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Opioid use and abuse: Reducing the risks

By Kathleen Shostek, RN, ARM, FASHRM, CPHRM, CPPS
Vice President, Healthcare Risk Management

Opioid overdose is now a leading cause of death in the United States. Moreover, 67.8% of emergency department visits for opioid overdoses involve prescription opioids.[1] The trend is alarming. Death rates from overdoses of opioid analgesic drugs, including hydrocodone, oxycodone, morphine and methadone, have quadrupled over the past 15 years. Some of the drivers of this trend include a shift in the philosophy toward more comprehensive pain management and prescribing of opioids, promulgation of pain management standards by healthcare accreditors and aggressive pharmaceutical marketing of analgesics, including opioids.

This risk has prompted the U.S. Department of Health and Human Services (HHS) to implement an initiative focused on reducing opioid morbidity and mortality. The effort, announced earlier this year, involves providing education and revised prescribing guidelines for healthcare providers, increasing the use and availability of naloxone (a drug that counters the effects of opioids) and expanding medication-assisted treatment for substance use disorders.[2] The value of providing the reversal agent naloxone to law enforcement officers has been recognized as an important intervention in preventing deaths from overdoses. For a listing of law enforcement departments carrying naloxone by state, go to http://www.nchrc.org/law-enforcement/us-law-enforcement-who-carry-naloxone/.

Other federal agencies are also involved in addressing the public health crisis regarding opioids. The HHS Substance Abuse and Mental Health Services Administration released updated "Federal Guidelines for Opioid Treatment Programs" in March 2015.[3] Revisions include new ways to assess and counsel patients, treating pregnant patients and the management of patients with chronic pain. The Food and Drug Administration (FDA) also recently released guidance for drug manufacturers on the development and labeling of abuse-deterrent opioids to support design of drug products that reduce misuse.[4]

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Prescription drug monitoring programs

Already dubbed an epidemic in many areas of the country, states have enacted programs to address the problem, taking a number of approaches to reduce opioid abuse and overdoses. These approaches include the implementation of prescription drug monitoring programs (PDMP). PDMP are state-run databases that collect information on prescription drugs including patient name, drug name and dispensing pharmacy. Currently, state PDMP databases are not standardized with regard to the data collected or reported; for example, some, but not all, PDMP include prescriber information.[5]

The data from PDMP can be used to detect patterns of concern, such as patients obtaining medications from multiple providers ("doctor shopping") particularly in succession or on the same day, and obtaining large quantities of pills. PDMP can also be used for the following purposes:

- To prevent and reduce prescription drug abuse
- To identify and investigate potential cases of drug diversion
- To identify and investigate professional misconduct involving inappropriate prescribing and dispensing
- To provide educational information regarding prescription drug use trends
- To promote public health initiatives
- To implement early intervention and prevention of opioid overuse/abuse

For a listing of state PDMP websites, see https://www.bja.gov/evaluation/program-substance-abuse/pdmp1.htm. While almost all states have implemented PDMP, one to watch is Washington, whose comprehensive interagency, healthcare facility and practitioner collaborative has reached a high level of success.[6]

A cross-boundary initiative called RxCheck Hub, managed by the Integrated Justice Information Systems (IJIS) Institute, seeks to enable real-time, interstate data sharing between PDMP for prescription and patient information.[7] Another interstate program run by the National Association of Boards of Pharmacy (NABP) facilitates the transfer of prescription monitoring program data across state lines, allowing participating state databases to be linked, providing a more effective means of combating drug diversion and drug abuse nationwide. Information on the NABP InterConnect is available at http://www.nabp.net/programs/pmp-interconnect/nabp-pmp-interconnect.

Opioid for pain management – prescribing guidelines

Opioid medications are used routinely to treat both acute and chronic cancer pain and noncancer pain. However, evidence for the long-term effectiveness of opioids in the treatment of patients with noncancer pain is weak, and may be associated with tolerance, dependence and lower quality of life.[8] The American Pain Society has published recommendations for selecting analgesics for acute or chronic pain and the Federation of State Medical Boards has established a "Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain."[9]

The Centers for Disease Control and Prevention (CDC), as part of the national initiative to combat opioid abuse, also developed prescribing guidelines with the intent of making them available in standardized, IT-enabled formats for decision support. Current CDC guidance on prescribing is available at http://www.cdc.gov/drugoverdose/prescribing/common-elements.html.

Helping prescribers make better decisions about treatment of pain is an overarching goal of opioid management. Several state hospital associations, in conjunction with opioid analgesic advisors and experts in pain control, have published guidelines for opioid prescribing, particularly in emergency departments (ED). For example, the Massachusetts Hospital Association (MHA) Substance Abuse Prevention and Treatment Task Force published guidelines for ED opioid management to promote a general standard for EDs in that state. The guidelines note that, while a patient's opioid medications should be obtained from and managed by one medical clinic or provider, there are circumstances when opioids should be prescribed from the ED. MHA guidelines focus on nine principles for opioid screening, prescribing practices and appropriate use of resources. The ED guidelines, available at https://www.mhalink.org/AM/Template.cfm?Section=Substance_Abuse&Template=/CM/ContentDisplay.cfm&ContentID=49021, include the following:

1. Develop a screening process for substance misuse
2. Consult the state PDMP before writing an opioid prescription
3. Develop or participate in an information exchange system to share patient ED visit histories with other ED providers and facilities to discourage drug-seeking behaviors
4. Implement a process to coordinate care of patients who frequently visit the ED, including notification of the patient's primary care provider (PCP) or clinic
5. Notify the patient's PCP regarding an ED visit for acute exacerbations of chronic pain and the medications prescribed
6. Refrain from providing prescriptions for controlled substances that were lost, destroyed or stolen
7. Unless otherwise clinically indicated, refrain from prescribing long-acting or controlled-release opioids, such as OxyContin®, fentanyl patches and methadone
8. When opioids are prescribed, counsel the patient about storage and proper disposal when pain is resolved, avoiding use for non-medical purposes and avoiding use

of other sedatives at the same time as opioids due to the risk of overdose

9. Prescribe a minimal amount of opioid analgesics lasting no more than five days for serious pain when clinically appropriate

Following ED opioid management guidelines and using PDMP information can have an impact on the amount of opioid medications ordered.[10] Further, patient screening, assessment and scoring systems can support improved physician decision-making and opioid prescribing. One tool, the Screening Brief Intervention and Referral to Treatment (SBIRT) process, has been used to identify patients who do not present overtly as moderate or high risk. Information on SBIRT is available at http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/prevention/screening-brief-intervention-and-referral-to.html. A web-based system, NARxCHECK® (http://www.appriss.com/narxcheck.html), uses PDMP data to assess an ED patient's likelihood of abuse or diversion of controlled substances by assigning a "Narx" score. A high score prompts the ED physician to closely evaluate the patient's pain and use of opioids.

Knowledge of pain medication prescribing and management, as well as recognition of drug abuse and addiction by physicians, nurses, social workers and other healthcare staff is critical to reducing the risks of opioid use and misuse. One free resource is the "SCOPE of Pain," a three-module program that includes clinical resources and assessment tools. SCOPE is available at https://www.scopeofpain.com.

A note of caution: while following them as a treatment guideline is recommended, it is *not* recommended that emergency departments post opioid and controlled substance guidelines in their entrances or waiting areas.[11] Complying with the Emergency Medical Treatment and Labor Act (EMTALA) regulations includes conducting a medical screening exam and stabilizing all patients presenting to the ED with pain. Because they could discourage patients from ether seeking treatment for pain or cause a patient presenting to the ED to leave before being screened or examined, posting these ED guidelines presents a potential EMTALA violation.

Broad approach necessary

The Institute for Safe Medication Practices includes opioids on its list of high-alert medications because of the high risk of patient harm when used inappropriately. Facilities should use a multifaceted approach to the use of opioids and the prevention of opioid abuse. Strategies include participating in a PDMP and accessing interstate databases, careful patient screening for risk of opioid abuse and assessment for opioid addiction, and following opioid prescribing guidelines, with communication and referral for intervention and treatment when warranted.

Education about treatment of noncancer chronic pain and awareness of the risks of opioids is also key. Risk management for chronic pain opioid therapy should include regular monitoring of the patient's pain level, functional status, progress towards established goals and patient compliance with pain management/opioid use agreements (PDMP data, pill counts, urine or serum drug screens and presence of red flag behaviors, such as requests for increased drug doses and doctor shopping). Considering all available tools and resources to address opioid use and abuse is a sensible and practical approach for healthcare organizations seeking to manage this growing challenge.

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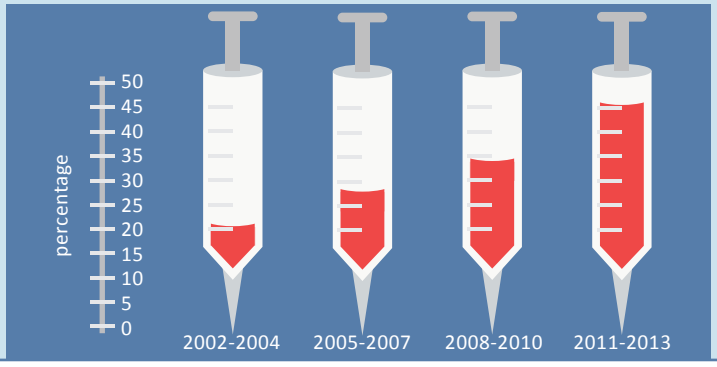
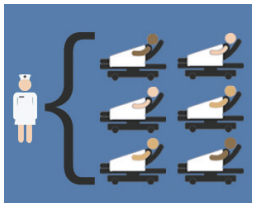
Opioid medications: Gateways to heroin use?

Did you know the percentage of heroin users with opioid pain reliever abuse or dependence more than doubled, from 20.7% in 2002-2004 to 45.3% in 2011-2013? *(See chart below, source: CDC Vital Signs release, July 10, 2015.)* Read more on our blog, *Connection*, and learn ways safety and risk leaders can act now to help protect patients and employees from this alarming trend.



SAFE STAFFING: BEST PRACTICES FOR HEALTHCARE FACILITIES

By Ann D. Gaffey, RN, MSN, CPHRM, DFASHRM and Cynthia Hartsfield, BSN, RN, MA, CPHRM



During hospital and healthcare facility risk assessments around the country, we often hear nurses' feedback about staffing challenges and heavy workloads. Is this perception or is it a reality that nurse staffing levels are impacting safety?

News reports and lawsuits related to nurse staffing issues suggest the problem is more than perception.[1,2] It is important for risk and safety managers to be aware of staffing concerns in order to support nurses and help hospital management develop solutions. Identifying and maintaining an appropriate number and mix of nursing staff is critical to the delivery of safe patient care. At the same time, reductions in nursing budgets have resulted in fewer nurses working longer hours caring for sicker patients – and the problem may continue to increase as hospitals face challenges in recruiting and retaining adequate numbers of qualified nursing and other staff into the next decade and possibly longer.

Research suggests that improved nurse staffing has a beneficial effect on patient outcomes. Conversely, research shows that the likelihood of patient mortality in the hospital following a complication associated with failure to rescue increases by 7% for each additional patient added to the average registered nurse workload.[3] A similar study focused on in-hospital cardiac arrest found a 4% decrease in the odds of survival for patients on hospital medical-surgical units with each additional patient per nurse.[4]

Legislation requiring adequate nurse staffing at state and federal levels has been introduced in both the House and the Senate. The Registered Nurse Safe Staffing Act of 2014 (S. 2353) was introduced in the U.S. Senate on May 15, 2014 and was referred to the Committee on Finance. The bill requires unit-by-unit staffing plans and public reporting of the plans, but does not impose nurse-patient ratios. This legislation is the companion to the Registered Nurse Safe Staffing Act of 2013 (H.R.1821).[5] It also provides whistleblower protections for nurses and others who file a complaint for inadequate staffing. Additionally, some state boards of nursing have adopted rules of practice to protect nurses who object to an unsafe assignment.[6] Currently, fifteen states and the District of Columbia have enacted legislation and/or adopted regulation to address nurse staffing.[7]

How can hospitals and healthcare professional organizations address concerns about staffing shortages? In its report "Workforce 2015: Strategy Trumps Shortage," the American Hospital Association (AHA) Long-Range Policy Committee developed recommendations and strategies that include:[8]

- Hospital work redesign to maximize efficiency, effectiveness and staff satisfaction
- Retention of existing workers, some of whom are near retirement
- Attracting a new generation of workers to replace a large group of retiring workers

Redesigned work models are most successful when developed by nursing staff at the bedside in collaboration with leadership and consider patient care needs, staff skills, competencies and hospital characteristics. In 2003, the Institute for Healthcare Improvement and the American Organization of Nurse Executives launched the "Transforming Care at the Bedside Project" (TCAB), funded by The Robert Wood Johnson Foundation, in an effort to improve hospital patient care and work environment by empowering front-line nurses to implement innovative practices on their units.[9] Since that time, hospitals across the country and the world are now applying TCAB principles and processes in their work. A toolkit containing best practice policies to involve staff, generate ideas and set goals to increase excellence of care and efficiency was created by 10 hospitals that participated in TCAB.[10]

The "Workforce 2015: Strategy Trumps Shortage" report also encourages adoption of tools such as TeamSTEPPS to improve communication and support redesigned healthcare teams to accomplish work in a more effective and efficient way.[11] Sedgwick's healthcare risk management team provides TeamSTEPPS training and coaching for teams in hospitals, long-term care and outpatient facilities and physician practices. Our consultants support long-term organizational rollouts through Champion training, post-training coaching with Champion trainers, leadership training and periodic webinars to address challenges, promote team engagement, develop solutions, maintain momentum and celebrate successes.

Whether perception or reality, hospital staffing concerns must be heard and resolved. Research demonstrates the strong correlation between lower nurse-to-patient ratios and improved patient and nurse satisfaction, better care outcomes and error reduction. Risk and safety leaders have an opportunity to collaborate with nurses at the bedside to create innovative strategies and develop solutions to build a safer environment for patients and nurses.

Ann Gaffey serves as Sedgwick's SVP, Healthcare Risk Management and Patient Safety. Cynthia Hartsfield is a valued contributor and former Sedgwick Healthcare Risk Management Consultant.

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Planning for thoughtful TeamSTEPPS™ implementation: Steps to take for success

By Julie Morris, Project Specialist

TeamSTEPPS, an evidence-based, teamwork training system designed to improve quality and safety in healthcare is rooted in more than three decades of research in high-stress, high-risk industries. It may be just the program for your organization to improve teamwork and communication challenges, but where do you begin?

The following tips for successful implementation and sustainment will provide a helpful guide.

There are three phases to a successful implementation of TeamSTEPPS: assessment phase, planning phase, and sustainment phase. Putting careful thought into the planning of each phase will ensure a successful TeamSTEPPS program.

I. **Assessment phase:** This phase has your leadership team asking, "Are we ready?" Culture change is a journey; perhaps the organization isn't ready because of dysfunctional relationships within or across units, or high turnover of leadership in clinical areas or in the executive suite. The tips below are compiled from the extensive experience of Sedgwick healthcare risk management consultants in their partnerships with many organizations during TeamSTEPPS training and sustainment engagements.

TIPS | The following sites identify assessment tools that will help you gauge the level of readiness for your facility:

- Organizational Readiness Assessment Checklist: http://teamstepps.ahrq.gov/readiness/
- Surveys on Patient Safety Culture: http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html
- Teamwork Attitudes Questionnaire (T-TAQ): http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/reference/teamattitude.html
- Teamwork Perceptions Questionnaire (T-TPQ): http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/reference/teampercept.html.

Once you determine the climate is conducive to change, and leadership is ready, willing and able to support the time and resources necessary for a long-term commitment, you can begin the ten steps suggested in the TeamSTEPPS Implementation Guideline.

Implementation timeline – Ten steps

Step 1: Create a change team

Step 2: Define the problem, challenge or opportunity for improvement

Step 3: Define the aim(s) of your TeamSTEPPS intervention

Step 4: Design a TeamSTEPPS intervention: Identify priority problem, challenge or opportunity from step 2

Step 5: Develop a plan for testing the effectiveness of your TeamSTEPPS intervention

Step 6: Develop an implementation plan

Step 7: Develop a plan for sustained continuous improvement

Step 8: Develop a communication plan

Step 9: Putting it all together: Write the TeamSTEPPS action plan

Step 10: Review your TeamSTEPPS action plan with key personnel

› Incorporate feedback from key personnel – back to step 2

Source: Implementation At-A-Glance Figure (Text Description). December 2012. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/reference/implglance.html

An executive sponsor for TeamSTEPPS should be selected who will be able to eliminate barriers, allocate resources, money and staff for the initiative. The executive sponsor should be influential, confident, respected, knowledgeable and passionate about creating a culture of safety. The executive sponsor can also help you facilitate physician participation, which is critical

to TeamSTEPPS success. To reinforce leadership's support for the initiative, the executive sponsor should provide opening comments for training courses, welcoming the providers chosen as the change team. Gear up for TeamSTEPPS and determine who should be involved using the information at http://teamstepps.ahrq.gov/informationitems.htm.

II. Planning phase *(action plan, training and implementation):* The selected change team should develop the action plan, review the plan with the executive sponsor, and confirm the selected approach, required resources and other needs. At this point, planning for the medical team training can begin and interventions can be implemented.

TIPS | Initial planning for the TeamSTEPPS training initiative

1. Create posters for break rooms and common areas announcing that TeamSTEPPS is coming. People can start talking about it and can plan for the confirmed training dates, if known.
2. Allow enough time for physicians to accommodate the training dates into their schedules. Their participation and buy-in is critical to the success of this initiative. Consider a lead time of two to four months prior to training, particularly when offering the two-day Master Training course.
3. Identify and reserve the training room space required. The most effective room setup to facilitate adult learning and interaction is the "U-shaped" table configuration with participants configured on the outside of the tables. Another option is the herringbone pattern of tables angled toward the front. Auditorium style and classroom style seating are discouraged as these arrangements do not encourage engagement or active discussions among participants.
4. If there are more than ten participants (consider limiting classes to a maximum of 30), there will be a need for two rooms for Day 2 of the Master Trainer course for the "teach-back" sessions, with half the participants in each room on the afternoon of the second day of training, with full audio-visual set-up.
5. Order Pocket Guides from AHRQ well in advance of training dates, one for each expected participant, plus some extras. These can be ordered from the following website: http://teamstepps.ahrq.gov/abouttoolsmaterials.htm.

The TeamSTEPPS curriculum is composed of three major training options, discussed below. Which option to use depends on the training needs and requirements of the target audience.

Master trainer course: Two-day "train the trainer" approach – this course option is taught by and produces master trainers. These individuals will be a part of your change team and are given the resources to train others within your organization. They gain the knowledge and skills required to implement and coach the behaviors needed to achieve positive results. For more, see the coaching workshop in Module 9 of the TeamSTEPPS curriculum, available at http://www.teamstepps.ahrq.gov.

Train the staff: These classes are not interchangeable and are audience specific.

If participants ARE direct providers of care: the TeamSTEPPS Fundamentals Course is used for instruction. This is a four-hour training course using the core curriculum, adaptable to any service or aspect of healthcare.

If the participants ARE NOT providers of direct, hands-on care: the TeamSTEPPS Essentials Course is used. This is an abbreviated version of the Fundamentals content and can be taught in two hours.

III. Sustainment phase *(monitor, coach and integrate):* The goal of this phase is to sustain and spread improvements in teamwork behavior and the associated clinical processes and outcomes. Simply put, the TeamSTEPPS change team monitors for and coaches to ensure that the new teamwork skills and process improvements are properly used and reinforced. The coaches help integrate the TeamSTEPPS tools and strategies into everyday activities (i.e. briefs, debriefs, huddles, call outs, check backs, situation monitoring and more).

TIPS | Keeping the ball rolling

1. At the start of your sustainment phase, consider weekly meetings with the change team to maintain momentum, evaluate what is going well, discuss areas where there are barriers and check progress toward team goals for the action plan.
2. Create a "tool or topic of the month" – create posters, emails, flyers, etc. to keep different tools or skills top of mind.
3. Embrace teaching moments to coach newly trained staff on how to use the tools and achieve the results they are looking for.
4. Celebrate small wins. Create competition, such as placing the name of someone who has used a tool or strategy successfully in a drawing for a small prize at the end of the month.
5. Create custom armbands, buttons or t-shirts so the staff knows who is a coach or instructor and can ask questions, use them as a sounding board or connect to practice newly acquired skills.

TeamSTEPPS is a teamwork and communication program to foster positive change in your organization. Just knowing TeamSTEPPS is insufficient; you must "do" TeamSTEPPS for the culture change to occur. Success will be achieved when there is a commitment to continuous improvement, regular monitoring of the implementation plan and a willingness to provide leadership and peer coaching for those people on the team ready to hear how care can be improved with the use of a formal language for communication.

GETTING BACK TO BASICS: RISK MANAGEMENT PRINCIPLES

Ann D. Gaffey, RN, MSN, CPHRM, DFASHRM, Senior Vice President, Healthcare Risk Management and Patient Safety

The core principles that drive decision-making for prioritizing and mitigating risk are likely embedded deep in most risk managers' brains, but as with many other bits of knowledge a review of the basics can be both reinforcing and refreshing. Our day-to-day work keeps us so busy we may not have the opportunity to provide basic education to organizational leaders, members of our department, physicians and staff about exactly what risk management is. Reinforcing these principles can help demonstrate how a robust risk management program supports achievement of the organization's mission and vision.

The five basic risk management principles of risk identification, risk analysis, risk control, risk financing and claims management can be applied to most any situation or problem. One doesn't realize that these principles are actually applied in daily life over and over until examples are brought to light. Using everyday examples in education programs as a way of introducing the principles, and then transitioning to scenarios and problems faced in patient care and healthcare operations, can be an effective teaching tool when promoting the contributions that risk management makes to the organization's success.

Risk identification is just what it sounds like – what risks are presented to me/my patient/my organization with the scenario in front of me? Using the everyday example of riding in or driving a car, one might identify the risk of having an accident due to poor maintenance of the car, failure to keep gas in the tank, speeding or driving under the influence. Other identified risks may be the risk of damaging property – either the car itself or someone else's property. There is a risk of financial loss if there isn't proper liability insurance in place, or if one gets a speeding ticket, and so forth.

The analysis of the risks identified begs one to ask, what is the worst that could happen? Put another way, how often could these adverse events happen (frequency), and if it does happen, what's the worst it could be (severity)? In our car scenario, the worst that could happen is someone loses their life. Additional analysis may determine the risk of being in an auto accident is low because the driver is never on the highway, only drives in good weather during daylight, on roads with speed limits of 30 miles per hour or less, in a well-maintained car, etc. As one can see, the analysis part of the risk management process should take the individual through several of these "what if" questions to help arrive at potential frequency and severity of an event.

Risk control offers opportunities for risk avoidance, risk prevention and risk reduction. The risk avoidance technique in our car example would be to not own a car or ride in a car. In reality, a minimal amount of risk still exists in that one could be hit by a car as a pedestrian, but in some scenarios, risk can be completely avoided. Risk prevention aims to reduce the frequency or likelihood of the event or loss. This might mean preventing car breakdowns by following maintenance and inspection schedules, keeping air in the tires and gas in the tank and following all driving laws. Risk reduction aims to lower the severity of a particular loss that has already occurred, for example ensuring property damage to another person's vehicle is repaired quickly so the time they are without a car is limited. The risk control program implemented will consider the various strategies already in place, and may introduce new techniques based on the findings of the analysis activity.

The fourth principle, risk financing, is a way to finance losses that the risk control techniques implemented did not stop from happening. In our example, even with all the proper maintenance on the car, safe driving, etc. an accident may still occur. By having appropriate automobile insurance, funds are generated by the insurance company to pay for the losses, or in this case, damage to the car.

The fifth principle is claims management. When a loss occurs, a claim may be filed to recover damages. In the car example, a claim may be filed with the driver at fault's insurance company to recover for the damage that occurred. If the driver at fault was not insured, a different course of action may be necessary to hold the driver personally responsible for paying for the damage.

When educating others in the organization about risk management, using an example such as the one outlined above can help make sense of what they may otherwise think of as a bit of a mystery. Engaging the audience with photos of scenarios can help start the conversation and enlist their feedback by posing different questions. Bring the education closer to home by using a healthcare example and walking through the five steps. For example, the scenario of a patient coming through the emergency department who needs to go directly to the operating room provides many points to discuss with risk identification, analysis and control. This also offers an opportunity to discuss the risk financing in place through the professional liability program and an employee's obligations for reporting adverse events and near misses.

Using the claims management principle, elements of medical negligence can be presented and applied to a potential adverse outcome scenario. While the first application of the five risk management principles may not be perfect, continuing to apply them in an educational framework in as many situations as possible will help to reinforce the understanding of how risk management works.

As healthcare risk management programs continue to evolve into an enterprise risk model, these basic principles still apply. Integrating each of the five elements into the decision-making process to manage uncertainty in the organization while adding value and maximizing opportunity to meet the mission and vision will continue to ensure the backbone of the risk management program remains intact.

Upcoming events

Visit the Sedgwick professional liability team at these upcoming conferences:

- **Florida Society for Healthcare Risk Managers & Patient Safety (FSHRMP) 2015 Annual Meeting**
  Aug 12-14 | Orlando, FL
  - *The Hidden Treasures in Physician Office Practices – moderator: Ann Gaffey (August 13)*
- **Society for Healthcare Risk Management of NJ (SHRMNJ)**
  September 18, 12:00 PM EDT
  - *Managing the Risks of Midlevel Providers – webinar presenter: Kathy Shostek*
  - *See http://shcrmnj.org for upcoming registration details*
- **OR Manager Conference**
  October 7-9 | Nashville, TN
  - *visit the Sedgwick booth*
- **American Society for Healthcare Risk Management Academy (ASHRM) 2015**
  October 18-21 | Indianapolis, IN
  - *visit Sedgwick at booth #415*
  - *Healthcare Access at Your Big Box Store: One Stop Shopping Takes on a Whole New Meaning and All New Risk – faculty: Jayme Vaccaro & Kathy Shostek (October 19)*
  - *Hidden Treasures in Physician Offices: Findings of the Hunt Revealed! – faculty: Ann Gaffey & Julie Radford (October 20)*

About Sedgwick

Sedgwick is the leading global provider of technology-enabled claims and productivity management solutions. Our healthcare risk management consultants bring years of risk management and patient safety experience to help clients identify risk and patient safety strategies for success. Our team of national experts addresses both traditional and emerging risks affecting healthcare organizations.

Are you concerned about a lack of teamwork in your perioperative area affecting patient care, possibly leading to retained foreign objects or wrong-site surgery? Our demonstrated success in reducing perioperative risk through assessments, team training, coaching, and ongoing education may be the solution for you. Please contact us today for a customized approach to your perioperative risk management and patient safety challenges.

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Or scan the QR code to the left to visit our **healthcare patient safety** page at www.sedgwick.com and learn more about our services and solutions.

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