who are at risk for witnessing an overdose how to prevent overdoses, recognize overdoses, respond appropriately to overdoses, and administer naloxone to reverse overdoses. Data from the 188 OOPPs in the United States indicates that people can and are willing to respond to overdoses, and that OOPP participants are saving lives by reversing overdoses (Wheeler et al., 2012).

Naloxone is safe, effective, and has no abuse potential; yet there remain barriers and opposition to preventing the widespread dissemination of naloxone to the public. First, opponents often argue that naloxone distribution provides people with a 'license to use' opioids. However there is no evidence to support this claim, and research indicates that participants in opioid overdose prevention programs report decreased heroin use (Seal et al., 2005). A nurse-led, opioid-overdose-prevention program in Ohio has adopted the slogan 'Prevention not Permission.' The program stresses the importance of preventing fatalities using naloxone as a lifeline to recovery. Winstanley's presentation (2014) to the Ohio House of Representatives described the value of naloxone in preventing opioid-overdose fatalities. Reversing an overdose with naloxone 'buys' healthcare providers another opportunity to provide treatment, and we know that with adequate time, treatment works.

Secondly, opponents of naloxone often invoke the 'choice argument,' claiming that initial use may have been a personal choice. However, it is important to remember that many cases of opioid dependence begin with the pharmacological treatment of pain. Over time, opioid use changes the functions of the brain leading to physical dependence and tolerance. Under certain circumstances, opioid dependence will progress to opioid addiction. Addiction is a disease of the brain that is progressive, chronic, and often fatal. Naloxone is the best means of preventing opioid-related overdoses. Nurses must be at the forefront increasing the dissemination of naloxone to those who are at risk for witnessing fatal overdoses.

Nurses are encouraged to get involved in legislation to increase access to naloxone. Contact your state representatives to find out which bills expand access to naloxone. In the state of Ohio, House Bill 170 aims to increase access to naloxone to family and friends of users, law enforcement officials, and emergency medical responders. To assist with successful adoption of this bill, written testimony outlining the safety of naloxone was submitted to the Medicaid, Health & Human Services Committee. An example of Dr. Erin Winstanley's testimony in support of HB 170 is available online.

Nurses are also encouraged to support other legislation aimed at alleviating the burden of opioid overdoses. The state of Ohio has 16 bills in the Ohio legislature that aim to decrease overdoses by targeting other areas besides naloxone. These areas include: substance abuse treatment, neonatal abstinence syndrome, chronic pain treatment, prescription drug abuse awareness education, and disclosure of drug addictiveness. Nurses providing testimony that raises awareness of the impact of the opioid epidemic and potential for this legislation to address this concern will promote a willingness to adopt these bills.

Good Samaritan laws in 17 states and the District of Columbia protect people acting in good faith during an opioid-related overdose (Davis, 2014). The Public Health Law Research (n.d.) website provides helpful information about Good Samaritan Laws related to drug overdose events. For more information on Good Samaritan laws in your state visit this website. More states are also considering medical amnesty laws that protect from liability those who seek medical attention as a result of illegal actions. Know the laws in your state. Work with officials at the state and community levels to communicate these laws to the public to decrease the fears associated with notifying emergency responders during overdose events. Research has shown that despite training, participants in OOPPs are hesitant to contact emergency responders for fear of police involvement (Sherman et al., 2008).

Incorporate overdose prevention into your everyday practice. Assess your agency's plan for responding to on-site overdose. If your agency does not have a plan, develop a policy and a plan. Additionally, it is important to integrate overdose prevention messages into conversations with patients, teach patients the risks factors for overdose, and prepare your patients to recognize the signs and symptoms of an opioid overdose and to respond appropriately if someone is experiencing an overdose. It is also important that nursing educators include opioid-overdose-prevention-training and naloxone administration in the curriculum.

Fatal opioid overdoses have reached epidemic proportions. However, through educational efforts and naloxone distribution overdoses can be prevented. Nurses, because of our unique hold in a variety of settings, have the ability to greatly impact opioid overdoses. Naloxone is a lifeline that allows us the opportunity to save lives and provide patients with the treatment they need in order to regain their lives.

Author

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Ms. Clark is a doctoral candidate in the College of Nursing at the University of Cincinnati in OH. Angela received her BSN and MSN degrees from the University of Tennessee, Knoxville. In her nine years of clinical and public health nursing experience, she has focused on the identification and treatment of at-risk communities and individuals. She remains an advocate for the public's health by emphasizing harm reduction strategies and focusing her primary research on substance abuse. Ms. Clark's interest in addiction ranges from the genetics and genomics of addiction to the treatment and harm-reduction efforts for addiction. She is currently working with an interdisciplinary team of researchers, evaluating an inpatient opioid-overdose-prevention program (OOPP). Her dissertation research will advance these interests as she develops an educational tool for OOPPs. Ms. Clark has recently published two articles in the *Journal of Addiction Medicine* addressing OOPPs.

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NYSED.gov

Office of the Professions

Practice Information

Non-Patient Specific Orders and Protocols

Professions: RNs, LPNs, CNSs & NPs

General Information

In most cases, New York State law requires a registered professional nurse (RN) to execute medical regimens (i.e., administer medications, medical treatments or tests) that are ordered for a specific patient by a physician or other qualified health care practitioner who has examined the patient. In addition, an RN cannot execute medical protocols that allow the RN to make medical diagnoses or perform medical services that are outside the scope of practice of the RN.

However, New York law allows RNs to execute non-patient specific orders and protocols, ordered by a physician or nurse practitioner, for administering: (1) immunizations; (2) anaphylaxis treatment; (3) TB tests; (4) HCV tests; (5) HIV tests; and, (6) opioid related overdose treatment. The ordering physician or nurse practitioner is not required to examine or have a treatment relationship with the recipient of the ordered tests or treatments.

Requirements for Non-Patient Specific Orders and Protocols

All non-patient specific orders and protocols must be in writing. Non-patient specific orders should include, at a minimum, the following:

- The name, license number and signature of the physician or nurse practitioner authorizing the non-patient specific order and protocol;
- Information concerning: (1) the name, dose and route of administration of the specific immunizing agent(s), anaphylactic agent(s), opioid overdose drug(s), TB test(s), HCV test(s) or HIV test(s) to be administered; (2) the time period that the order will be in effect, including start and end dates; and, (3) the group of persons to be treated pursuant to the order (i.e., students at X college, pediatric patients at X medical practice, employees of X corporation, residents of X nursing home, etc.);
- Identification of the RNs authorized to execute the orders by: (1) including the name(s) and license number(s) of RNs authorized to administer the ordered tests or treatments; **or** (2) identifying the health care provider that employs or contracts with the RNs who implement the order (i.e., X medical practice, X hospital's inpatient pediatric unit); and,

- A protocol for executing the order or a specific reference to a separate written protocol for executing the order.

Protocols should, at a minimum, address the following:

- *Initial Screening* The protocol must include criteria for screening or assessing potential recipients for eligibility for (and contraindications to) the ordered test or treatment.
- *Pre-Test/ Pre -Treatment Counseling* The protocol must include information regarding the health risks and benefits of the ordered test or treatment, which must be disclosed to potential recipients (or legally responsible person for a child or other potential recipient who lacks capacity to consent to testing or treatment).
- *Informed Consent* The protocol must define criteria for obtaining informed consent from the potential recipient (or legally responsible person for a potential recipient who lacks capacity to consent to testing or treatment). In some cases, such as HCV screening in a hospital, a protocol may permit documentation of informed consent for testing or treatment be covered under "general consent" form. An RN is not required to obtain informed consent during an emergency in order to provide anaphylactic treatment or opioid overdose related treatment to a person who is not capable of consenting.
- *Clinical Instructions* The protocol should include necessary instructions for administering the ordered test or treatment and also address relevant storage and handling requirements for equipment and supplies needed to implement the ordered test or treatment.
- *Documentation* The protocols must describe record keeping and medical documentation requirements that apply to recipients as well as to potential recipients who do not qualify for, or who refuse the ordered test or treatment. The medical record of a recipient of an ordered tests or treatment should include: the non-patient specific order and protocol; the recipient's name; applicable documentation informed consent; the date, time and type of treatment or test that was administered; and, the administering nurse.
- *Post-Test or Post-Treatment Actions* The protocol must describe applicable follow up actions to be undertaken by an RN such as, post- test counseling, disclosing test results, referring patients for follow-up care or disclosing information to other health care providers.

Information for Nurses

An RN who is responsible for implementing a non-patient specific order and protocol may assign licensed practical nurses (LPNs) to help (i.e., administer the ordered test or treatment, recordkeeping), provided that the RN performs required nursing assessments of potential recipients for eligibility for (and contraindications to) the ordered test or treatment. The RN must provide on-site direction to the LPN, except in emergency situations. A ratio of no more than three LPNs to one RN should be maintained.

If an RN is self-employed and is the "provider of record" of the ordered test or treatment, the RN shall be responsible for complying with applicable documentation, recordkeeping, reporting and other relevant requirements set forth in law.

Opioid Related Overdose Treatment

Opioid related overdose treatment includes the urgent or emergency administration of naloxone or another drug approved by the federal Food and Drug Administration to treat opioid related overdose to a person who is experiencing an opioid related overdose or is suspected of experiencing an opioid related overdose. RNs who administer opioid related overdose treatment (or who direct LPNs to administer opioid related overdose treatment) should be currently certified in CPR or BCLS or have received CPR training by health facility in-service departments.
When administering opioid related overdose treatment pursuant to a non-patient specific order and protocol, the RN should:

- Administer the ordered opioid related overdose treatment in an emergency, if the recipient of the treatment is not capable of giving informed consent.
- Arrange for immediate follow-up care (i.e., by contacting an emergency medical service provider and reporting the recipient's name, and the name, time, dose[s] and strength of the opiate antagonist drug administered and route of administration).
- Ensure that a record is maintained of all recipients of opioid related overdose treatment, which includes, at a minimum: the non-patient specific order and protocol, the recipient's name, date, the address of administration site, the name of the administering nurse, and the opiate antagonist drug administered.

Additional information regarding opioid related overdose treatment is available on the New York State Department of Health website. www.health.ny.gov.

Information for Pharmacists

Pharmacists may provide syringes, needles, medications and other supplies needed by RNs to execute non-patient specific orders and protocols. The sale of these immunization agents, medications, needles and syringes may be considered a wholesale transaction. However, a wholesale registration from the State Board for Pharmacy will not be necessary for these transactions.

In addition, qualified pharmacists may execute a non-patient specific regimen prescribed or ordered by a physician or nurse practitioner for administering certain immunizing agents, including influenza, pneumonia, diphtheria, pertussis, tetanus, meningococcal and herpes zoster vaccines. For more information, please visit the New York State Pharmacy Board website. http://www.op.nysed.gov/prof/pharm/

References: Education Law §6909, §6801 and 8 NYCRR §64.7.

Last Updated: June 27, 2016

What Does the 911 Good Samaritan Law Do?

The bill includes immunity protections from *charge and prosecution* for possession of drugs up to and including an A2 felony offense (possession of up to 8 oz of a controlled substance); alcohol (for underage drinkers); marijuana (any amount); paraphernalia offenses; and *sharing* of drugs (in NY sharing constitutes a "sales" offense).

There are some specific drug charges for which there are NO PROTECTIONS: People in possession of A1 felony amounts of narcotics (NOT marijuana) – this means possessing 8 oz or more of a controlled substance – are NOT protected from charge and prosecution. An A1 felony is the most serious of all felony charges.

Does the law protect against arrest?

In limited circumstances, yes. The new 911 Good Samaritan law protects against *arrest* for misdemeanor amounts of controlled substances (very small and residual amounts), but *not* misdemeanor amounts of marijuana.[7] For example, possessions up to 3.5 grams of cocaine and up to 3.5 grams of heroin are misdemeanor drug possession offenses.

The original version of the bill proposed protections from arrest for felony narcotic drug possession – but this provision was reduced to only misdemeanor amounts of narcotic drugs in the final negotiations around the legislation.

Does the law's protection extend to an open warrant for my arrest or for a parole or probation violation?

Unfortunately, the law does not provide protection from arrest for an open warrant. There is also no specific protection for a parole or probation violation.

What happens if I'm accused of selling drugs when I call 911 during an overdose?

The bill includes affirmative defense *for sales of a controlled substance or marijuana* when the defendant seeks medical help during an overdose situation. This means that if a person is accused of a drug sales crime or a marijuana sales crime because of evidence discovered at the scene of an overdose, they can be acquitted if they prove that they called for medical help during the overdose.

What isn't Covered Under this Law?

Exclusions from this provision: A1 and A2 sales offenses, but the act of seeking medical help during an overdose is included as a **mitigating factor** for these offenses during sentencing. This means that, in the court proceedings, the defendant can ask the judge to consider, during sentencing, the fact that the defendant called 911 in order to save a life.

Also excluded: the individual cannot be previously convicted for an A1, A2, or B drug felony sales or attempted sales offense.

Who Supports this Law?

The legislation received unusual bi-partisan support across New York. The legislation passed the New York Senate unanimously, and passed the Assembly with only 2 "no" votes. The bill sponsors and co-sponsors range from the most conservative to the most progressive legislators in the state. Particularly strong support for the legislation came from Long Island, New York City and the Syracuse area. This means that these legislators – Republicans and Democrats alike – want to support strategies to prevent fatal overdoses and are allies on overdose prevention.

Law enforcement largely opposed the legislation. Governor Cuomo supported it. Some law enforcement officials expressed concern with the bill and opposed its passage. In his message approving the legislation, Governor Cuomo outlined why a health-based approach was needed. "The benefit to be gained by the bill – saving lives – must be paramount," he wrote. In essence, saving lives requires prioritizing a health-based approach over a criminal justice approach. The governor also took a step toward effective implementation, instructing the Division of Criminal Justice Services to conduct training so law enforcement officials understand the new law. This is similar to such implementation practices included in the syringe access bill enacted last year.

What Does this Mean for Preventing Fatal Overdoses in New York?

This new law creates an important opportunity to save lives. But it also will foster increased discussion about effective measures to prevent fatal drug overdoses. For this law to work, people have to know about it. They have to understand that they should call 911 in an emergency. Service providers must understand what the law does and doesn't do, and be able to share that information with their clients. Defense attorneys must understand the law and the protections it provides their clients. And – crucially – law enforcement officials must understand that the New York State Legislature and Governor Andrew Cuomo have made it very clear that saving lives is more important than arrest and prosecution for simple drug or alcohol possession. In short, for this law to work, implementation must be taken up by harm reduction practioners, treatment providers, advocates, government agencies and community members.

Making Sure 911 Good Samaritan Is Implemented Effectively – and Works

The original version of the bill protected against arrest for alcohol or any drug possession. This bill does not, but it is more far-reaching than similar laws in New Mexico or Washington – only in New York is a person protected against arrest when holding a *residual* amount of drugs, and only in New York is a person protected against charge and prosecution for "sharing" drugs (charged as a sales offense). But as of now, there are no states that protect against arrest for possession of small amounts of drugs.

To make this work, we need buy-in from two key stakeholders: the witnesses of overdose and law enforcement. If witnesses of an overdose are afraid to call for medical help or don't know that they should call for emergency services immediately, then a life could be lost. And if law enforcement officials don't understand the new law, they'll continue arresting and prosecuting folks at an overdose scene, leading to legitimate fear of calling 911 in an overdose situation, which will lead to more unnecessary deaths. Thus meetings with police and prosecutors are an urgent priority – as is more robust public education efforts for preventing overdose fatalities.

What You Can Do

- Make sure your clients know to call 911 in the event of an overdose!
- Contact your local Health Department to find out if they know about the new law and discuss its implementation.
- Reach out to local law enforcement, including your District Attorney's office and police precinct, to discuss the new law and its implementation. They will likely welcome hearing from experts in preventing overdose fatalities who can educate them about accidental drug overdose and policies to save lives such as the 911 Good Samaritan law and naloxone.
- Join the Purple Ribbons for Overdose Prevention campaign on Facebook: http://www.causes.com/causes/209554

To learn more about the new 911 Good Samaritan law and how to get involved with its implementation, or if you've been in an overdose situation and think you qualify for limited immunity, contact Evan Goldstein of the Drug Policy Alliance at egoldstein@drugpolicy.org, or 212.613.8038

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[4] Paone D, Heller, et al. page 3.

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[7] Private possession of up to 25 grams of marijuana is a violation, *not* a criminal offense.

SAMHSA

Opioid Overdose

TOOLKIT

Facts for Community Members

Five Essential Steps for First Reponders

Information for Prescribers

Safety Advice for Patients & Family Members

Recovering from Opioid Overdose

Substance Abuse and Mental Health Services Administration
SAMHSA
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ACKNOWLEDGMENTS

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SCOPE OF THE PROBLEM

Opiate overdose continues to be a major public health problem in the United States. It has contributed significantly to accidental deaths among those who use, misuse or abuse illicit and prescription opioids. In fact, U.S. overdose deaths involving prescription opioid analgesics increased to about 17,000 deaths a year in 2010 [1, 2], almost double the number in 2001 [1]. This increase coincided with a nearly fourfold increase in the use of prescribed opioids for the treatment of pain [3].

WHAT ARE OPIOIDS? Opioids include illegal drugs such as heroin, as well as prescription medications used to treat pain such as morphine, codeine, methadone, oxycodone (Oxycontin, Percodan, Percocet), hydrocodone (Vicodin, Lortab, Norco), fentanyl (Duragesic, Fentora), hydromorphone (Dilaudid, Exalgo), and buprenorphine (Subutex, Suboxone).

Opioids work by binding to specific receptors in the brain, spinal cord and gastrointestinal tract. In doing so, they minimize the body's perception of pain. However, stimulating the opioid receptors or "reward centers" in the brain also can trigger other systems of the body, such as those responsible for regulating mood, breathing and blood pressure.

HOW DOES OVERDOSE OCCUR? A variety of effects can occur after a person takes opioids, ranging from pleasure to nausea, vomiting, severe allergic reactions (anaphylaxis) and overdose, in which breathing and heartbeat slow or even stop.

Opioid overdose can occur when a patient deliberately misuses a prescription opioid or an illicit drug such as heroin. It also can occur when a patient takes an opioid as directed, but the prescriber miscalculated the opioid dose or an error was made by the dispensing pharmacist or the patient misunderstood the directions for use.

Also at risk is the person who takes opioid medications prescribed for someone else, as is the individual who combines opioids — prescribed or illicit — with alcohol, certain other medications, and even some over-the-counter products that depress breathing, heart rate, and other functions of the central nervous system [4].

WHO IS AT RISK? Anyone who uses opioids for long-term management of chronic cancer or non-cancer pain is at risk for opioid overdose, as are persons who use heroin [5]. Others at risk include persons who are:

- Receiving rotating opioid medication regimens (and thus are at risk for incomplete cross-tolerance).
- Discharged from emergency medical care following opioid intoxication or poisoning.
- At high risk for overdose because of a legitimate medical need for analgesia, coupled with a suspected or confirmed history of substance abuse, dependence, or non-medical use of prescription or illicit opioids.
- Completing mandatory opioid detoxification or abstinent for a period of time (and presumably with reduced opioid tolerance and high risk of relapse to opioid use).
- Recently released from incarceration and a past user or abuser of opioids (and presumably with reduced opioid tolerance and high risk of relapse to opioid use).

Tolerance develops when someone uses an opioid drug regularly, so that their body becomes accustomed to the drug and needs a larger or more frequent dose to continue to experience the same effect.

Loss of tolerance occurs when someone stops taking an opioid after long-term use. When someone loses tolerance and then takes the opioid drug again, they can experience serious adverse effects, including overdose, even if they take an amount that caused them no problem in the past.

STRATEGIES TO PREVENT OVERDOSE DEATHS

STRATEGY 1: Encourage providers, persons at high risk, family members and others to learn how to prevent and manage opioid overdose. Providers should be encouraged to keep their knowledge current about evidence-based practices for the use of opioid analgesics to manage pain, as well as specific steps to prevent and manage opioid overdose.

Federally funded Continuing Medical Education courses are available to providers at no charge at http://www.OpioidPrescribing.com (six courses funded by the Substance Abuse and Mental Health Services Administration) and on MedScape (two courses funded by the National Institute on Drug Abuse).

Helpful information for laypersons on how to prevent and manage overdose is available from Project Lazarus at http://projectlazarus.org/ or from the Massachusetts Health Promotion Clearinghouse at http://www.maclearinghouse.org.

Encourage providers and others to learn about preventing and managing opioid overdose.

STRATEGY 2: Ensure access to treatment for individuals who are misusing or addicted to opioids or who have other substance use disorders. Effective treatment of substance use disorders can reduce the risk of overdose and help overdose survivors attain a healthier life. Medication-assisted treatment, as well as counseling and other supportive services, can be obtained at SAMHSA-certified and DEA-registered opioid treatment programs (OTPs), as well as from physicians who are trained to provide care in office-based settings with medications such as buprenorphine and naltrexone.

Information on treatment services available in or near your community can be obtained from your state health department, state alcohol and drug agency, or from the federal Substance Abuse and Mental Health Services Administration (see page 7).

Ensure access to treatment for individuals who are misusing or addicted to opioids or who have other substance use disorders.

STRATEGY 3: Ensure ready access to naloxone. Opioid overdose-related deaths can be prevented when naloxone is administered in a timely manner. As a narcotic antagonist, naloxone displaces opiates from receptor sites in the brain and reverses respiratory depression that usually is the cause of overdose deaths [5]. *During the period of time when an overdose can become fatal, respiratory depression can be reversed by giving the individual naloxone* [4].

On the other hand, naloxone is *not* effective in treating overdoses of benzodiazepines (such as Valium, Xanax, or Klonopin), barbiturates (Seconal or Fiorinal), clonidine, Elavil, GHB, or ketamine. It also is not effective in overdoses with stimulants, such as cocaine and amphetamines (including methamphetamine and Ecstasy). However, if opioids are taken in combination with other sedatives or stimulants, naloxone may be helpful.

Naloxone injection has been approved by FDA and used for more than 40 years by emergency medical services (EMS) personnel to reverse opioid overdose and resuscitate persons who otherwise might have died in the absence of treatment [6].

Naloxone has no psychoactive effects and does not present any potential for abuse [1, 4]. Injectable naloxone is relatively inexpensive. It typically is supplied as a kit with two syringes, at a cost of about $6 per dose and $15 per kit [7].

For these reasons, it is important to determine whether local EMS personnel or other first responders have been trained to care for overdose, and whether they are allowed to stock naloxone in their drug kits. In some jurisdictions, the law protects responders from civil liability and criminal prosecution for administering naloxone. So-called "Good Samaritan" laws are in effect in 10 states and the District of Columbia, and are being considered by legislatures in at least a half-dozen other states [8]. Such laws provide protection against prosecution for both the overdose victim and those who respond to overdose. To find states that have adopted relevant laws, visit the CDC's website at: http://www.cdc.gov/HomeandRecreationalSafety/Poisoning/laws/immunity.html.

Encourage the public to call 911.

STRATEGY 4: Encourage the public to call 911. An individual who is experiencing opioid overdose needs immediate medical attention. An essential first step is to get help from someone with medical expertise as quickly as possible [9, 10]. Therefore, members of the public should be encouraged to call 911. All they have to say is, "Someone is not breathing" and give a clear address and location.

Encourage prescribers to use state Prescription Drug Monitoring Programs.

STRATEGY 5: Encourage prescribers to use state Prescription Drug Monitoring Programs (PDMPs). State Prescription Drug Monitoring Programs (PDMPs) have emerged as a key strategy for addressing the misuse and abuse of prescription opioids and thus preventing opioid overdoses and deaths. Specifically, prescribers can check their state's PDMP database to determine whether a patient is filling the prescriptions provided and/or obtaining prescriptions for the same or similar drug from multiple physicians.

While a majority of states now have operational PDMPs, the programs differ from state to state in terms of the exact information collected, how soon that information is available to physicians, and who may access the data. Therefore, information about the program in a particular state is best obtained directly from the state PDMP or from the board of medicine or pharmacy.

RESOURCES FOR COMMUNITIES

Resources that may be useful to local communities and organizations are found at the following websites:

Substance Abuse and Mental Health Services Administration (SAMHSA)
National Treatment Referral Helpline
1-800-662-HELP (4357) or 1-800-487-4889
(TDD — for hearing impaired)

National Substance Abuse Treatment Facility Locator:
http://www.findtreatment.samhsa.gov/TreatmentLocator to search by state, city, county, and zip code

Buprenorphine Physician & Treatment Program Locator:
http://www.buprenorphine.samhsa.gov/bwns_locator

State Substance Abuse Agencies:
http://findtreatment.samhsa.gov/TreatmentLocator/faces/abuseAgencies.jspx

Center for Behavioral Health Statistics and Quality (CBHSQ):
http://www.samhsa.gov/data/

SAMHSA Publications: http://www.store.samhsa.gov
1-877-SAMHSA (1-877-726-4727)

Centers for Disease Control and Prevention (CDC)
http://www.cdc.gov/Features/VitalSigns/PainkillerOverdoses
http://www.cdc.gov/HomeandRecreationSafety/Poisoning

White House Office of National Drug Control Policy (ONDCP)
State and Local Information: http://www.whitehouse.gov/ondcp/state-map

Association of State and Territorial Health Officials (ASTHO)
Prescription Drug Overdose: State Health Agencies Respond (2008):
http://www.astho.org

National Association of State Alcohol and Drug Abuse Directors (NASADAD)
State Issue Brief on Methadone Overdose Deaths:
http://www.nasadad.org/nasadad-reports

National Association of State EMS Officials (NASEMSO)
National Emergency Medical Services Education Standards:
http://www.nasemso.org

American Association for the Treatment of Opioid Dependence (AATOD)
Prevalence of Prescription Opioid Abuse: http://www.aatod.org/

Resources that may be useful to local communities and organizations...

FIVE ESSENTIAL STEPS FOR FIRST RESPONDERS

Overdose is common among persons who use illicit opioids such as heroin and among those who misuse medications prescribed for pain, such as oxycodone, hydrocodone, and morphine. The incidence of opioid overdose is rising nationwide. For example, between 2001 and 2010, the number of poisoning deaths in the United States nearly doubled, largely because of overdoses involving prescription opioid analgesics [1]. This increase coincided with a nearly fourfold increase in the use of prescribed opioids for the treatment of pain [3].

To address the problem, emergency medical personnel, health care professionals, and patients increasingly are being trained in the use of the opioid antagonist naloxone hydrochloride (naloxone or Narcan), which is the treatment of choice to reverse the potentially fatal respiratory depression caused by opioid overdose. (Note that naloxone has no effect on non-opioid overdoses, such as those involving cocaine, benzodiazepines, or alcohol [11].)

Based on current scientific evidence and extensive experience, the steps outlined below are recommended to reduce the number of deaths resulting from opioid overdoses [2, 4, 7, 12-14].

STEP 1: CALL FOR HELP (DIAL 911)

AN OPIOID OVERDOSE NEEDS IMMEDIATE MEDICAL ATTENTION. An essential step is to get someone with medical expertise to see the patient as soon as possible, so if no EMS or other trained personnel are on the scene, dial 911 immediately. All you have to say is: "Someone is not breathing." Be sure to give a clear address and/or description of your location.

STEP 2: CHECK FOR SIGNS OF OPIOID OVERDOSE

Signs of **OVERDOSE**, which often results in death if not treated, include [11]:

- Face is extremely pale and/or clammy to the touch
- Body is limp
- Fingernails or lips have a blue or purple cast
- The patient is vomiting or making gurgling noises
- He or she cannot be awakened from sleep or is unable to speak
- Breathing is very slow or stopped
- Heartbeat is very slow or stopped.

Signs of **OVERMEDICATION**, which may progress to overdose, include [11]:

- Unusual sleepiness or drowsiness
- Mental confusion, slurred speech, intoxicated behavior
- Slow or shallow breathing
- Pinpoint pupils
- Slow heartbeat, low blood pressure
- Difficulty waking the person from sleep.

Because opioids depress respiratory function and breathing, one telltale sign of a person in a critical medical state is the "death rattle." If a person emits a "death rattle" — an exhaled breath with a very distinct, labored sound coming from the throat — emergency resuscitation will be necessary immediately, as it almost always is a sign that the individual is near death [13].

STEP 3: SUPPORT THE PERSON'S BREATHING

Ideally, individuals who are experiencing opioid overdose should be ventilated with 100% oxygen before naloxone is administered so as to reduce the risk of acute lung injury [2, 4]. In situations where 100% oxygen is not available, rescue breathing can be very effective in supporting respiration [2]. Rescue breathing involves the following steps:

- Be sure the person's airway is clear (check that nothing inside the person's mouth or throat is blocking the airway).
- Place one hand on the person's chin, tilt the head back and pinch the nose closed.
- Place your mouth over the person's mouth to make a seal and give 2 slow breaths.
- The person's chest should rise (but not the stomach).
- Follow up with one breath every 5 seconds.

STEP 4: ADMINISTER NALOXONE

Naloxone (Narcan) should be administered to any person who shows signs of opioid overdose, or when overdose is suspected [4]. Naloxone injection is approved by the FDA and has been used for decades by emergency medical services (EMS) personnel to reverse opioid overdose and resuscitate individuals who have overdosed on opioids.

Naloxone can be given by intramuscular or intravenous injection every 2 to 3 minutes [4, 13-14]. The most rapid onset of action is achieved by intravenous administration, which is recommended in emergency situations [13]. The dose should be titrated to the smallest effective dose that maintains spontaneous normal respiratory drive.

Opioid-naive patients may be given starting doses of up to 2 mg without concern for triggering withdrawal symptoms [2, 4, 7, 14].

The intramuscular route of administration may be more suitable for patients with a history of opioid dependence because it provides a slower onset of action and a prolonged duration of effect, which may minimize rapid onset of withdrawal symptoms [2, 4, 7].

DURATION OF EFFECT. The duration of effect of naloxone is 30 to 90 minutes, and patients should be observed after this time frame for the return of overdose symptoms [4, 13-14]. The goal of naloxone therapy should be to restore adequate spontaneous breathing, but not necessarily complete arousal [4].

More than one dose of naloxone may be needed to revive someone who is overdosing. Patients who have taken longer-acting opioids may require further intravenous bolus doses or an infusion of naloxone [4].

Comfort the person being treated, as withdrawal triggered by naloxone can feel unpleasant. As a result, some persons become agitated or combative when this happens and need help to remain calm.

SAFETY OF NALOXONE. The safety profile of naloxone is remarkably high, especially when used in low doses and titrated to effect [2, 4, 13, 17]. When given to individuals who are not opioid-intoxicated or opioid-dependent, naloxone produces no clinical effects, even at high doses. Moreover, while rapid opioid withdrawal in tolerant patients may be unpleasant, it is not life-threatening.

Naloxone can safely be used to manage opioid overdose in pregnant women. The lowest dose to maintain spontaneous respiratory drive should be used to avoid triggering acute opioid withdrawal, which may cause fetal distress [4].

STEP 5: MONITOR THE PERSON'S RESPONSE

All patients should be monitored for recurrence of signs and symptoms of opioid toxicity for at least 4 hours from the last dose of naloxone or discontinuation of the naloxone infusion. Patients who have overdosed on long-acting opioids should have more prolonged monitoring [2, 4, 7].

Most patients respond by returning to spontaneous breathing, with minimal withdrawal symptoms [4]. The response generally occurs within 3 to 5 minutes of naloxone administration. (Rescue breathing should continue while waiting for the naloxone to take effect. [2, 4, 7])

Naloxone will continue to work for 30 to 90 minutes, but after that time, overdose symptoms may return [13, 14]. Therefore, it is essential to get the person to an emergency department or other source of medical care as quickly as possible, even if he or she revives after the initial dose of naloxone and seems to feel better.

SIGNS OF OPIOID WITHDRAWAL. The signs and symptoms of opioid withdrawal in an individual who is physically dependent on opioids may include, but are not limited to, the following: body aches, diarrhea, tachycardia, fever, runny nose, sneezing, piloerection, sweating, yawning, nausea or vomiting, nervousness, restlessness or irritability, shivering or trembling, abdominal cramps, weakness, and increased blood pressure. In the neonate, opioid withdrawal may also include convulsions, excessive crying, and hyperactive reflexes [13].

NALOXONE-RESISTANT PATIENTS. If a patient does not respond to naloxone, an alternative explanation for the clinical symptoms should be considered. The most likely explanation is that the person is not overdosing on an opioid but rather some other substance or may even be experiencing a non-overdose medical emergency. A possible explanation to consider is that the individual has overdosed on buprenorphine, a long-acting opioid partial agonist. Because buprenorphine has a higher affinity for the opioid receptors than do other opioids, naloxone may not be effective at reversing the effects of buprenorphine-induced opioid overdose [14].

In all cases, support of ventilation, oxygenation, and blood pressure should be sufficient to prevent the complications of opioid overdose and should be given priority if the response to naloxone is not prompt.

SUMMARY:

Do's and Don'ts in Responding to Opioid Overdose

- **DO** support the person's breathing by administering oxygen or performing rescue breathing.
- **DO** administer naloxone.
- **DO** put the person in the "recovery position" on the side, if he or she is breathing independently.
- **DO** stay with the person and keep him/her warm.
- **DON'T** slap or try to forcefully stimulate the person — it will only cause further injury. If you are unable to wake the person by shouting, rubbing your knuckles on the sternum (center of the chest or rib cage), or light pinching, he or she may be unconscious.
- **DON'T** put the person into a cold bath or shower. This increases the risk of falling, drowning or going into shock.
- **DON'T** inject the person with any substance (salt water, milk, "speed," heroin, etc.). The only safe and appropriate treatment is naloxone.
- **DON'T** try to make the person vomit drugs that he or she may have swallowed. Choking or inhaling vomit into the lungs can cause a fatal injury.

NOTE: All naloxone products have an expiration date, so it is important to check the expiration date and obtain replacement naloxone as needed.

RESOURCES

Information on opioid overdose and helpful advice for overdose survivors and their families can be found at the following websites:

Substance Abuse and Mental Health Services Administration (SAMHSA)

- National Treatment Referral Helpline 1-800-662-HELP (4357) or 1-800-487-4889 (TDD — for hearing impaired)
- National Substance Abuse Treatment Facility Locator: http://www.findtreatment.samhsa.gov/TreatmentLocator to search by state, city, county, and zip code
- Buprenorphine Physician & Treatment Program Locator: http://www.buprenorphine.samhsa.gov/bwns_locator
- State Substance Abuse Agencies: http://findtreatment.samhsa.gov/TreatmentLocator/faces/abuse-Agencies.jspx

Centers for Disease Control and Prevention (CDC): http://www.cdc.gov/Features/VitalSigns/PainkillerOverdoses

National Institutes of Health (NIH), National Center for Biotechnical Information: http://www.ncbi.nlm.nih.gov

The Partnership at Drug-Free.org: http://www.drugfree.org/uncategorized/opioid-overdose-antidote

Project Lazarus: http://projectlazarus.org

Harm Reduction Coalition: http://harmreduction.org

Overdose Prevention Alliance: http://overdosepreventionalliance.org

Toward the Heart: http://towardtheheart.com/naloxone

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19. National Treatment Referral Helpline 1-800-662-HELP (4357) or 1-800-487-4889 (TDD for hearing impaired)

20. National Substance Abuse Treatment Facility Locator: http://www.findtreatment.samhsa.gov/TreatmentLocator to search by state, city, county, and zip code

21. Buprenorphine Physician & Treatment Program Locator: http://www.buprenorphine.samhsa.gov/ bwns_locator

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Combatting the Heroin and Opioid Crisis

Heroin and Opioid Task Force Report

June 9, 2016

NEW YORK STATE | Built to Lead

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Arlene Gonzalez-Sanchez	NYS OASAS Commissioner, co-chair
Maria Vullo	Acting NYS DFS Superintendent
Dr. Howard Zucker	NYS DOH Commissioner
Joshua Vinciguerra	NYS DOH, Bureau of Narcotic Enforcement Director
Michael Green	NYS DCJS Executive Commissioner
Lt. Colonel Frank Kohler	Lead on Heroin/Opioids, NYS State Police
Tino Hernandez	President, Samaritan Village
Daniel Raymond	Policy Director, Harm Reduction Coalition
Charles Brack	Peer/Family Support Specialist, United Healthcare
Patrice Wallace-Moore	CEO of Arms Acres
Michael McMahon	Richmond County District Attorney
Adrienne Abbate	Executive Director, SI partnership for Community Wellness
Kym Laube	Executive Director, Human Understanding & Growth Services
Dr. Jeffrey Reynolds	President and CEO of Family and Children's Association
Anne Constantino	CEO of Horizon Health Services
Cortney Lovell	Director, Wrise Consulting
Susan Salomone	Executive Director of Drug Crisis in Our Backyard
Patrick Seche	Director of Services, Addiction Psychiatry, University of Rochester Medical Center
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Terrence Murphy	NYS Senate
Linda Rosenthal	NYS Assembly

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Dear Governor Cuomo,

On behalf of the members of the Heroin and Opioid Task Force, we are pleased to present you with our report and recommendations for state actions to tackle the public health crisis of heroin and opioid addiction that is spreading across New York State.

Thousands of New Yorkers are dying each year due to the disease of addiction. In 2014, 2,028 New Yorkers died of a drug overdose.[1] More than 30 percent of these fatal overdoses were in New York City; nearly one in five happened on Long Island. While these numbers are shocking, they also likely reflect underreporting, as information from medical examiner and police reports is often not added to vital statistics records.

You charged us with leading a Task Force dedicated to the development of a comprehensive plan that includes immediate, actionable steps to tackle this crisis from every angle. The Task Force worked tirelessly, traveled around the state in a short time period, read hundreds of comments submitted online, and convened as a group to identify legislative and programmatic steps to end this crisis.

The Task Force has focused its work across four main areas: Prevention, Treatment, Recovery, and Enforcement to address the root causes of the crisis as well as effective rehabilitation for the individuals and families who need help.

The time to act is now. We believe that these recommendations provide the State of New York with common sense next steps for ending the crisis of heroin and opioid addiction. On behalf of the Task Force, we thank you for trusting us with this critical charge, and for giving us the opportunity to help New Yorkers in need and save lives.

Sincerely,

Kathy Hochul
Lieutenant Governor of the State of New York

Arlene González-Sánchez
Commissioner, Office of Alcoholism and Substance Abuse Services (OASAS)

Co-Chairs
New York Heroin and Opioids Task Force

[1] New York State Department of Health (2014). Drug Overdose Deaths.

Executive Summary

Across the state the Task Force has heard from families who have loved ones addicted to heroin or other opioids, who have overdosed or have had serious health problems as a result of their addiction. Heroin overdose is now the leading cause of accidental death in the state.[2] Between 2005 and 2014, upstate New York has seen an astonishing 222 percent increase in admissions to OASAS certified treatment programs among those 18 to 24 years of age for heroin and other opioids; Long Island has seen a 242 percent increase among the same age group for heroin and other opioids. In all, approximately 1.4 million New Yorkers suffer from a substance use disorder.[3]

Heroin and opioid addiction is now a major public health crisis in New York State. Further work must continue to fully realize the Governor's vision for a more responsive, accessible, and compassionate health care system for patients, as well as stronger education, prevention, and enforcement measures. The Task Force recommends that study and work on these issues continue as a high priority, so that New York can remain in the forefront when it comes to helping patients and their families.

New York has taken important steps to address the urgent needs of those in critical condition and to prevent future generations from suffering from the disease of addiction. For the 2016 fiscal year, New York State allocated over $1.4 billion to the Office of Alcoholism and Substance Abuse Services (OASAS) to fight this battle including funding for 1,455 beds for patients in crisis; 2,221 beds for inpatient rehabilitation programs; 5,247 beds for intensive residential programs; 2,142 beds for community residential programs; 1,842 beds in supportive living programs; and 265 beds in residential rehabilitation programs for youth.[4] Additionally, OASAS provides more than $74 million to fund prevention services through 165 providers serving communities in every county, including 1,400 schools across the state.[5]

The State has also enacted legislation to address this growing epidemic. In 2012 the State enacted the Prescription Drug Reform Act,[6] overhauling the way prescription drugs are dispensed and tracked in New York to improve safeguards for drugs that are prone to abuse. The Act updated the Prescription Monitoring Program (PMP) Registry (also known as I-STOP) to require pharmacies to report information about dispensed controlled substances on a "real time" basis, as well as require health care practitioners to consult the PMP Registry before prescribing or dispensing certain controlled substances most prone to abuse and diversion. The Act also mandated electronic prescription of controlled substances, updated the Controlled Substances Schedules, improved education and awareness efforts for prescribers, and established a safe disposal program for prescription drugs. By the end of 2015, I-STOP had led to a 90 percent decrease in "doctor

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[2] New York State Office of Alcoholism and Substance Abuse Services (2016).

[3] Substance Abuse and Mental Health Services Administration (2015). Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health. Retrieved May 31, 2016, from http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf.

[4] New York State Office of Alcoholism and Substance Abuse Services (2015). Data as of December 1, 2015.

[5] New York State Office of Alcoholism and Substance Abuse Services (2016). OASAS Fast Facts.

[6] Chapter 447 of the Laws of New York, 2012.

shopping" – when patients visit multiple prescribers and pharmacies to obtain prescriptions for controlled substances within a three-month time period.[7] Earlier this year, New York State entered into an agreement with New Jersey to share PMP data both ways and prevent "doctor shopping" across state borders.

In 2014, the State enacted legislation that granted Good Samaritan protections to individuals who administer an opioid antagonist like naloxone, expanded access to naloxone by allowing non-patient-specific prescriptions, enacted insurance reforms to improve treatment options for individuals suffering from addiction, directed OASAS to create a wraparound services demonstration program to provide services to adolescents and adults for up to nine months after successful completion of a treatment program, and enhanced penalties to crack down on illegal drug distribution.[8]

Despite being on the forefront of nationally-recognized best practices, the epidemic continues to grow in New York. In response, Governor Andrew M. Cuomo convened a team of experienced healthcare providers, policy advocates, educators, parents, and New Yorkers in recovery to serve on a Heroin and Opioid Task Force and develop a comprehensive plan to bring the crisis under control. The Task Force's work was informed by two executive meetings, eight listening sessions across the state, and the 246 comments submitted through www.ny.gov/herointaskforce.

This public process resulted in the following recommendations—broken into four areas: prevention, treatment, recovery, and enforcement—to continue to address the crisis.

[7] New York State Department of Health Bureau of Narcotic Enforcement (2016).

[8] NY Penal Law §220.78 and NY Practice Criminal Law §26:27.50

Prevention

The Task Force heard from multiple stakeholders, including health care providers, law enforcement officials, and concerned community members that prevention is key to tackling the root causes of the heroin epidemic. In the listening sessions, members of the public expressed the need for more education and community outreach. These thoughts were echoed by dozens of website comments.

In the 2016 state fiscal year, OASAS invested more than $74 million in prevention services through 165 providers serving communities in every county, including 1,400 schools across the state. OASAS prevention programs reach more than six million New Yorkers each year, including approximately 300,000 students. In New York City, OASAS works with the Department of Education to support 256 full-time staff focused on prevention efforts in public schools. Moreover, prevention efforts are cost effective. Studies have shown that prevention programs have been estimated to save taxpayers an average of $16 for every $1 invested.[9]

Stuart Rosenblatt, Executive Director of New Choices Recovery Center; Paul Samuels, President/Director of the Legal Action Center; and Linda Beers, Public Health Director at Essex County Public Health, all urged that prevention efforts engage school districts and community organizations. Prevention scholars agree that schools and the community play an important role in preventing addiction, along with families and peers.[10] The Task Force also heard that awareness and education activities also serve to reduce the stigma that keeps many from seeking the help they need.

In addition to education and awareness, Gale Burstein, Commissioner of Health of Erie County; Jeremy Klemanski, CEO of Syracuse Behavioral Healthcare; and Patrick M. O'Shaughnessy, Vice President for Medical Affairs and Chief Medical Officer of Catholic Health System of Long Island, all testified to the Task Force that one of the most effective ways to prevent addiction to prescription opioids is by strengthening prescriber education requirements. The relationship between non-medical use of opioid analgesics and heroin use is well established, with one study reporting that nearly 80 percent of recent heroin users started with opioid analgesics.[11]

The Task Force finds that the State should enhance its prevention efforts so that fewer people become addicted to heroin and opioids. Specifically, the Task Force recommends the following:

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[9] Washington State Institute for Public Policy (2016). Benefit-Cost Results. Retrieved May 31, 2016, from http://www.wsipp.wa.gov/BenefitCost/Pdf/9/WSIPP_BenefitCost_Public-Health-Prevention.

[10] Hawkins, David, et al. (1992). Risk and Protective Factors of Alcohol and Other Drug Problems in Adolescence and Early Adulthood: Implications for Substance Abuse Prevention. Retrieved May 31, 2016, from https://cre8tiveyouthink.files.wordpress.com/2011/12/social-developmental-prevention-and-yd.pdf.

[11] Jones, CM (2013). Heroin Use and Heroin Use Risk Behaviors among Nonmedical Users of Prescription Opioid Pain Relievers: United States, 2002-2004 and 2008-2010. Retrieved May 31, 2016, from http://www.ncbi.nlm.nih.gov/pubmed/23410617.

Recommendation One: Mandate ongoing education for prescribers on pain management, palliative care, and addiction.

The Task Force heard from people suffering from heroin and opioid addiction who had a ready supply of legally prescribed prescription pain medication. While these medications play an important role in the treatment and management of pain, it is critical that prescribers receive updated education on these medications, their use, and potential associated risks for patients.

Massachusetts, Connecticut, and Maine have all enacted legislation amending continuing education requirements for all prescribers to include training relative to risks of abuse and addiction associated with opioid medication, appropriate prescription quantities, opioid antagonists and overdose prevention, among other topics.

The Task Force recommends requiring health care professionals to complete up to four hours of ongoing education on pain management, palliative care, and addiction. Since many types of health care professionals have the ability to prescribe opioids, the Task Force believes this requirement should apply to physicians, nurse practitioners, physician assistants, podiatrists, dentists, and midwives.

The Task Force also recommends that the State explore how best to encourage medical schools in New York to incorporate curricula on pain management, including the appropriate use of opioids; encourage hospitals to hold grand rounds[12] twice annually focusing on the same topic; and work with national board certification organizations, such as the American Board of Medical Specialties, to incorporate questions on pain management and the appropriate use of opioids in board specialty certification and recertification examinations.

Recommendation Two: Limit first-time opiate prescriptions for acute pain from 30 days to no more than a 7-day supply.

According to the federal Centers for Disease Control and Prevention (CDC), health care providers wrote enough prescriptions for opioid analgesics in 2012 for every adult in the United States to have a bottle of pills.[13] In New York, nearly 11 million opioid analgesic prescriptions were dispensed in 2014, enough for approximately 70 percent of New Yorkers over 18 years-old to have a bottle of pills in their medicine cabinet.

While the New York PMP has been successful in significantly reducing "doctor shopping", overprescribing continues, and admissions to OASAS-certified treatment programs for opioids increased 20 percent from 2011 to 2015.[14] In public listening sessions, Task Force members heard stories about teens receiving month-long opioid prescriptions after dental procedures or sports injuries. Even when the original patient does not become addicted to prescribed opioids, there is a ready supply of pills in the home to which family members and visitors have access.

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[12] Grand rounds are a traditional hospital-based teaching tool for discussion of clinical issues that are generally held in lecture format.

[13] Centers for Disease Control and Prevention (2016). CDC Guideline for Prescribing Opioids -- United States, 2016. Retrieved May 31, 2016, from http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.

[14] New York State Office of Alcoholism and Substance Abuse Services (2016). Admissions Data.

In March 2016, the CDC issued a new *Guideline for Prescribing Opioids for Chronic Pain* recommending that "when opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed."[15]

Several states have taken steps to limit first-time prescriptions of opioids, including Massachusetts, Connecticut, and Maine, which have all imposed a 7-day supply limit.

To limit access to unused medication and reduce the likelihood that a patient with a prescription may become addicted to opioids, the Task Force recommends that the State limit the initial prescription of an opioid to no more than a 7-day supply, with exceptions for chronic pain, cancer, and palliative care and provisions that reduce any associated financial burden related to co-payments for prescriptions of greater duration.

Recommendation Three: Encourage the use of the Prescription Monitoring Program (PMP) in emergency departments.

In 2012, Governor Cuomo signed legislation updating the PMP to require health care practitioners to consult the PMP Registry before prescribing or dispensing certain controlled substances most prone to abuse and diversion, but it exempted practitioners from doing so in an emergency department setting.

Emergency departments play an important role in the opioid and heroin crisis, both in terms of treatment as well as understanding the full picture of patients' prescription histories. Patient prescription histories contain critical information for other providers, such as primary care physicians and specialists, to prevent or identify addiction to opioid painkillers. To improve the usage of PMP Registry information across the continuum of care, the Task Force recommends that the State engage hospitals and other stakeholders to encourage use of the PMP Registry when health care providers prescribe controlled substances in the emergency department of a general hospital.

Recommendation Four: Improve data and reporting on naloxone dispensing and overdose reversals.

The Task Force heard about the need for better data on the use of naloxone to target efforts to prevent overdoses from heroin and opioids. To address this, the Task Force recommends that the State require healthcare providers, pharmacies, and opioid overdose prevention programs to report the number of naloxone kits dispensed or purchased each month, by county. The Task Force further recommends that the Department of Health publish this information quarterly to inform State and community efforts.

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[15] Centers for Disease Control and Prevention (2016). CDC Guideline for Prescribing Opioids -- United States, 2016. Retrieved May 31, 2016, from http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.

First responders, law enforcement, and other potential witnesses trained at a registered overdose prevention program already report data on naloxone revivals to the State by mail, fax or e-mail. However, this data is spotty and underreports the use of naloxone to reverse heroin and opioid overdoses. The Task Force further recommends that the State direct individuals who administer naloxone to report reversal data to the State. To simplify and increase the collection of this important data, the Task Force recommends that the State design and deploy a user-friendly mobile application to track overdose reversals.

Recommendation Five: Require that pharmacists provide important information to consumers when dispensing opioids.

Consumers need additional knowledge about the dangers and addiction risks posed by opioid painkillers.

The Task Force heard about the importance of consumer education across the state, including from Gale Burstein, Erie County Commissioner of Health, who argued that pharmacies should be required to counsel all patients who receive narcotic medications. Both prescribers and dispensers have an important role to play in educating consumers about these medications before they become addicted. The Task Force recommends that the State require that pharmacists disseminate information to consumers at the time of dispensing to educate them about the risk of addiction and available treatment resources.

Further, for any extended-release hydrocodone medications approved by the Federal Drug Administration (FDA), such as Zohydro, the Task Force recommends that the State issue warnings to prescribers based on the risk of potential addiction, abuse, and misuse of these medications which can lead to overdose and death. The State should also develop specific educational materials for prescribers on this class of particularly potent opioids.

Recommendation Six: Expand consumer access to medications that are difficult to crush or dissolve and are designed to prevent abuse.

The FDA has recently approved a set of opioid prescription drugs that contain abuse-deterrent properties. That is, these drugs are designed in a way to prevent individuals from breaking them down or otherwise altering them in a way to abuse them. Research on these medications is promising, but in its early stages. To ensure that consumers have access to abuse-deterrent opioids that prevent abuse, the Task Force recommends that the State provide standing authority to relevant State agencies to allow the Commissioners to require that such drugs be added to insurance carrier or health plan drug formularies based on a determination that the abuse-deterrent properties are scientifically and medically established and there is no disproportionate costs imposed on consumers from such decision.

Recommendation Seven: Improve use and reporting of data in State response to heroin and opioid crisis to better target resources and increase efficacy.

The State and its partners collect a wide array of data related to heroin and opioid addiction including information reported to the Prescription Monitoring Program (PMP), information

reported by hospitals, and information on overdose deaths. As technology and data collection evolves, the Task Force recommends that DOH utilize its $2.9 million grant from the Centers for Disease Control and Prevention to improve the use of technology and data in fighting opioid and heroin overdoses. Such efforts could include integration of the PMP with patient electronic health records, the development of an app-like function for prescribers using smartphones and tablets, and improved analysis of PMP data to enhance compliance with prescribing guidelines through outreach, education, and investigations. The Task Force also recommends that DOH use the grant to launch a Rapid Response Project to use the state's syndromic surveillance system to spot trends in opioid-related emergency room visits, so the state can quickly respond to local needs with additional resources as needed such as naloxone training and distribution.

The Task Force also recommends that the State's Chief Data Analytics Officer work across all relevant agencies, including OASAS, DOH, the Department of Financial Services, and the Department of Criminal Justice Services to develop actionable insight to increase the State's effectiveness in combatting the heroin and opioid crisis.

Recommendation Eight: Expand and target awareness campaigns.

The Task Force heard across the state about the importance of continuing to raise awareness about heroin and opioid addiction since lack of awareness, stigma, and misinformation create significant barriers in addressing addiction. In recent years, OASAS has reached millions of New Yorkers with its multi-media *Combat Heroin* campaign and informational materials such as the *Kitchen Table Toolkit*. However, with approximately five New Yorkers dying each day from drug overdose, more must be done to increase awareness to prevent addiction, increase access to treatment, and save lives.

The Task Force recommends that State agencies work together to develop awareness efforts that use data to target groups with tailored content across relevant platforms, including social media. For example, research shows that women 45-64 years-old are prescribed more opioids than any other age group,[16] and research suggests the majority of teen heroin users began abusing opioids by stealing prescription opioid painkillers from family members. Accordingly, the State should target those demographics with content about the dangers of opioid analgesics and caution parents to count pills and lock their medicine cabinets. In New York, overdose victims are overwhelmingly men in their 20's to 40's, so the State should target this demographic with a campaign about preventing overdose, both among those who use opioids and their friends and family.[17]

The Task Force also recommends that the State expand its programs to increase awareness about the following facts:

- Opioid and heroin abuse affects all demographics;

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[16] New York State Department of Health Aids Institute (2015). New York State Opioid Poisoning, Overdose and Prevention. Retrieved May 20, 2016, from http://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/docs/annual_report2015.pdf.

[17] New York State Department of Health Aids Institute (2015). New York State Opioid Poisoning, Overdose and Prevention. Retrieved May 20, 2016, from http://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/docs/annual_report2015.pdf.

- Addiction is a disease, not a moral failure – stigma is a barrier to treatment and recovery;
- Medication-assisted treatment can be effective;
- Naloxone works and there are multiple ways to secure it;
- The Good Samaritan law protects individuals who administer naloxone to save a life.

Recommendation Nine: Support regional coalitions and partnerships.

The Task Force heard from presenters at listening sessions around the state that coalitions and partnerships help communities come together and respond in a coordinated, more effective way. The Task Force recommends that the State take steps to promote regional coalitions and partnerships by holding regional forums where families, service providers, educators, law enforcement, state agencies, and local leaders can identify region-specific resources and challenges, assess current efforts, and increase cross-sector collaboration on the prevention and treatment of substance use disorder. The Task Force further recommends that OASAS provide support for community projects that encourage partnership, for example, prescription drug take back events jointly organized by local prevention providers and law enforcement.

Treatment

Approximately 107,300 New Yorkers received treatment for opioid substance use disorder in 2015.[18] OASAS oversees a treatment system that includes nearly 12,500 treatment beds across the state. These beds come in many forms, including withdrawal and stabilization beds, inpatient rehabilitation beds, supportive living, and residential rehabilitation for youth, among others. Between 2011 and 2015, admissions to OASAS-certified treatment programs for heroin increased by 42 percent, and by 20 percent for any opioid. In the last two years, OASAS has added more than 200 addiction treatment beds across the state to meet growing demand. In the last two years, OASAS has opened Staten Island's first intensive residential treatment program for youth, a 24-bed facility; broken ground on a new 18-bed women's residential treatment facility in Broome County; and established two new 25-bed adolescent and young adult residential treatment facilities, one in Niagara and one in Suffolk County.

In addition, OASAS recently added nearly 2,000 new outpatient opioid treatment program (OTP) slots in Albany, Buffalo, Peekskill, Plattsburgh, Syracuse, and Troy. An additional OTP will open in Watertown later this summer and another in Utica will provide 100 new slots for medication-assisted treatment in the Mohawk Valley in 2017.

In February 2016, OASAS launched the new Treatment Availability Dashboard that helps New Yorkers connect with these and other treatment options across the state.

The Task Force heard from panelists and community members about insufficient access to treatment beds as well as barriers to accessible, effective treatment due to insurance delays or lack of coverage. Notably, more than fifty website submissions mentioned insurance coverage problems with respect to treatment. During a Task Force listening session, Kevin Connally, of Hope House Inc. expressed concern about lengthy insurance approval timeframes. Torin Finver of Horizon Village Terrace House urged insurance companies to stop requiring prior authorizations for necessary medications, a position echoed by dozens of online comments that called for greater access to medication-assisted treatment. Stuart Rosenblatt of New Choices Recovery Center argued that New York needs more access to medically-assisted treatment in every community. Parents at listening sessions also requested the State to expand mandatory hold authority to get loved ones stabilized during times of crisis.

The Task Force believes that the State should continue to protect and expand access to treatment for New Yorkers suffering from substance use disorder. Specifically, the Task Force recommends the following:

Recommendation Ten: Require all treatment providers and insurance companies to use an objective, state-approved criteria to determine insurance coverage for necessary inpatient treatment.

Today, insurance companies utilize different rubrics to determine the appropriate duration and scope of coverage for inpatient residential treatment, which has often served as a barrier to needed

[18] New York State Office of Alcoholism and Substance Abuse Services (2016).

inpatient treatment. The Task Force heard from presenters and community members who observed that multiple rubrics result in uncertainty for patients and treatment providers and can lead to inconsistent and seemingly random determinations that impact critical treatment decisions.

To ensure consistent and fair insurance coverage determinations, the Task Force recommends that the State streamline access to treatment by requiring insurance companies to utilize an objective, State-approved rubric when determining what level of care is required for a patient. Using a single set of rules will improve access to care and decrease administrative burden for providers, insurers, and clients. This would be a first-of-its-kind requirement, and New York would be a model for other states across the country.

Recommendation Eleven: Remove barriers to treatment by eliminating prior insurance approvals for inpatient treatment as long as it is necessary.

Any person who needs inpatient medical services at a detoxification or treatment facility must first receive prior approval from their insurance company before they can be admitted. This process can take several days and prevents individuals from getting timely access to treatment. In some circumstances the patient, confronted with delay decides ultimately not to seek treatment. Further, even after admission to a facility, insurers can immediately conduct clinical reviews to determine that inpatient treatment remains necessary. The Task Force heard repeatedly around the state that these processes take valuable time away from clinical staff and serve as a barrier for people trying to access inpatient treatment.

o ensure that clinical staff and families can focus on what's most important – providing care and support to persons suffering from addiction – the Task Force recommends that the State take steps to ensure that individuals have access to unlimited necessary inpatient treatment. The State should eliminate prior authorization for necessary inpatient treatment services to get patients in the door of a treatment facility and only allow insurers to commence utilization review after fourteen days. These provisions will improve access to inpatient care and give patients and their loved ones the peace of mind that they will not be forced to leave treatment before clinical staff deem they are ready.

Recommendation Twelve: Increase access to critical medications to manage substance abuse and withdrawal by eliminating prior authorization by insurance companies to such medications.

Medications such as buprenorphine and injectable naltrexone are used to treat heroin and opioid addiction and to assist when a person is experiencing withdrawal from the use of heroin or other opioids. According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), "buprenorphine represents the latest advance in medication-assisted treatment (MAT). Medications such as buprenorphine, in combination with counseling and behavioral therapies, provide a whole-patient approach to the treatment of opioid dependency. When taken as prescribed, buprenorphine is safe and effective."[19]

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[19]Substance Abuse and Mental Health Services Administration (2016). Buprenorphine. Retrieved June 2, 2016, from http://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine.

The Task Force heard from families and those in recovery that individuals often encounter difficulty getting their insurance providers to cover the medications doctors may wish to prescribe to treat their addiction. Further, even when insurance companies *do* cover medications, they require a doctor to first contact the insurance company and request prior authorization to prescribe the medication. This process may take several days and creates an unnecessary barrier to treatment.

To improve access to life-saving treatment, the Task Force recommends that the State require commercial insurance companies and managed care providers to cover, without prior authorization, emergency supplies of medications for the treatment of substance use disorder.

The Task Force also heard that MAT is not utilized to the fullest extent because practitioners are restricted, by federal law, to prescribe buprenorphine to a maximum of 100 patients, an outdated and arbitrary limit on the number of patients each provider is able to treat. This law applies even to providers who work in state certified substance use disorder treatment programs. The Task Force recommends that Congress amend the Registration Requirements title of the Controlled Substances Act[20] to increase the statutory cap on qualifying practitioners. In the alternative, the Substance Abuse and Mental Health Services Administration and the Department of Health and Human Services should amend the proposed rule for Medication Assisted Treatment for Opioid Use Disorders (0930-AA22) to include this exemption within regulation.

Access to MAT is also limited because only physicians are allowed to prescribe. Allowing mid-level practitioners such as Nurse Practitioners and Physician Assistants to practice to the full extent of their abilities would help to relieve the severe shortage in professionals able to treat substance use disorders with MAT, especially in rural areas. Toward this end, the Task Force recommends that Congress amend the Controlled Substances Act[21] to include Nurse Practitioners and Physician Assistants licensed under State law to prescribe additional scheduled medications.

Recommendation Thirteen: Require State-certified treatment providers and agencies to educate individuals and families about treatment options and their rights to appeal denials of insurance coverage.

Individuals in treatment and their families should focus their time and attention on recovery, not on battles with insurance companies with respect to treatment options and breadth of insurance coverage. To ensure that these parties know what treatment options exist and their rights under State law, the Task Force recommends that OASAS-certified treatment providers educate consumers about the process for determining the scope of treatment and associated coverage, as well as their right under State law to file an external appeal with the Department of Financial Services to contest denial of insurance coverage.

Recommendation Fourteen: Increase the length of time for involuntary commitment of an addicted person from 48 to 72 hours.

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[20] 21 U.S.C. § 823(g)

[21] 21 U.S.C. § 823(g)(2)(G)

Under existing New York State Mental Health Law, individuals incapacitated due to drugs and/or alcohol abuse can be transported to a hospital, where they can be held for up to 48 hours to receive emergency treatment services.[22] Testimony from family members and treatment providers suggest that 48 hours is insufficient time to stabilize and engage an individual whose cognitive ability has been significantly impaired by active addiction, especially someone who has been revived from an overdose. Furthermore, an OASAS-designated treatment facility might be better suited than a hospital to ensure the person, once stabilized, is offered the opportunity to continue treatment for addiction. To enhance treatment for incapacitated individuals who are at risk of harming themselves, the Task Force recommends that the State increase the length of commitment from 48 to 72 hours and ensure that patients are directly connected to medical care within this timeframe.

Recommendation Fifteen: Issue guidance to educate consumers about insurer obligations regarding equal coverage of substance use disorder treatments and provide an avenue to report potential violations.

Patients and families may not be aware about the protections they are entitled to under the Mental Health Parity and Addiction Equity Act (MHPAEA), which requires insurers to ensure that financial requirements (such as co-pays) and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. To strengthen enforcement of MHPAEA in New York, the Task Force recommends that State agencies develop accessible consumer guidance on insurance parity, with accessible information and resources including how to report a potential violation to the Department of Financial Services for investigation.

Recommendation Sixteen: Increase the number of treatment beds across New York.

There are more than 12,500 treatment beds across New York. A new web-based tool developed and hosted by OASAS launched in February 2016 helps families, friends, and health care providers identify open beds by type, insurance coverage, and location. While this tool helps to connect demand with supply, the Task Force repeatedly heard from presenters and in testimony that a shortage of treatment beds still exists in certain areas of the State.

The Task Force recommends that the State take steps to increase the number of treatment beds and expand the type of treatment beds. For example, the State should explore the conversion of existing beds at its Addiction Treatment Centers into a new flexible model that allows for both short- and long-term stays and treatment.

The Task Force also recommends that the State continue its efforts to increase the number of opioid treatment program (OTP) slots to improve access to medication-assisted treatment in underserved areas of the state.

Through its operating certificate process, OASAS sets a cap on the number of individuals that certified residential and inpatient programs can treat at one time. However, the Task Force heard

[22] The issue of involuntarily holding an individual for emergency treatment is a complex one; and in making this recommendation the Task Force attempts to strike a difficult balance between the need to protect an incapacitated person's health and respecting that same person's civil rights.

from multiple providers that they have available space and resources to treat individuals over and above this cap. To allow individuals to access this capacity, the Task Force also recommends that the State allow certified residential and inpatient providers that have additional unused space and existing resources to increase their intake capacity by 10 percent on a temporary basis, provided they meet certain health and safety and treatment standards.

Recommendation Seventeen: Increase the number of Family Support Navigators across the state to help connect patients and families with appropriate treatment options.

Families of individuals suffering from addiction are often in crisis. They require help understanding treatment options, accessing treatment, and obtaining insurance coverage for services. The State's existing Family Support Navigators step in to help families and friends work with insurers and treatment providers and connect to other State resources.

The Task Force repeatedly heard during listening sessions that identifying appropriate treatment with the right insurance coverage is overly time consuming and stands as a barrier to efficient and effective treatment. Currently, there are navigators working with families in Central New York, the Mohawk Valley, and Western New York. To expand this important service, the Task Force recommends that the State add more navigators in every region to assist patients and families identify options for treatment and insurance coverage.

Recommendation Eighteen: Provide discharge planning for patients from emergency departments to connect to potential treatment options.

Individuals suffering from substance use disorder are often admitted at hospital emergency rooms, some after having been revived after overdose. Too often, these individuals are discharged after being stabilized, but an opportunity is missed to connect them to treatment services.

The Task Force heard testimony from medical professionals that patients who receive naloxone at a hospital or before admission often leave unattended and at higher risk of dying from an overdose. To address this issue, the Task Force recommends that the State increase the number of On-Call Peers across New York to help link patients admitted at hospital emergency rooms to OASAS-certified treatment programs.

The Task Force also recommends that the Department of Health (DOH) and OASAS, in consultation with hospitals and treatment providers, develop best practices and guidelines for first responders and hospital emergency departments. This guidance should include best practices in treating someone who has been reversed with naloxone, ensuring care that is stigma-free, and maintaining a continuum of care by engaging an On-Call Peer or other local resources.

The Task Force further recommends that the DOH initiate a pilot for the development of Health Hubs in three harm reduction programs in Erie County, the Southern Tier, and the Capital District. Collectively, these programs have the capacity to reach 30 counties in New York State. To better engage individuals who are in emergency departments, trained staff from these "hubs" would make a concerted effort to engage overdose patients while they are in the hospital to connect them to treatment options offered by DOH or OASAS. Alternatively, if the individual does not want to

Responding to the Opioid Crisis: The RN's Role

Course Activity Exam

Instructions: Complete the exam questions below by marking your answers on the answer sheet provided. Be sure to complete the evaluation form on the back of the answer sheet. **For those members wishing to earn CHs/CEU for this course, please return completed evaluation form and answer sheets to NYSNA at the conclusion of the program.**

1. In all cases, New York State law requires a registered professional nurse (RN) to execute medical regimens (i.e., administer medications, medical treatments or tests) that are ordered for a specific patient by a physician or other qualified health care practitioner who has examined the patient.
    A. True
    B. False

2. New York law allows RNs to execute non-patient specific orders and protocols, ordered by a physician or nurse practitioner, for administering: opioid related overdose treatment. The ordering physician or nurse practitioner is not required to examine or have a treatment relationship with the recipient of the ordered tests or treatments.
    A. True
    B. False

3. Non-patient-specific orders and protocols that are ordered by a physician or a nurse practitioner do not have to be in writing.
    A. True
    B. False

4. RNs who administer opioid related overdose treatment (or who direct LPNs to administer opioid related overdose treatment) should be currently certified in CPR or BCLS or have received CPR training by health facility in-service departments.
    A. True
    B. False

5. Opioid overdoses affect individuals, families, friends and communities. The societal costs of opioid overdoses exceeds how many billions of dollars annually?
    A. 5 Billion
    B. 10 Billion
    C. 20 Billion

6. When can an opioid overdose occur?
    A. When a person deliberately misuses a prescription opioid or an illicit drug such as heroin
    B. When a patient takes an opioid as directed, but the prescriber miscalculated the opioid dose or an error was made by the dispensing pharmacist
    C. Patient misunderstood the directions for use
    D. All of the above

7. When someone is experiencing an opioid overdose, it is a potentially fatal cyanotic event which can result in brain damage, coma and death. First responders must be educated on how to prevent and manage opioid overdose. What are the signs of opioid overdose?
    A. Breathing slows
    B. Oxygen levels in the blood decreases
    C. Oxygenation to vital organs decreases
    D. Unconsciousness
    E. Answers A & C
    F. All of the above

8. The New York 911 Good Samaritan law that went into effect on September 18, 2011 protects people acting in good faith during an opioid-related overdose.
    A. True
    B. False

9. Nurses working as community advocates, educators and providers of critical public health services can use their skills to alleviate the opioid epidemic by using which of these preventative strategies?
    A. Encourage providers and others to learn about preventing and managing opioid overdose
    B. Ensure access to treatment for individuals who are misusing or addicted to opioids or who have other substance use disorders.
    C. Encourage the public to call 911
    D. Encourage prescribers to use state Prescription Drug Monitoring Programs
    E. None of the above
    F. All of the above

10. After an RN administers Naloxone to revive a patient who is in danger of an overdose, the patient should:
    A. Go home and recuperate
    B. Proceed to an Emergency Department
    C. It depends on the patient's condition

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Phone: 212-785-0157
Fax:212-785-0429
Email: courses@nysna.org

Responding to the Opioid Crisis: The RN's Role (1.0 CH/0.1 CEU)

Answer Sheet

CODE:

Please print legibly and verify that all information is correct.

First Name: _____ **MI:** _____ **Last Name:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Daytime Phone Number (include area code): _____

E-mail: _____

Facility: _____ **NYSNA Member #:** _____

For those members wishing to earn CHs/CEU for this course, please return completed evaluation form and answer sheets to NYSNA at the conclusion of the program. Please print your answers in the spaces provided below. **There is only one answer for each question.** All answers are located within the course content.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please complete the course evaluation on the back.

Responding to the Opioid Crisis: The RN's Role (1.0 CH/0.1 CEU)

Please use the following scale to rate statements 1-7 below:	Poor	Fair	Good	Very Good	Excellent
1. The content fulfills the overall purpose of the course.	○	○	○	○	○
2. The content fulfills each of the course objectives.	○	○	○	○	○
3. The course subject matter is current and accurate.	○	○	○	○	○
4. The material presented is clear and understandable.	○	○	○	○	○
5. The teaching/learning method is effective.	○	○	○	○	○
6. The test is clear and the answers are appropriately covered in the course.	○	○	○	○	○
7. How would you rate this course overall?	○	○	○	○	○
8. Was this course fair, balanced, and free of commercial bias?				Yes / No (Circle One)	

9. Comments: _____

_____

10. Do you have any suggestions about how we can improve this course? _____

_____

_____

_____

Thank You!

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Nurses Improving New York's Healthcare System Disaster Response Planning and Preparedness

NYSNA Continuing Education

The New York State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This course has been awarded .5 contact hours and is intended for RN's and other healthcare providers. In order to receive contact hours participants must read the course material, complete and return the post-test answer sheet with a score of 80% or better, and submit the completed evaluation for this course. The completed post-test answer sheet and evaluation must be returned to NYSNA no later than January 26, 2021.

All American Nurses Credentialing Center (ANCC) accredited organizations' contact hours are recognized by all other ANCC accredited organizations. Most states with mandatory continuing education requirements recognize the ANCC accreditation/approval system. Questions about the acceptance of ANCC contact hours to meet mandatory regulations should be directed to the professional licensing board within that state.

NYSNA wishes to disclose that no commercial support was received.

Introduction and Purpose Statement

Since 1970, records show an escalation in the intensity of tropical cyclone activity in the North Atlantic, which scientist suggests correlates to the increase in sea surface temperatures due, in large part, to manmade greenhouse gas emissions. The change in climatic temperatures has also been associated with heavy rains extending hundreds of miles inland further increasing flood risk.

Using the historical occurrence, a future probability and average annual losses analysis was determined for hurricane events in New York State. The number of years recorded was divided by the number of occurrences, resulting in a simple past-determined recurrence interval.

From the historical records, the following can be expected on average in a typical year in New York State:

- 3.23 hurricane events
- Nearly $1.5 million in property and crop damage
- 1 Injuries
- .24 Fatalities

Based on hurricane probability models derived from historical frequency, Suffolk County has the highest chance of being impacted by a hurricane during any given season. From previous occurrences of hurricane related hazard events, the counties with the highest probability of future occurrences, based on recurrence interval, are Suffolk (21%), Nassau (19%), and Bronx (17%).

Hurricane Sandy's profoundly destructive track stands alone in the historical record dating back to 1851, although its track is estimated as an event that would occur about once every 714 years. However, that does not mean that a storm like Sandy won't affect New York for another 714 years, but rather that the average annual probability of another Hurricane Sandy occurring is .14 percent. That being said, global warming-related sea level rise is likely to make destructive storm surges like Hurricane Sandy's much more common in the next few decades, regardless of whether storms follow a path similar to Sandy.

The importance of a vibrant civil society to disaster relief efforts can neither be under-stated nor under-estimated. Nongovernmental organizations (NGOs), faith-based organizations and churches, hospitals, schools, parent groups, community advisory boards, and businesses all play roles that governments cannot fulfill on

their own. Due to the bureaucratic nature of government responses, these organizations play a crucial role in reaching out to the victims of disaster in a rapid, responsive, and adaptive manner. Any disaster response must include such organizations, since they are often the greatest source of relief in the immediate aftermath of a disaster. Furthermore, these organizations are often not only the first responders, but they are also central to long-term relief and rebuilding efforts.

Evidence and real-world events have illustrated that hospitals cannot be successful in response to climate change disasters without robust community healthcare coalition preparedness—and engaging critical partners. Critical partners include emergency management, public health, mental/behavioral health providers, as well as community and faith-based partners. Together these partners make up a community's healthcare community coalition. A key goal of nurses is to strengthen the capabilities of the healthcare community coalition, not just the individual hospital in which the nurse is employed. Healthcare community coalitions are part of a community-wide planning for healthcare resiliency.

Course Objectives

At the completion of this learning activity the learner will be able to:

- Recognize the risks of climate change disasters in NYS
- Understand why healthcare organizations, community and government groups need to join together to meet the needs of the community in the event of a disaster

About the Author

Carol Lynn Esposito, EdD, JD, MS, RN

Carol Lynn Esposito, EdD, JD, MS, RN, is the Director, Nursing Education and Practice for the New York State Nurses Association (NYSNA) and an attorney with over 15 years' experience in organizing and educating unionized nurses on how to develop leadership skills, build power in their workplaces, and make real improvements in their living and working conditions.

Dr. Esposito received her Ed.D. in Educational Administration, Leadership & Technology at Dowling College, her Juris Doctorate in Law from Brooklyn Law School, her Master in Science with a specialization in nursing education from Excelsior College, and her Baccalaureate in Science from Adelphi University's School of Nursing.

Dr. Esposito and NYSNA's nursing and practice education team design, develop, implement and evaluate the association's nursing practice and occupational health and safety law continuing education programs. Dr. Esposito has been adjunct faculty at Adelphi University, Hofstra University, and Excelsior College where she has taught courses on Contemporary Legal Issues in Healthcare, Collective Bargaining, Ethics, Policy and Politics in Nursing, Communications in Nursing, and Violence in the Healthcare Setting. She has also taught courses in Introduction to Law, Civil Litigation, Risk Management, Medical Malpractice, and Birth Injuries. An attorney with over 25 years' experience in the trial of medical and nursing malpractice cases, Dr. Esposito has worked for several medical malpractice and personal injury firms, and for the United States Attorney's Office in their civil litigation department.

Dr. Esposito has been an honorarium and keynote speaker for various schools of nursing and professional organizations. She has authored articles on Informed Consent, Malpractice Insurance, Transcultural Nursing, and Nursing Ethics and has developed course and text materials for the New York State Nurses Association and the National Center of Professional Development.

Key Principles

1. A rapidly increasing percentage of the U.S. population is located on or near the coast.
2. Storm occurrences in the New York State region date back as far as 1821, yet the first named storm to hit the area were not until Hurricane Carol in 1954.
3. Coastal storms, including Nor'easters, tropical storms, and hurricanes can, either directly or indirectly, impact all of New York State. More densely populated and developed coastal areas, such as New York City, are the most vulnerable to hurricane-related damages.
4. Before a storm is classified a hurricane, it must pass through four distinct stages: tropical disturbance, tropical depression, tropical storm and lastly a hurricane.
5. Key terms related to hurricanes, tropical storms, coastal storms and nor'easters include:
    - **Nor'easter**- An intense storm that can cause heavy rain and snow, strong winds, and coastal flooding. Nor'easters have cold, low barometric cores.
    - **Tropical Storm**- An organized system of strong thunderstorms with a defined surface circulation and maximum sustained winds of 39-73mph.
    - **Tropical Cyclone**- An organized, rotating, low-pressure weather system of clouds and thunderstorms that develops in the tropics.
    - **Tropical Depression**- A tropical cyclone with sustained winds of 38 mph or less.
    - **Hurricane**- Tropical cyclones, formed in the atmosphere over warm
      ocean areas, in which wind speeds reach 74mph or more and blow in a large spiral around a relatively calm center or "eye". Circulation is counterclockwise in the Northern Hemisphere.
    - **Storm Surge**- A dome of water pushed on shore by hurricane and tropical storm winds Storm surges can reach 25 feet high and be 50-100 miles wide.
    - **Storm Watch**- A warning issued by the National Weather Service indicating that Hurricane/ Tropical Storm are possible in the specified area, usually within 36 hours.
    - **Storm Warning**- A warning issued by the National Weather Service indicating that Hurricane/ Tropical Storm conditions are expected in the specified area usually within 24 hours.

6. Since 2011, the State of New York has experienced a tropical storm, two hurricanes, two mandatory evacuation ordinances, and billions of dollars in damages.
7. Considering Hurricane Sandy alone, the governor's office estimates that 305,000 homes have been destroyed primarily from storm surges.
8. New York City's Office of Management and Budget, appraises the total damage including private, public, and indirect cost to be $19 billion ($4.5 billion to city agencies; $5 billion to New York City Metropolitan Transit Authority (MTA), and $2.5 billion in supplementary transportation infrastructure).
9. Presidential Declared Disaster totals by county for hurricane events for the period of 1954 through July 2013 reveal Suffolk, Ulster, Nassau, and Orange Counties have had the highest number of hurricane declarations. Suffolk, Nassau, and Putnam Counties are the top three counties with the highest total property loss ($58 -80 million).
10. Since Hurricane Irene and Hurricane Sandy, evacuation zones for the City of New York have been updated. The final updates were made in June of 2013 and announced by the City of New York which included evacuation zones for 600,000 more residents who were not covered in previous zoning systems

Adapted from: 2014 New York Hazard Mitigation Plan. Online article retrieved July 18, 2014 from http://www.dhses.ny.gov/oem/mitigation/documents/2014-shmp/Section-3-12-Hurricane.pdf.

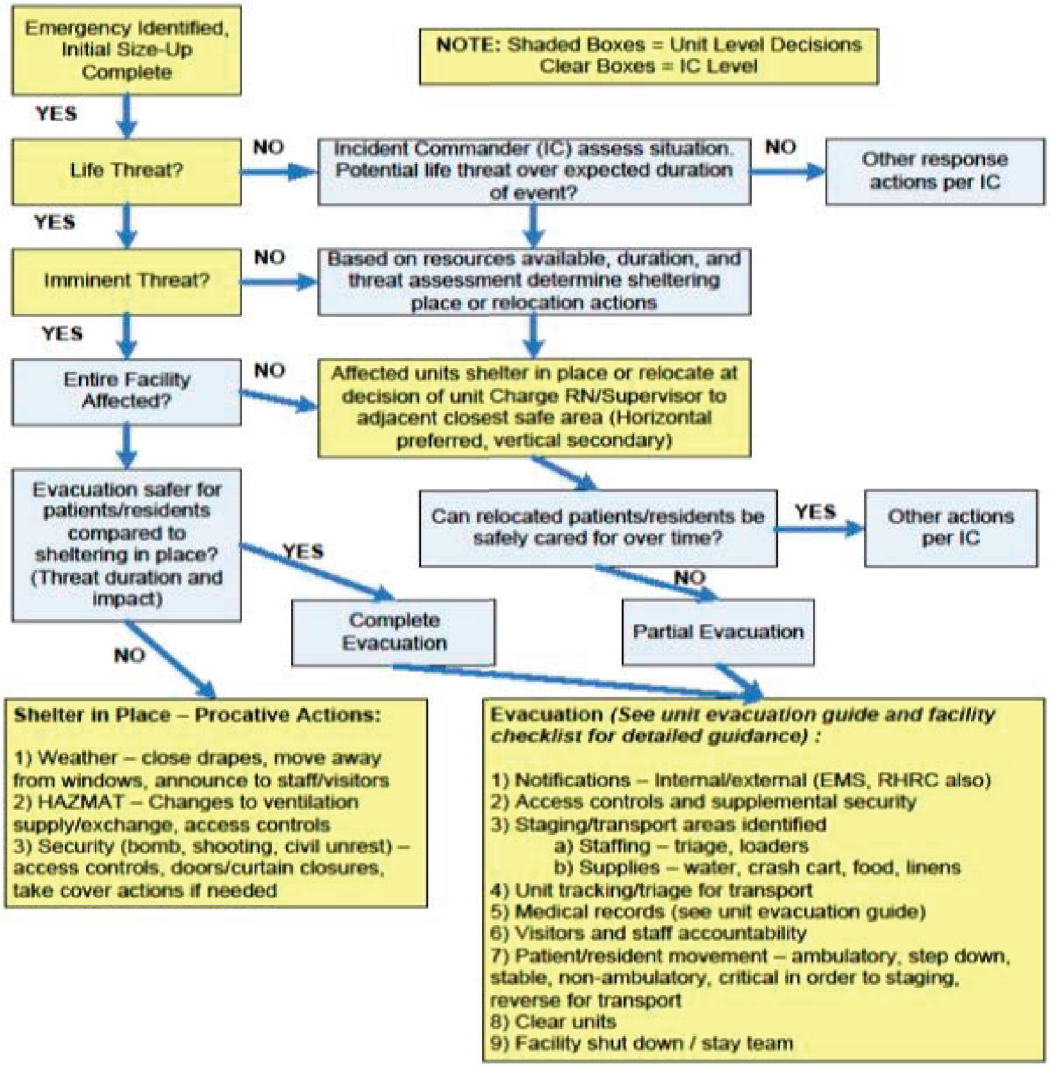
Estimated Population in Storm Surge Zones

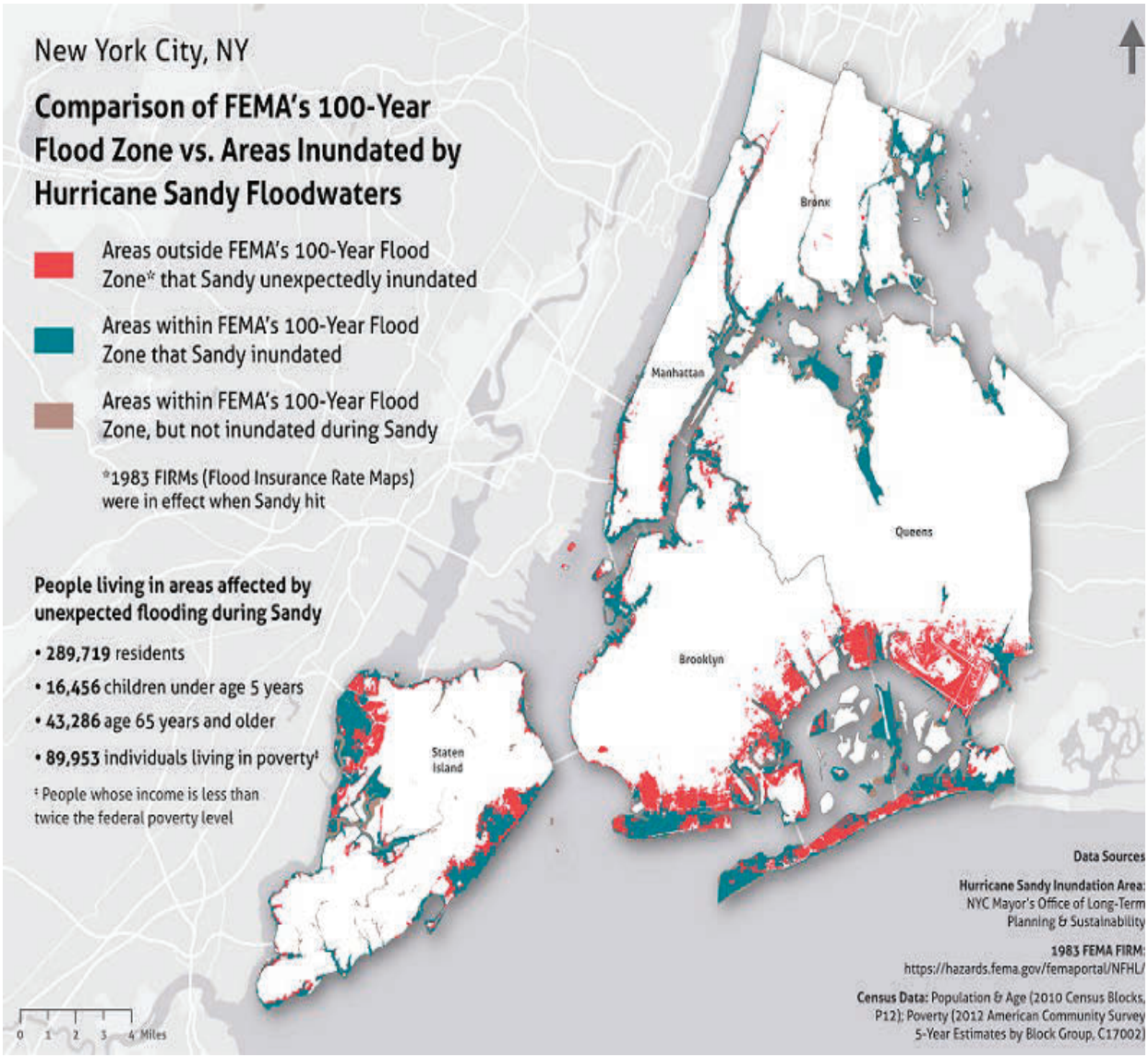
Storm Zone	Population
Category 1	517,940
Category 2	1,549,103
Category 3	2,429,424
Category 4	3,225,374

(Category 2-4 Inclusive of Proceeding Storm Surge)

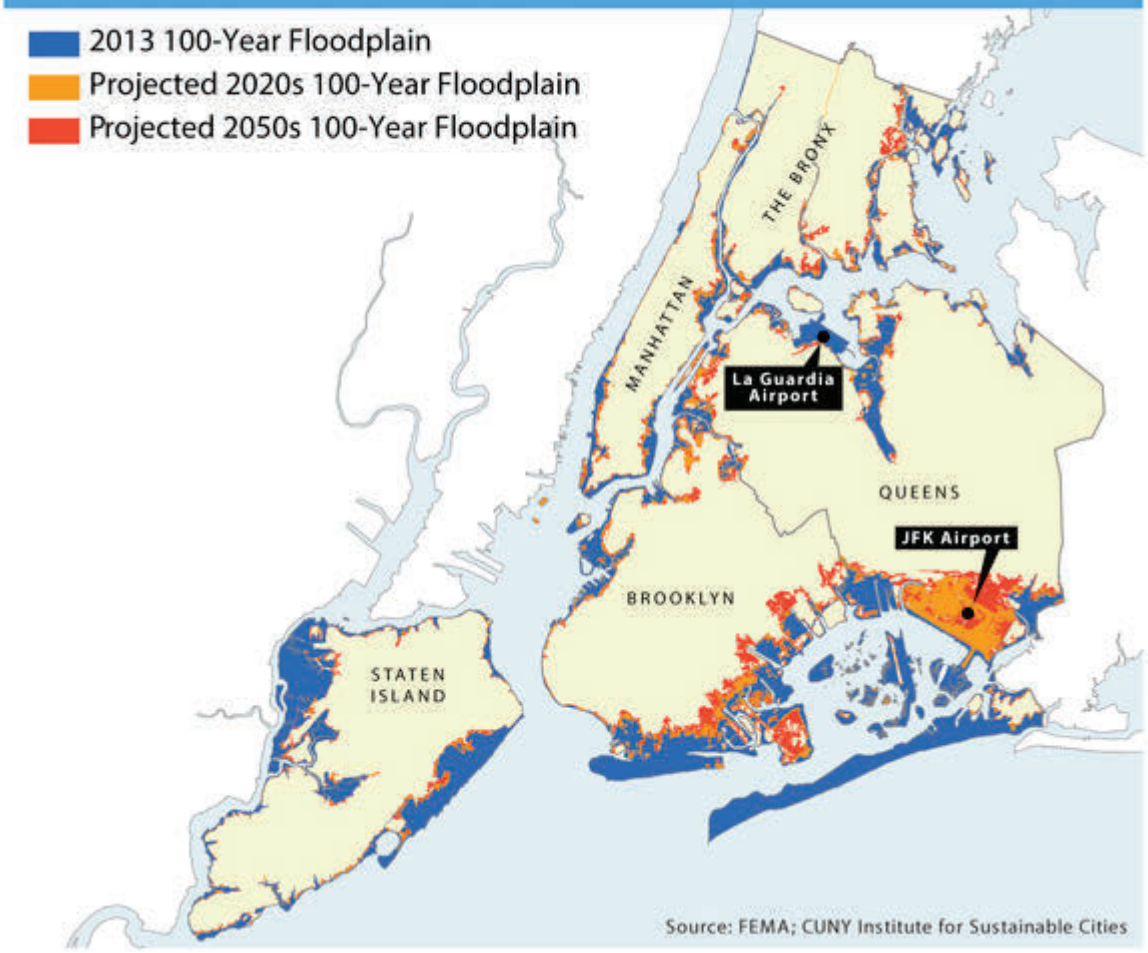
Saffir-Simpson Hurricane Scale				
Category	**Storm Surge (ft.)**	**Winds (mph)**	**Damage**	**Damage Description**
1	6.1-10.5	74-95	Moderate	• Damage primarily to trees and unanchored homes • Some damage to poorly constructed signs • Coastal road flooding
2	13.0- 16.6	96-110	Moderate-Severe	• Some roofing material, door, and window damage to buildings • Considerable damage to shrubbery and trees • Flooding of low-lying areas • Some structural damage to residences and utility buildings
3	14.8-25	111-130	Extensive	• Foliage blown off trees and large trees blown down • Structures close to the coast will have structural damage by floating debris • Curtainwall failures with utilities and roof structures on residential buildings
4	24.6-31.3	131-155	Extreme	• Shrubs, trees, and signs all blown down • Extensive damage to doors and windows • Major damage to lower floors of structures near the shore
5	Not predicted	>155	Catastrophic	• Complete roof failure on many residences and industrial buildings • Some complete building and utility failures • Severe, extensive window and door damage • Major damage to lower floors of all structures close to shore

Sheltering, Relocation, and Evacuation Decision Tree




New York City, NY
Comparison of FEMA's 100-Year Flood Zone vs. Areas Inundated by Hurricane Sandy Floodwaters
Areas outside FEMA's 100-Year Flood Zone* that Sandy unexpectedly inundated
Areas within FEMA's 100-Year Flood Zone that Sandy inundated
Areas within FEMA's 100-Year Flood Zone, but not inundated during Sandy
*1983 FIRMs (Flood Insurance Rate Maps) were in effect when Sandy hit
People living in areas affected by unexpected flooding during Sandy
• 289,719 residents
• 16,456 children under age 5 years
• 43,286 age 65 years and older
• 89,953 individuals living in poverty‡
‡ People whose income is less than twice the federal poverty level
Bronx
Manhattan
Queens
Brooklyn
Staten Island
0 1 2 3 4 Miles
Data Sources
Hurricane Sandy Inundation Area: NYC Mayor's Office of Long-Term Planning & Sustainability
1983 FEMA FIRM: https://hazards.fema.gov/femaportal/NFHL/
Census Data: Population & Age (2010 Census Blocks, P12); Poverty (2012 American Community Survey 5-Year Estimates by Block Group, C17002)

Future Flood Maps for the 2020s and 2050s



Total Deaths in NYS Caused by Tropical Storms		
Name	**Year**	**Number of deaths**
New England Hurricane of 1938	1938	60
Hurricane Sandy	2012	53
Hurricane Edna	1954	29
1821 Norfolk and Long Island hurricane	1821	17
Hurricane Five	1894	10
Hurricane Agnes	1972	6
1944 Great Atlantic Hurricane	1944	6
Hurricane Irene	2011	5
Tropical Storm Cristobal	2002	3
Tropical Storm Beryl	1994	2
Hurricane Bob	1991	2
Hurricane Floyd	1999	2
Hurricane Belle	1976	1
Hurricane Gloria	1985	1
Hurricane Isabel	2003	1
Hurricane Frances	2004	1
Tropical Storm Tammy	2005	1

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Lin, N., K. A. Emanuel, J. A. Smith, and E. Vanmarcke (2010), Risk assessment of hurricane storm surge for New York City, J. Geophys. Res., 115, D18121, doi:10.1029/2009JD013630. ©2010 American Geophysical Union. Online article retrieved July 18, 2014 from http://hdl.handle.net/1721.1/62845.

Nurses Improving New York's Healthcare System Disaster Response Planning and Preparedness

Course Activity Exam

Instructions: Complete the exam questions below by marking your answers on the answer sheet provided. Be sure to complete the evaluation form on the back of the answer sheet. **For those members wishing to earn CHs for these courses, please return completed evaluation form and answer sheets to NYSNA no later than January 26, 2021.**

1. From historical records, New York State residents can expect more than 2 hurricane events and over $1 million dollars in property and crop damage in a typical year.

    A. True
    B. False

2. Based on hurricane probability models derived from historical frequency, Staten Island has the highest chance of being negatively impacted by a hurricane during any given season.

    A. True
    B. False

3. Global warming due, in large part, to manmade greenhouse gas emissions, is likely to make destructive storm surges like Hurricane Sandy's much more common in the next few decades.

    A. True
    B. False

4. Presidential Declared Disaster totals by county for hurricane events for the period of 1954 through July 2013 reveal that Suffolk, Nassau, and Staten Island Counties have the highest number of hurricane declarations and the highest total property loss.

    A. True
    B. False

5. Since Hurricane Sandy, evacuation zones for the City of New York have been updated and include more than 1/2 million more residents who were not covered in previous zoning systems.

    A. True
    B. False

6. A category 4 storm is defined as one with major damage to lower floors of structures near the shore and with an estimated affected population of 3,225,374.

    A. True
    B. False

7. When sheltering in place is safer for patients/residents compared to evacuation, proactive actions include moving patients away from windows, making changes to ventilation supply/exchanges, and closing doors and curtains.

    A. True
    B. False

8. Hurricane Sandy affected more than 280,000 residents in areas that were unexpectedly flooded during the storm.

    A. True
    B. False

9. LaGuardia and JFK Airports will not be affected by projected floodplains until the year 2050.

    A. True
    B. False

10. Hurricane Sandy caused the greatest numbers of NY deaths in NYS history.

    C. True
    D. False

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Nurses Improving New York's Healthcare System Disaster Response Planning and Preparedness

Answer Sheet

CODE:

Please print legibly and verify that all information is correct.

First Name: _____ **MI:** _____ **Last Name:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Daytime Phone Number (include area code): _____

E-mail: _____

Facility: _____ **NYSNA Member #:** _____

For those members wishing to earn CHs for these courses, please return completed evaluation form and answer sheets. Please print your answers in the spaces provided below. **There is only one answer for each question.** All answers are located within the course content.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please complete the course evaluation on the back.

Nurses Improving New York's Healthcare System Disaster Response Planning and Preparedness: Evaluation

Please use the following scale to rate statements 1-7 below:	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
1. The content fulfills the overall purpose of the course.	○	○	○	○	○
2. The content fulfills each of the course objectives.	○	○	○	○	○
3. The course subject matter is current and accurate.	○	○	○	○	○
4. The material presented is clear and understandable.	○	○	○	○	○
5. The teaching/learning method is effective.	○	○	○	○	○
6. The test is clear and the answers are appropriately covered in the course.	○	○	○	○	○
7. How would you rate this course overall?	○	○	○	○	○
8. Was this course fair, balanced, and free of commercial bias?				Yes / No (Circle One)	

9. Comments: _____

_____

10. Do you have any suggestions about how we can improve this course? _____

_____

_____

_____

Thank You!