Edging up

Short takes on emerging industry issues – state legislative changes, OSHA regulations and drug safety concerns

WA adding paid family and medical leave benefits

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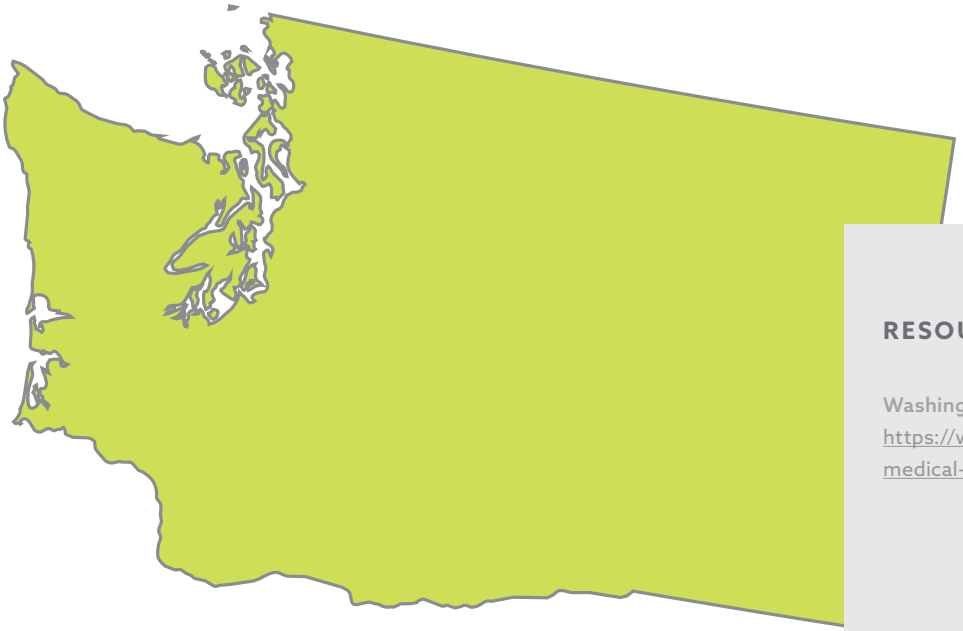
Beginning January 1, 2020, the state of Washington will offer paid family and medical leave benefits for employees. The program will be administered by the Employment Security Department (ESD) and funded by premiums paid by employees and employers. With this new program, Washington will become the fifth state in the nation to offer paid family and medical leave benefits. California, New Jersey, New York and Rhode Island currently offer various types of paid family leave programs.

Under Washington's new program, eligible employees will receive up to 12 weeks of paid family and medical leave annually for:

- Bonding after the birth or placement of a child
- A family member's serious health condition
- The employee's own serious health conditions, as defined in the federal Family and Medical Leave Act
- Certain military assignments such as leave for short notice deployments, military events and post-deployment activities

The benefits will be a percentage of the employee's average weekly wages during the two highest quarters in the qualifying period and the maximum weekly benefit amount will be $1,000. Employees will be eligible for benefits after working at least 820 hours during the qualifying period. The initial premium rate will be 0.4% of wages and premium assessment will begin January 1, 2019. Employers may deduct 100% of the premiums for family leave and up to 45% of the premiums for medical leave from the employees' wages.

The ESD is in the first phase of the rulemaking process for this new law. For more details on the program, please see the Washington ESD website. Currently, Washington ESD estimates rules to be final on June 1, 2018. Keep an eye out for ongoing updates from Sedgwick regarding the WA paid family and medical leave and areas of consideration for affected clients.



RESOURCE

Washington ESD website:
https://www.esd.wa.gov/paid-family-medical-leave

Florida passes legislation with key workers' compensation changes

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Benefits for first responders with PTSD

The Florida Legislature unanimously passed a measure to expand workers' compensation benefits to first responders who suffer job-related post-traumatic stress disorder (PTSD). This is the focus of Senate Bill 376, which was signed by Florida Governor Rick Scott on March 27, 2018. Under the bill, PTSD suffered by firefighters, paramedics, emergency medical technicians and law enforcement officers acting within the course of their employment is an occupational disease compensable under workers' compensation. A physical injury is not required if diagnosed by a licensed psychiatrist who is an authorized treating physician. First responders will be required to show clear and convincing evidence that an event they witnessed was the source of the PTSD. The bill becomes effective October 1, 2018.

Measures to control opioid use

On March 14, 2018, the governor signed House Bill 21, which includes legislation to help combat Florida's opioid epidemic. The law becomes effective on July 1, 2018.

Florida is the 25th state since 2016 that has passed legislation imposing limits or guidelines on opioid prescriptions. The Florida Department of Law Enforcement reported that opioids were identified as either the cause of death or were present in the individual's system in 5,725 cases in the state in 2016.

A key part of the legislation impacts the medication supply limits for acute pain. Under the new law, a prescription for an opioid drug listed as a Schedule II controlled substance such as OxyContin, Fentanyl and Vicodin may not exceed a three-day supply for acute pain. Up to a seven-day supply may be prescribed if the prescriber believes that more than a three-day supply is medically necessary, adequately documents the justification for the deviation in the

medical records and indicates "ACUTE PAIN EXCEPTION" on the prescription. The supply limits for acute pain do not apply to people with chronic long-term pain, cancer, terminal illnesses and some serious traumatic injuries.

Additional provisions in the new law include:

- A concurrent prescription for an emergency opioid antagonist (i.e. naloxone, naltrexone) is required for treatment of pain related to a traumatic injury with an Injury Severity Score of 9 or greater
- Registered practitioners authorized to prescribe controlled substances must complete a board-approved two-hour continuing education course on the standards for prescribing controlled substances as part of their biennial license renewal
- Healthcare regulatory boards are required to adopt rules that establish guidelines for prescribing controlled substances for acute pain and provide that failure to follow such guidelines will constitute grounds for disciplinary action
- Any public or privately-owned pain management clinics must register with the department or hold a valid certification of exemption that is prominently displayed
- A prescriber or dispenser or their designee must consult the system to review a patient's controlled substance dispensing history before prescribing or dispensing a controlled substance that contains opioids for a patient age 16 or older
- A person who willfully and knowingly fails to report the dispensing of a controlled substance as required commits a 1st degree misdemeanor, and a non-disciplinary citation is required to be issued to any prescriber or dispenser who fails to consult the system
- Requirements are provided for pharmacists to dispense controlled substances to persons without proper identification and to dispense controlled substances upon receipt of an electronic prescription

RESOURCES

Senate Bill 376:
http://www.flsenate.gov/Session/Bill/2018/00376

House Bill 21:
http://www.flsenate.gov/Session/Bill/2018/00021

Drugs Identified in Deceased Persons by Florida Medical Examiners. 2016 Interim Report. Medical Examiners Commission. Florida Department of Law Enforcement. May 2017.

OSHA electronic reporting update

BY **MALCOLM DODGE**

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The Occupational Safety and Health Administration (OSHA) recently updated its final rule requiring employers to submit work-related injury and illness records electronically.

The original rule stated that, beginning with 2017 reporting, establishments with at least 250 employees would need to include in their submissions certain data fields from Forms 300 (Log of Work-Related Injuries and Illnesses) and 301 (Injury and Illness Incident Report). However, according to an update on OSHA's website, "Covered establishments with 250 or more employees are only required to provide their 2017 Form 300A [Summary of Work-Related Injuries and Illnesses] summary data. **OSHA is not accepting Form 300 and 301 information at this time.**" This revision means that the reporting requirements for 2017 data are the same as those for 2016, so employers will not need to include data from Forms 300 and 301 in their electronic filings.

Additionally, according to the Office of Information and Regulatory Affairs, OSHA intends to issue a notice of proposed rulemaking to reconsider, revise, or remove provisions of its final tracking rule. The proposal is related to the recordkeeping requirement for establishments with 250 or more employees. Under the proposed rule, these establishments would only be required to electronically submit information from Form 300A.

Below are the reporting deadlines for the 2017 and 2018 reporting years:

For the 2017 reporting year:

- Employers that have establishments with a headcount of at least 250 employees must submit their OSHA 300A by July 1, 2018
- Employers that have establishments with a headcount of 20–249 employees and fall within certain North American Industry Classification System (NAICS) codes must submit their 300A by July 1, 2018

For the 2018 reporting year:

- Employers that have establishments with a headcount of at least 250 employees must submit their OSHA 300A by March 2, 2019
- Employers that have establishments with a headcount of 20–249 employees and fall within certain NAICS codes must submit their OSHA 300A by March 2, 2019

Employer establishments that fall within partially exempt NAICS codes or have fewer than 20 employees are not subject to electronic reporting. For any electronic reporting, it is the individual establishment, its NAICS code and headcount, not the company as a whole, that determines whether an electronic reporting obligation exists for that location.

Sedgwick will be able to submit reports on behalf of customers that utilize our OSHA services. However, employers will ultimately be responsible for the completeness and accuracy of the data.

For more information on the format of the files to be prepared for submission, please contact your client services director.

RESOURCE

OSHA wesite: final rule
https://www.osha.gov/recordkeeping/finalrule/

Kratom: A dangerous self-help path for opioid addiction?

BY **REEMA HAMMOUD** *Pharm.D., BCPS*

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The current opioid epidemic has had a devastating impact on people and the economic burden of opioid misuse in the United States is $78.5 billion a year.[1] Part of this cost includes traditional addiction treatments, which can be time-consuming and expensive. Successful recovery usually involves medically-supervised opioid withdrawal, inpatient rehabilitation, followed by outpatient behavioral treatment such as cognitive behavioral therapy.

An increasing number of opioid-dependent people are seeking a way to withdraw from opioids on their own, instead of relying on treatment centers or hospitals. A newly popular method is to use the herb kratom. Using kratom includes risks and safety concerns as outlined below.

Mitragyna speciosa, also known as kratom or ketum, is a tropical evergreen tree native to Southeast Asia. The tree's leaves contain psychoactive opioid compounds that provide stimulant-like effects, analgesia and anxiolytic effects. The primary psychoactive compounds found in kratom are mitragynine and 7-hydroxymitragynine. Mitragynine is 13 times more potent as an analgesic than morphine, while 7-hydroxymitragynine is four times more potent than mitragynine.

Kratom is being used as an herbal alternative to medical treatment to control withdrawal symptoms and cravings caused by addiction to other opioids. However, there is no scientific evidence that kratom is effective or safe for this purpose. Animal models have shown that kratom possesses addiction potential when given orally for five days. Users have reported dependence to Kratom and withdrawal symptoms include muscle aches, insomnia, aggression, emotional changes and jerky movements. Kratom can interact with other drugs including muscle relaxants, opioids, benzodiazepines and modafinil. These drug interactions can cause respiratory depression, seizures and even death. Commercial forms of kratom have been found to be laced with other compounds

that have resulted in death. A preparation of kratom mixed with O-desmethyltramadol (the active metabolite of tramadol), called krypton has caused multiple fatal overdoses.

While kratom is currently legal in the United States, it has been banned in multiple states including Alabama, Arkansas, Indiana, Tennessee and Wisconsin. It can be purchased online and in convenience stores and minimarts; 30 capsules cost about $20. The Drug Enforcement Administration (DEA) is working towards putting this drug in a schedule I class. Kratom is listed as a controlled substance in Thailand, Malaysia, Australia, Sweden and Germany. The U.S. Food and Drug Administration (FDA) has recently strengthened its warnings against the use of kratom, expressing concerns about kratom's potential for abuse, addiction and serious health consequences, including death.

Scientists have further analyzed the chemical structure of kratom compounds, providing even stronger evidence of kratom compounds' opioid properties. In a report released on February 6, 2018 by the FDA, Dr. Scott Gottlieb highlighted the adverse effects of kratom in humans by calling it an opioid. The FDA utilized Public Health Assessment via Structural Evaluation (PHASE) methodology

and proved that 22 out of the 25 kratom compounds bind to mu-opioid receptors and two out of the five most prevalent ones activate opioid receptors. The FDA is now reporting 44 deaths associated with the use of kratom which is an increase from 36 deaths reported in November 2017.[2]

There is no reliable evidence to support the use of kratom as a treatment for opioid use disorder. Significant safety concerns exist with the use of kratom. Kratom is even riskier than other opioids because of the variability in how it is being formulated, sold, and used recreationally. Mixing kratom with other opioids and other medications is extremely dangerous. Kratom should not be used to treat opioid withdrawal or dependence. Only FDA-approved medications including buprenorphine (+/- naloxone), clonidine, methadone or naltrexone should be used.

REFERENCES

Centers for Disease Control and Prevention. Opioid Overdose. 2017 August 30. https://www.cdc.gov/drugoverdose/epidemic/index.html

FDA. Statement from FDA Commissioner Scott Gottlieb, M.D., on the agency's scientific evidence on the presence of opioid compoundsin kratom, underscoring its potential for abuse. February 6, 2018. https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm595622.htm

RESOURCES

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