THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

Wisdom for Your Life.

Opioid & Pain Management in the In-Patient Setting

J. L. Epps, MD

Chief Medical Officer

Our Mission

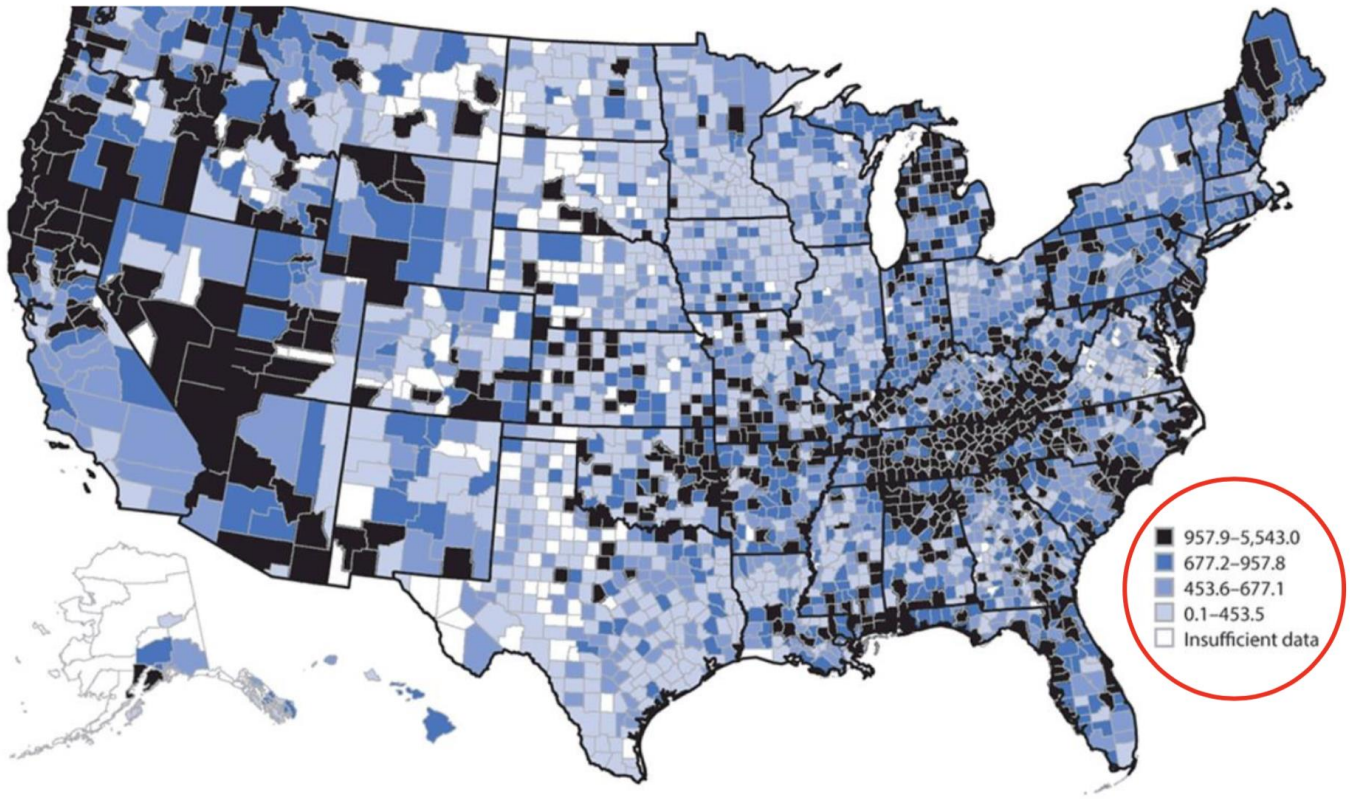
To serve through healing, education and discovery

BEST REGIONAL HOSPITALS U.S.News & WORLD REPORT KNOXVILLE, TN RECOGNIZED IN 11 TYPES OF CARE 2017-18

MAGNET RECOGNIZED AMERICAN NURSES CREDENTIALING CENTER

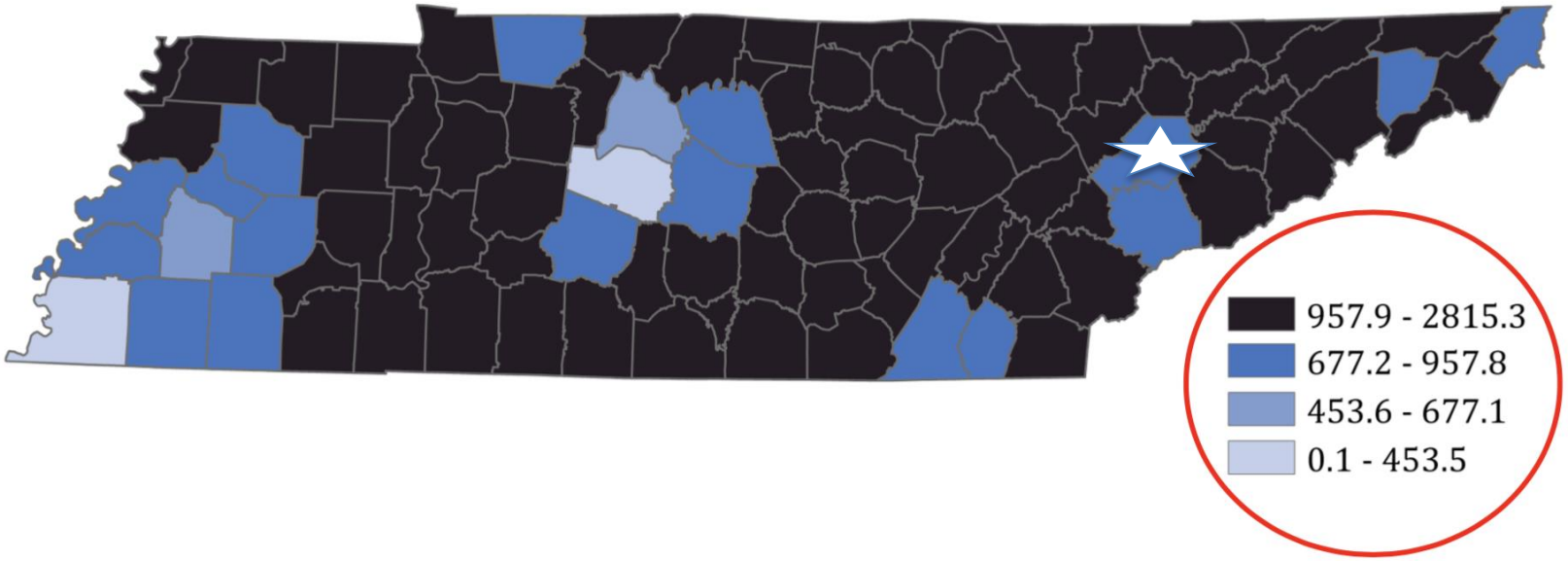
Tennessee Center for Performance Excellence 2016 EXCELLENCE AWARD

MME per capita in 2015 by County (CDC)



MME Dispensed Per Capita (2017)

The MME of opioids dispensed was enough to provide oxycodone 5mg three times a day to every man, woman, and child in the state for **six weeks**.



Why Do Physicians Overprescribe?

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- How Physicians Were Trained
- Lack of knowledge
  - How many pills most patients actually take to relieve postoperative pain
  - Percentage of opioid naïve patients who remain on narcotics 1 year after surgery
- Inconvenience
  - Patient
  - Provider

Doctor's Do Not Treat Pain Effectively

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1980s

Published studies and letters posit that opioids ***do not carry significant risks for adverse events or addiction***[1,2]

1998

Pain is established as a "fifth vital sign." ***Consistent pain management guidelines that rely on opioids are created***[3,4]

2016

"Today, more Americans die because of drug overdoses than because of car crashes, and most of these overdoses involve some form of opioid" [5]

-US Surgeon General

References: 1. Porter J et al. *N Engl J Med*. 1980;302(2):123. **2.** Portenoy RK et al. *Pain*. 1986;25(2):171-186. **3.** *Pain as the 5th Vital Sign Toolkit*. Washington, DC: Dept of Veterans Affairs; 2000. **4.** Federation of State Medical Boards of the United States, Inc. http://www.fsmb.org/Media/Default/PDF/FSMB/ Advocacy/pain_policy_july2013.pdf. Accessed March 3, 2017. **5.** Murthy VH. Public Health Reports. 2016;131:387-388..

Common Surgeries Create a Surplus of Opioids That Flood the "Market"

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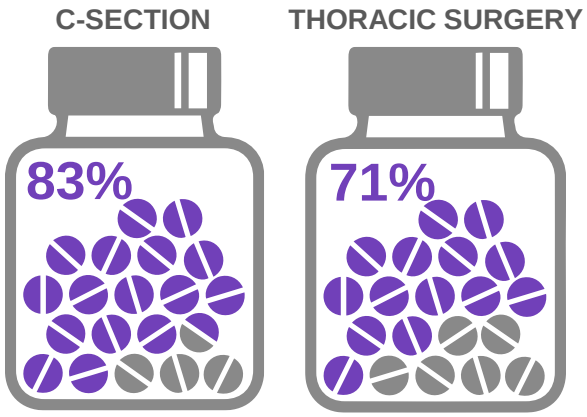
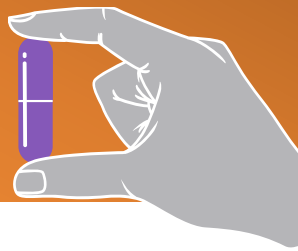
Proportion of patients taking half or less of prescribed opioid pills[1]



Outpatient upper extremity surgery[2]

- ~ **300 patients, with 92% reporting adequate pain control**
- Usually received **30 narcotic pills**
- >50% took pain pills for 2 days or less
- **Consumed an average of 11 pills per patient**

Almost 5000 leftover tablets



Initiation of short-term opioid therapy may lead to long-term use

References: 1. Bartels K et al. *PLoS ONE*. 2016;11(1):e0147972**. 2.** Rodgers J et al. *J Hand Surg Am.* 2012;37(4):645-650.

Postsurgical Opioid Utilization Can Lead to Chronic Use

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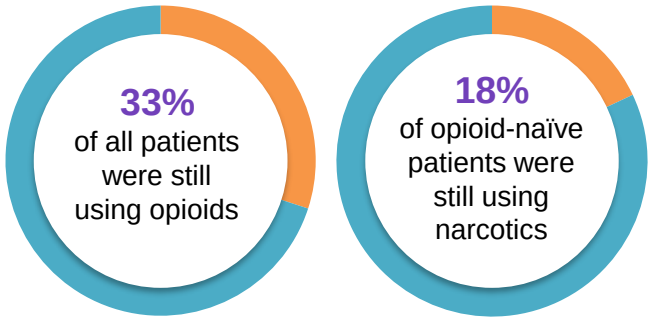
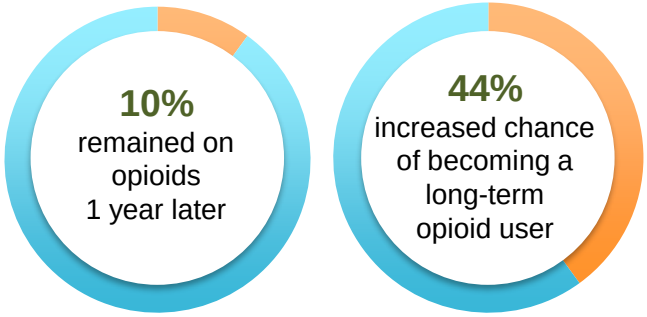
Patients 1 year after surgery[1]



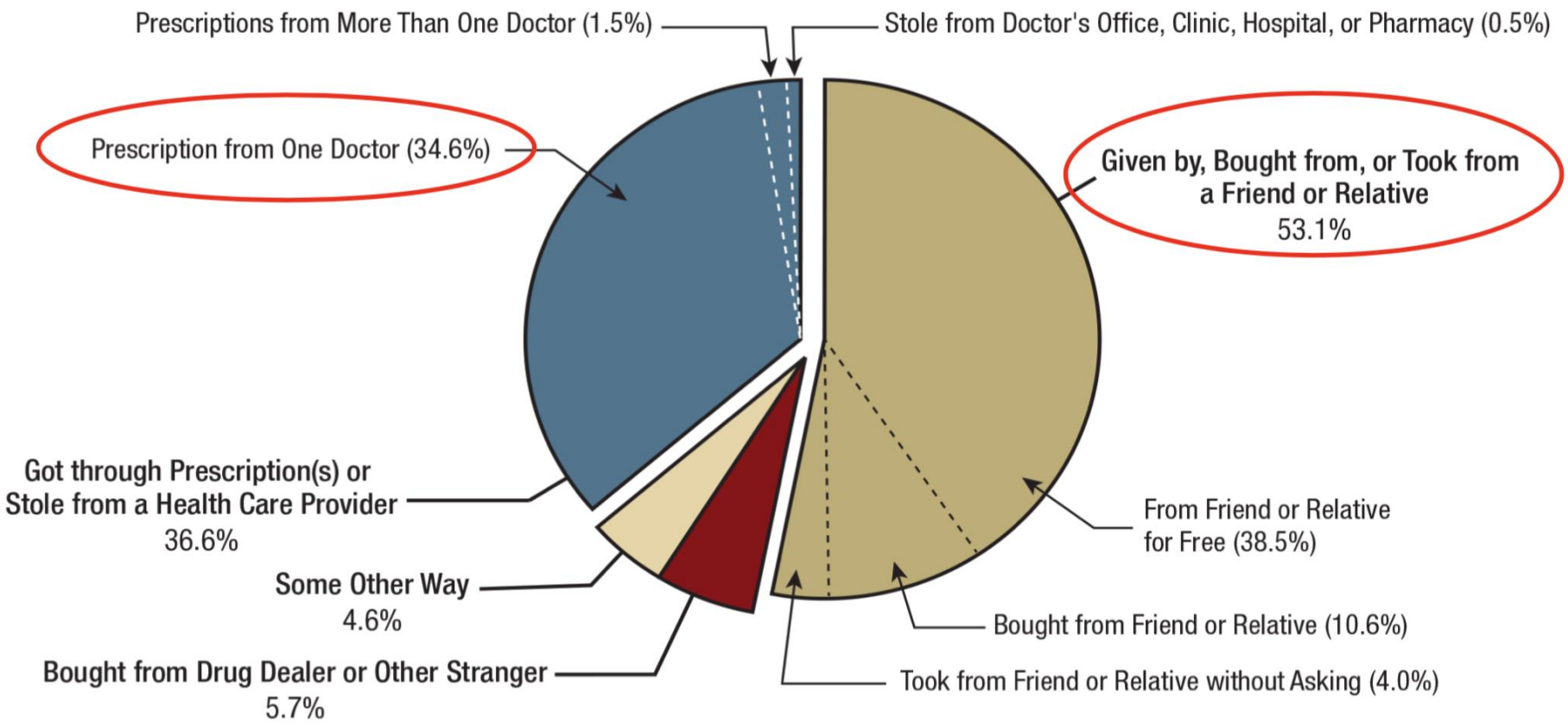
Patient aged ≥65 years with an opioid prescription 7 days postsurgery[2]



Postsurgical Opioid Utilization Can Lead to Chronic Use

References: 1. Wang M et al. *Spine J.* 2013; 13(9):S6-S7. **2.** Alam A et al. *Arch Intern Med.* 2012;172(5):425-430.

Drug Source



11.1 Million People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year

TN Together

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Prevention

- Place reasonable limits on supply and dosage of prescription opioids.
- Increase public awareness through outreach campaign and targeted education.
- Promote best practices in the medical community for pain management.

Treatment

- Ensure that all Tennesseans who need treatment have better access to recovery services and resources.
- Effectively target areas for resources through data, improved access and sharing.
- Expand treatment options and recovery programs, including those within the criminal justice system.
- Create incentives for offenders to complete intensive substance use treatment programs while incarcerated.

Law Enforcement

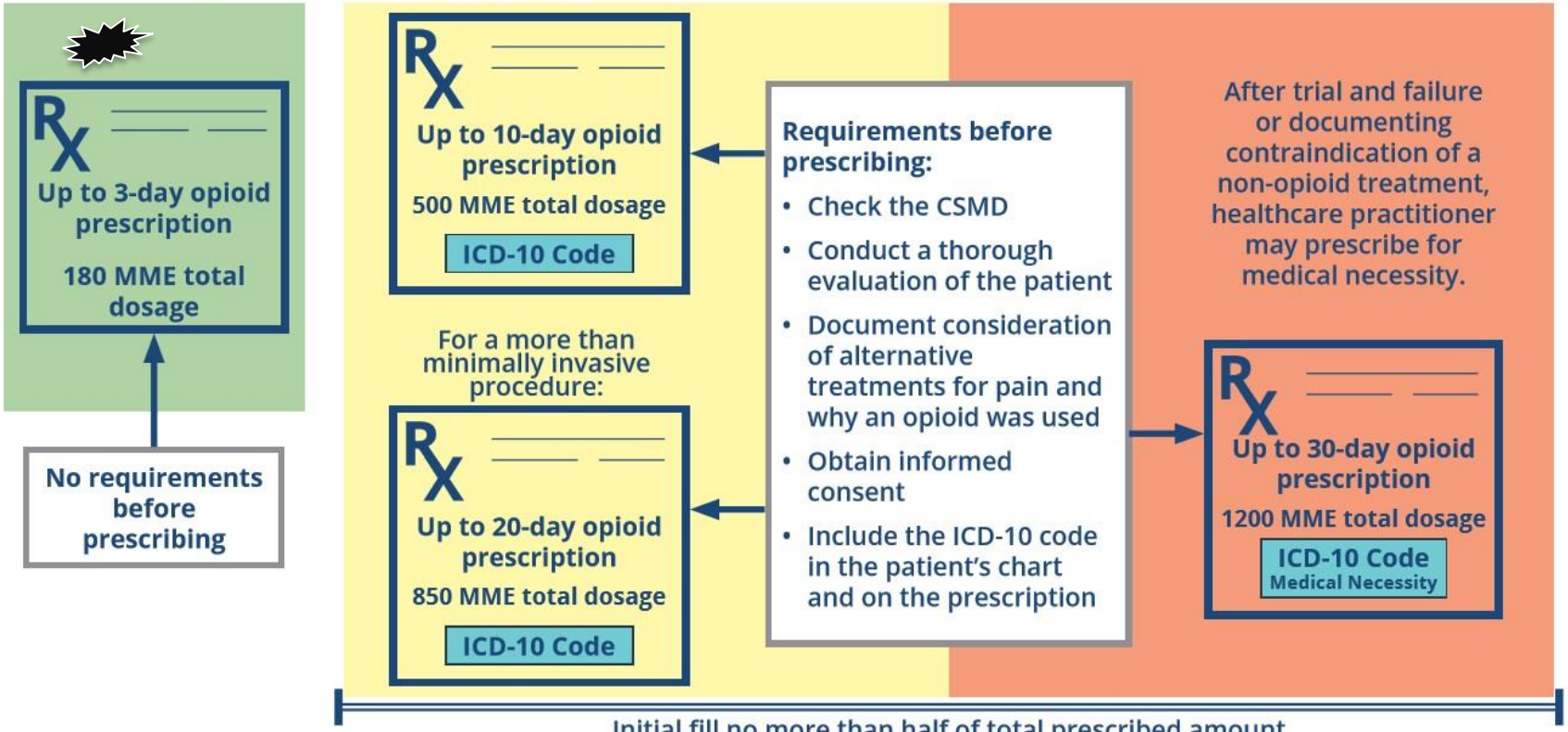
- Increase funding to address unlawful sale and trafficking of opioids.
- Provide every Tennessee state trooper with Narcan for emergency treatment of overdoses.
- Update the schedule of controlled substances to better track, monitor and penalize the use and unlawful distribution of opioids.

HB1831/SB2257 *Proposed Amendment* | To place more guidelines for and checkpoints between healthcare practitioners and patients before an individual is put on a chronic regimen of opioids.

TN TOGETHER

ENDING THE OPIOID CRISIS

A healthcare practitioner may prescribe:



The following are individuals exempted if the prescription includes the ICD-10 Code and the word "exempt":

- Patients receiving active or palliative cancer treatment
- Patients receiving hospice care
- Patients with a diagnosis of sickle cell disease
- Patients in a licensed facility
- Patients seeing a pain management specialist
- Patients who have been treated with an opioid for 90 days or more in the last year or who are subsequently treated for 90 days or more
- Patients being treated with methadone, buprenorphine, or naltrexone
- Patients who have suffered severe burns or major physical trauma

UTMC Response

Pain Management: Standardization in the Midst of an Opioid Epidemic

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Pain Scale

–Emphasis on function

Pathways: Impact in Cerner

–For pain orders imbedded in Disease/Procedural Pathway: Minimal Change

–Guidance established for inexperienced clinicians via two new Pain Pathways

–Experienced Clinicians (Hospitalists) using General Medicine Pathways essentially unaffected

–Multi-modal (Non-narcotic Options) easier to access in Computerized Physician Order Entry

–Pain Flow Sheet

"3 Strikes…You're Out (Evaluate)"

– Guidance for expected responses for both nursing and physicians established

Red Flags

–Prompt to identify the *Accurate Diagnosis* and treat the *CAUSE* of the pain

Use of Sedation Scales

Escalation of Nursing or Patient Concerns

–"Something's not right!"

Mandatory Attending Evaluation

Morphine Milligram Equivalents

– Common language of "how much"

On-Site Drug Disposal Receptacle

–Secure and Responsible Drug Disposal Act 2014

Decreasing the Number of Opioid Pills Prescribed

Standardized Management of IV Drug Use – Associated Infections

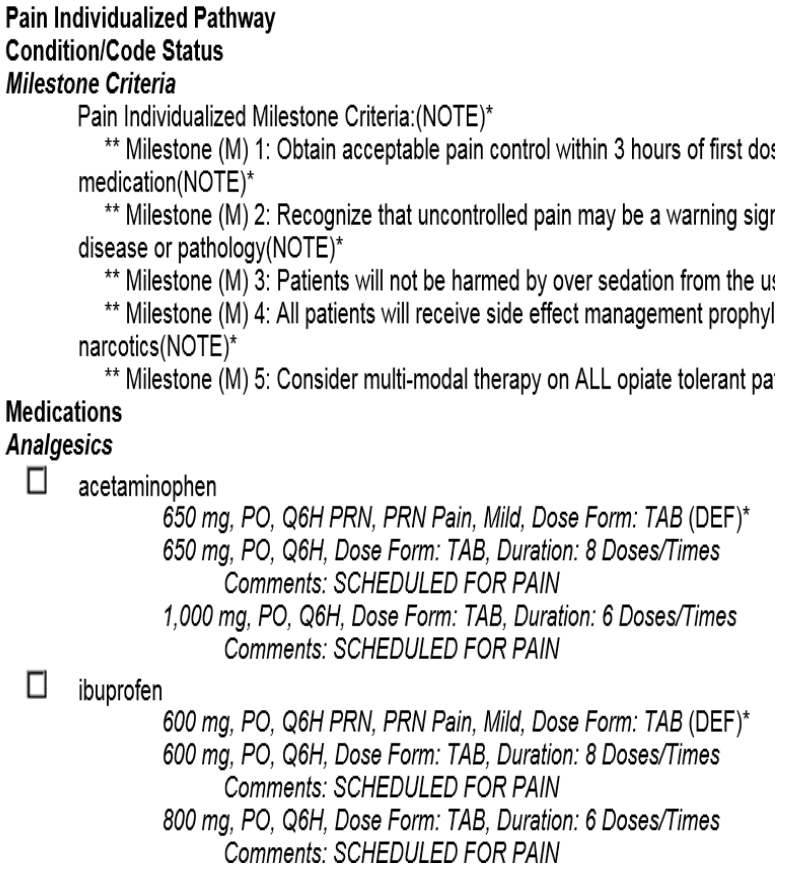
–Plan of Care

–Withdrawal Management

–Addiction treatment

Expected Pain Level: Pathway Orders in CPOE

1. Pain Non-Narcotic Pathway
2. Pain Low Narcotic Pathway
3. Pain High Narcotic Pathway
4. Pain Individualized Pathway
5. Pain Orders in Procedural / Disease Pathways



Pain Individualized Pathway
Condition/Code Status
Milestone Criteria
Pain Individualized Milestone Criteria:(NOTE)*
** Milestone (M) 1: Obtain acceptable pain control within 3 hours of first dos
medication(NOTE)*
** Milestone (M) 2: Recognize that uncontrolled pain may be a warning sigr
disease or pathology(NOTE)*
** Milestone (M) 3: Patients will not be harmed by over sedation from the us
** Milestone (M) 4: All patients will receive side effect management prophyl
narcotics(NOTE)*
** Milestone (M) 5: Consider multi-modal therapy on ALL opiate tolerant pa
Medications
Analgesics
☐ acetaminophen
650 mg, PO, Q6H PRN, PRN Pain, Mild, Dose Form: TAB (DEF)*
650 mg, PO, Q6H, Dose Form: TAB, Duration: 8 Doses/Times
Comments: SCHEDULED FOR PAIN
1,000 mg, PO, Q6H, Dose Form: TAB, Duration: 6 Doses/Times
Comments: SCHEDULED FOR PAIN
☐ ibuprofen
600 mg, PO, Q6H PRN, PRN Pain, Mild, Dose Form: TAB (DEF)*
600 mg, PO, Q6H, Dose Form: TAB, Duration: 8 Doses/Times
Comments: SCHEDULED FOR PAIN
800 mg, PO, Q6H, Dose Form: TAB, Duration: 6 Doses/Times
Comments: SCHEDULED FOR PAIN

Pathway: Pain Meds Summary

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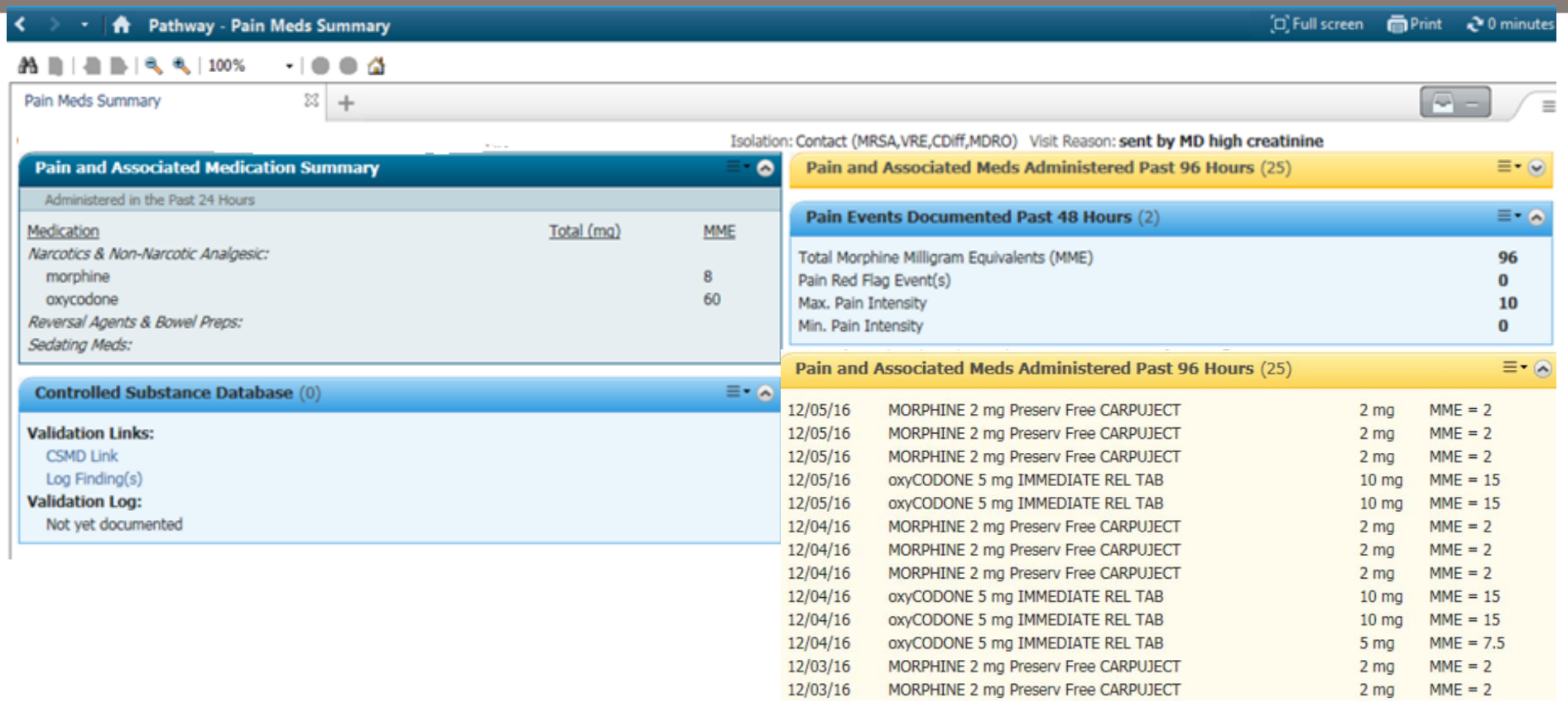

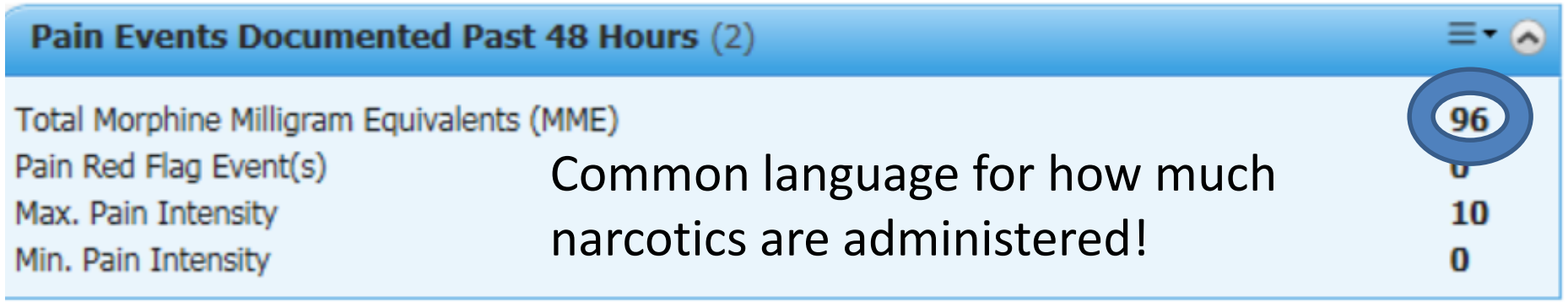

Standardization of Pain Control

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Drug	2016	2018	%Decrease
Lortab	8.2	7.4	10%
Percocet	13.5	11.9	12%
Morphine IV	48.2	31.3	35%
Dilaudid IV	4.0	2.8	30%

*Opioid Doses per patient

- Believed to be result of multi-modal analgesia & increased use of regional anesthesia
- Use of Ofirmev has decreased

Unexpected Financial Benefit: IV Acetaminophen (Ofirmev)

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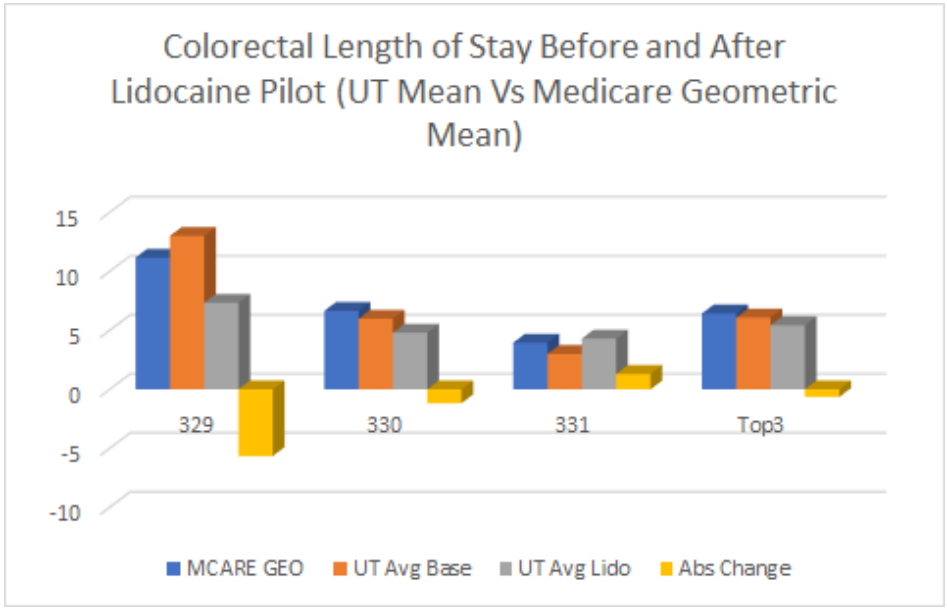
Year	Drug	Spend
2017	Ofirmev	$1,259,826
2018	Ofirmev	$603,100
2019 (Projected)	Ofirmev	$318,088

- UTMC received a 35% volume discount
- 2019 projected use based upon July – Dec 2018 data
- 2019 volume discount decreased to 33%

IV Lidocaine

- Multiple studies have confirmed the benefits of perioperative IV lidocaine infusions including decreases in pain scores, analgesic consumption, and side-effects with improvements in ERAS outcomes
- Common practice at UTMC in specific patient populations e.g. colectomy & renal colic



TN Together Impact

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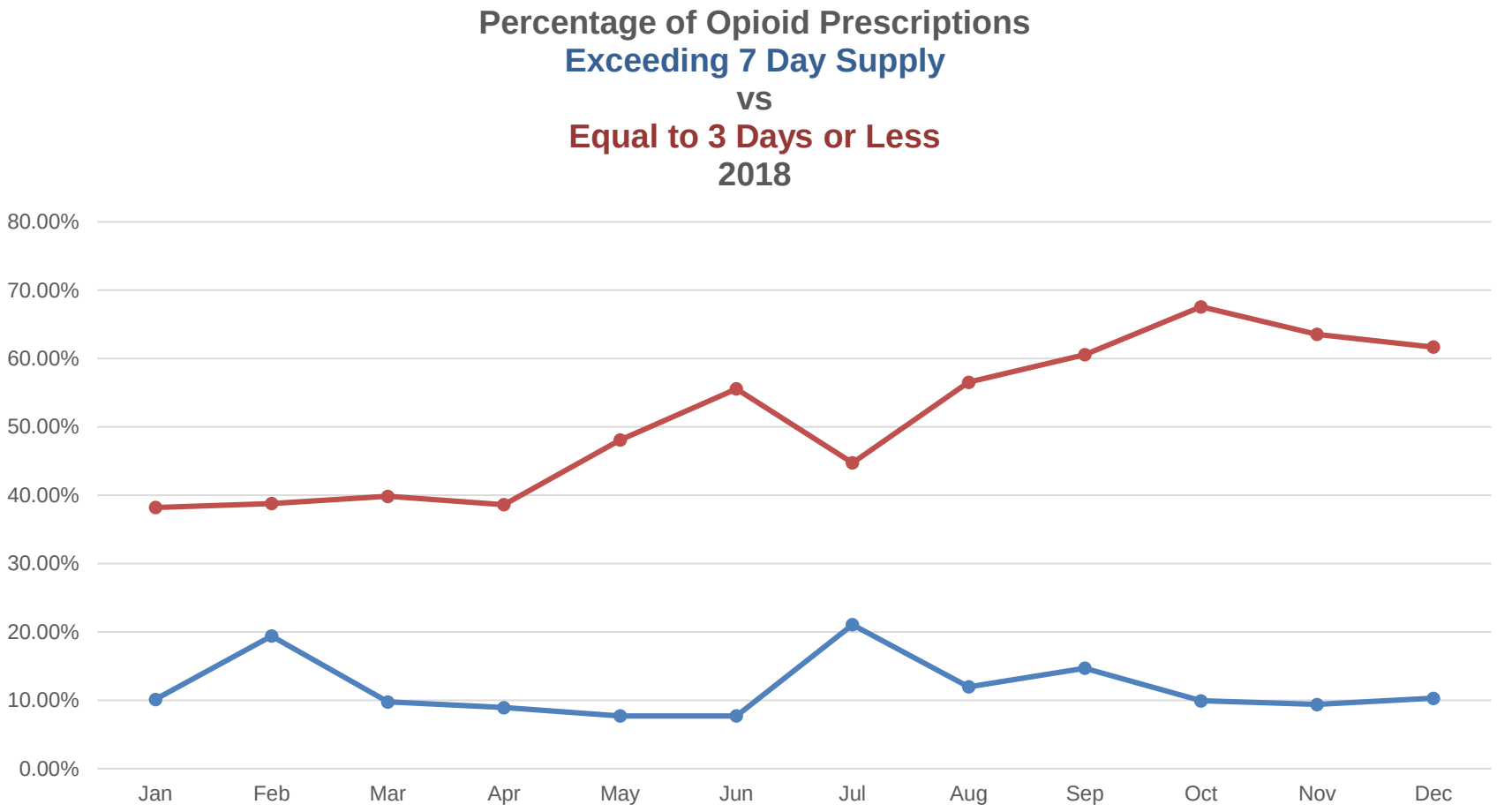

Pain Scale

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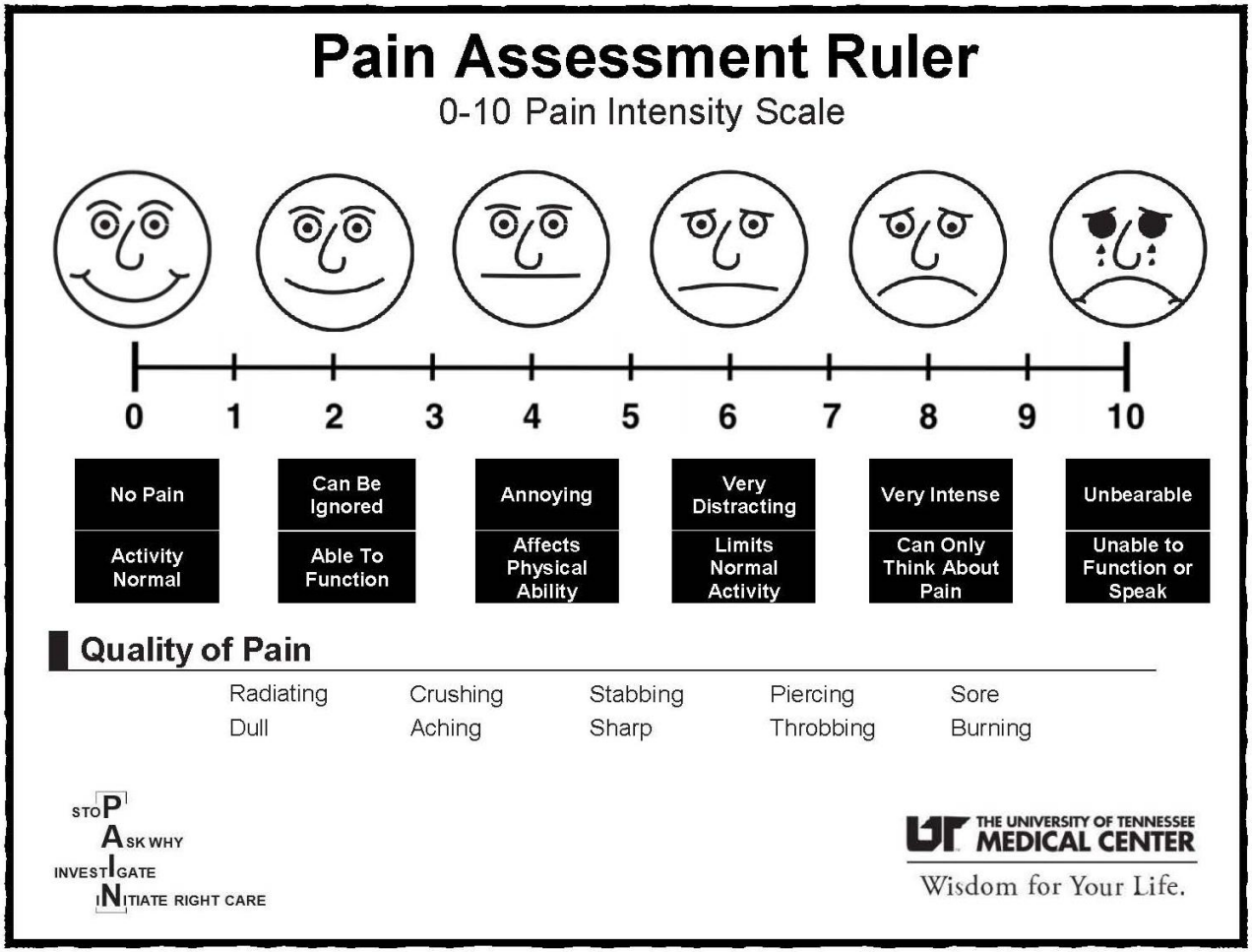
- The Pain Scale incorporates **patient functional abilities**
- This will ideally help the patient to score their pain more accurately with a reference point



Pain Scale

- Previous process mandated nursing reassessment if pain scale was ≤ 4
- In patients with chronic pain and scores, the pain assessment flow sheet would sometimes show the pain score going from 8 to 0 in patients whose baseline pain was never less than 6
- Pain assessment process was revamped to a baseline based upon function

Sedation Scale: UTOSS

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- Prevention of respiratory arrest from excessive opioid administration or patient sensitivity is best predicted by the degree of sedation

Level	State	Guideline
S	Sleeping, easy to arouse	No action; increase opioid if needed
1	Awake & alert	No action; increase opioid if needed
2	Drowsy, easy to arouse	No action; increase opioid if needed
3	Frequently drowsy	Unacceptable; Decrease opioid 25 – 50%; notify MD; consider non-narcotics until SS improves
4	Somnolent; minimal response to stimuli	Unacceptable; stop opioid; consider naloxone; notify MD

UTOSS Impact

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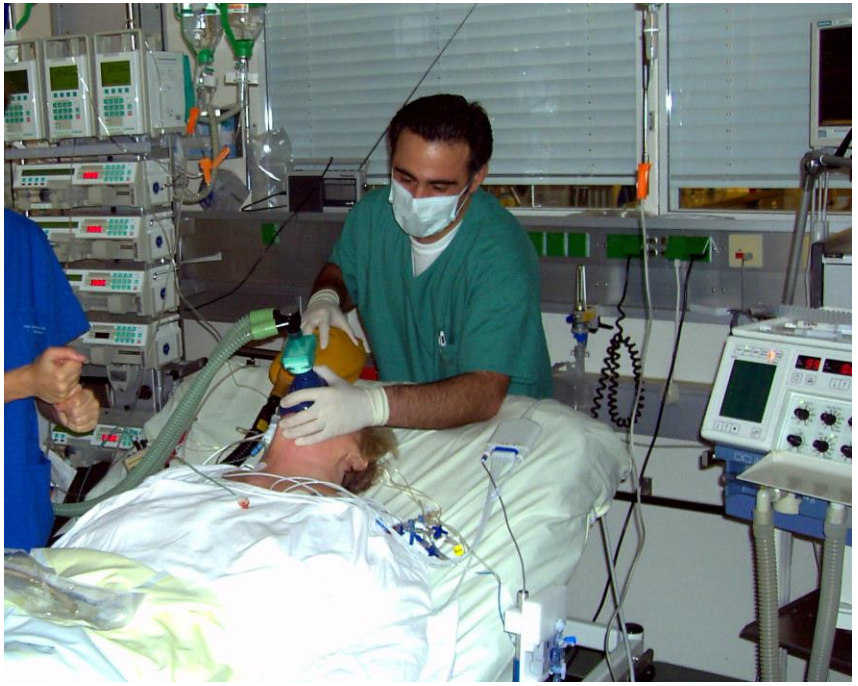
- No adverse or sentinel events due to opioid induced respiratory depression since UTOSS instituted on our medical or surgical floors



Red-Flags

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- If pain management therapies are unsuccessful, there may be an underlying complication which is resulting in their pain
- Don’t just treat the pain score, treat the CAUSE of the pain
- Consider the following questions (Red-Flags) when evaluating the patient’s pain
  - Is pain outside the expected location?
  - Is pain out of proportion to the diagnosis?
  - Is something ‘just not right?’

Three Strikes!!!: An Example

72 y.o. female with a fractured femur awaiting surgery tomorrow morning after a fall following admission for syncope evaluation

- Provider selects Drug and Dose from Pathway
- Nurse tries Prescribed Therapy
- Not Effective (no PAIN RED FLAG present) = ***STRIKE 1*** → **RETRY**
  - Nurse re-tries next available ordered dose
- Not Effective (or PAIN RED FLAG present) = ***STRIKE 2*** → **ESCALATE**
  - Nurse escalates to provider
  - Provide pain score UTOSS and vital signs
  - Provider determines proper escalation strategy
- Not Effective (or PAIN RED FLAG present) = ***STRIKE 3*** → **EVALUATE**
  - Nurse calls provider to evaluate using script
  - Provider further evaluates the situation
    - Additional Hx, repeat PE, review or order new Dx Testing

Communication Script

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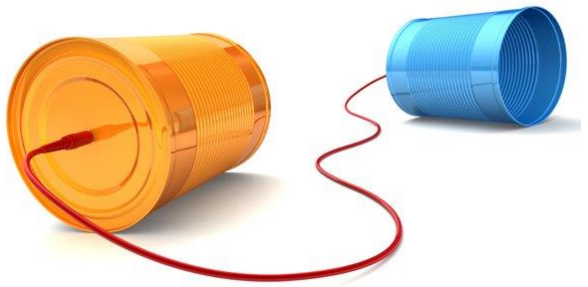
The communication script outlines the information the provider will need in order to determine an appropriate escalation strategy for the patient in the event previous therapies have been unsuccessful.

1. This is [45 y.o. male] admitted with [kidney stones].
2. Now complaining of [abdominal pain].
3. Pain score is [7]
4. He has received [Lyrica] and [4 mg morphine] with [no] relief.
5. Sedation score is [2]. Vital Signs are [xxxxx]
6. Has [no or 1-3] **Red Flags**.
7. How would you like me to proceed?



PACT

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Patient-family
Activated
Concern/Safety
Team

At The University of Tennessee Medical Center, patient safety and quality care are our top priorities. If you have concerns about your care or the care of your loved one, the PACT offers an additional safety net to ensure you receive compassionate and excellent care.

TJC 2018 Guidelines

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- "Kick Start Your Hospital's Program To Reduce Opioid-Induced Ventilatory Impairment"
  - Ongoing assessment of pain should not solely be based on numeric (1–10) scales & should include functional criteria
  - Every patient receiving opioids should have regular nursing assessments of the level of sedation at appropriate intervals including after dosing of an opioid
  - Standardized handoffs & communicate

apsf | NEWSLETTER
THE OFFICIAL JOURNAL OF THE ANESTHESIA PATIENT SAFETY FOUNDATION

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Decreasing the Number of Opioid Pills Prescribed

Standardized Management of IV Drug Use – Associated Infections

–Plan of Care

–Withdrawal Management

–Addiction treatment

Drug Associated Infections: The Mandate

- Standardized approach to the management of patients hospitalized with drug use associated infections
- Focus on:
  - Safety
    - The Patient
    - Other Patients
    - Visitors
    - Team Members
  - Pain Management
  - Addiction Treatment

PET Scan in Addicts

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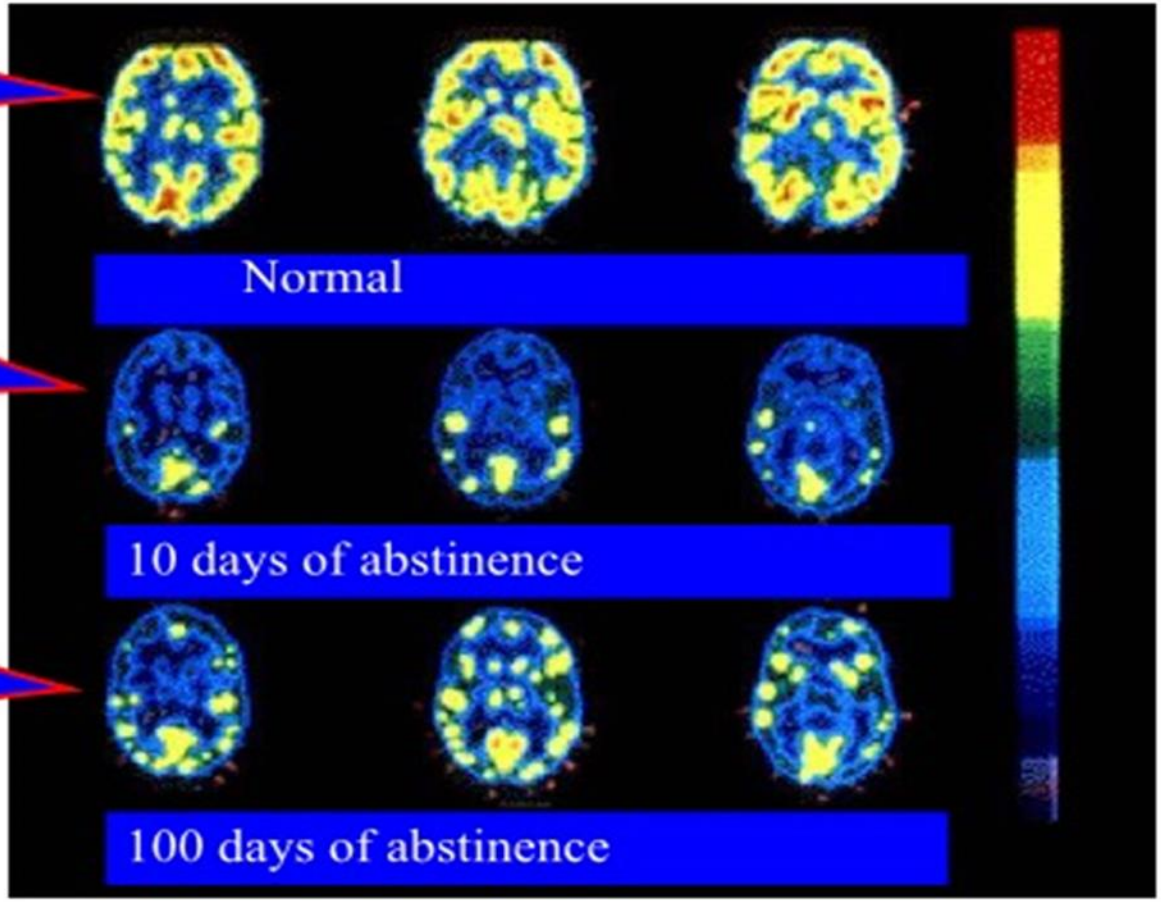
Normal levels of brain activity in PET scans show up in yellow to red

Reduced brain activity after regular use can be seen even after 10 days of abstinence

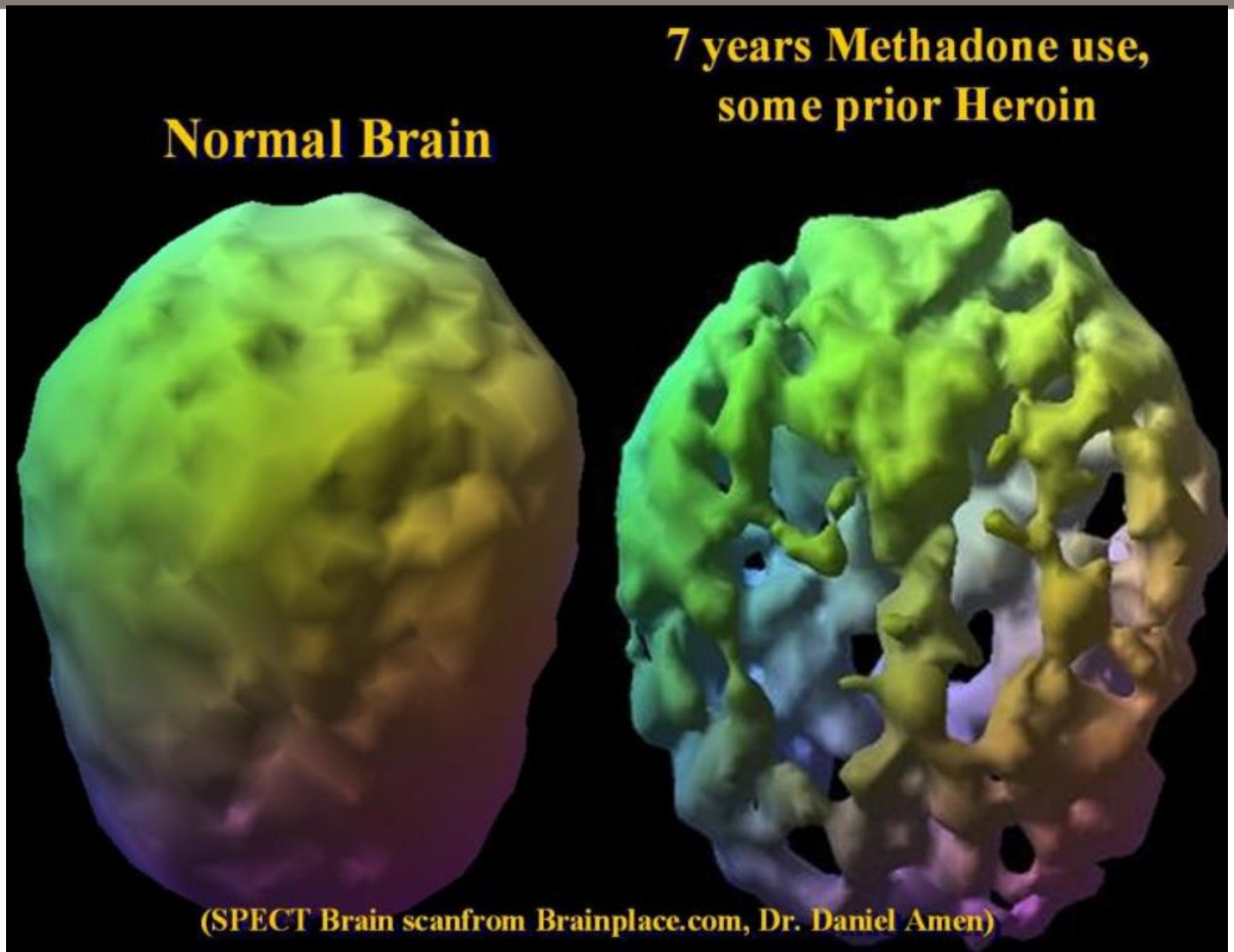
After 100 days of abstinence, we can see brain activity "starting" to recover



Source: Volkow ND, et al. Synapse 11:184-190, 1992; Volkow ND, et al. Synapse 14:169-177, 1993.

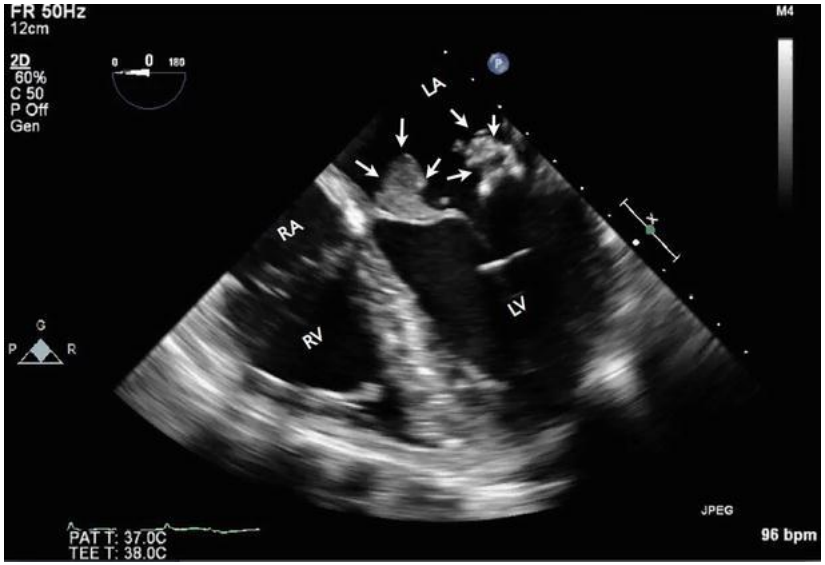
Science = Solutions

SPECT Brain Scan



The Team

- Thirty member task force
  - Nurse Managers
  - Physicians
  - Security
  - Pharmacy
  - Patient Advocacy
  - Compliance
  - General Counsel
  - Medical Ethicist



Plan of Care for Drug Use Associated Infections

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- The admitting physician orders that the DUAI Plan of Care be instituted
- Search performed by security
- Personal property including clothing removed
- All patients will be placed in a specific and identifiable gown
- No access to personal cellular phone
- Patients are restricted to the floor
- Conversion of tablet medication (especially pain & sedative medications) to liquid form when feasible with proof of swallowing
- No visitors

Plan of Care for DUAI Infections: Initiation

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- The admitting physician orders that the DUAI Plan of Care be instituted
- The physician (APN/PA) and the Nurse Manager of the floor where the patients resides discuss the need for the plan based on patient safety
- The physician usually leaves after the introduction of the plan
- The nurse manager with security present goes over the plan of care in detail
- The patient signs the POC to acknowledge the tenets
- A signed copy is left in the room

DUAI POC

- Patient Clothing
  - All patients will be placed in a specific and identifiable gown
  - Personal property including clothing removed
- Floor Restriction
  - Patients are restricted to the floor
- Conversion of tablet medication (especially pain & sedative medications) to liquid form when feasible with proof of swallowing

DUAI POC

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- Visitation Policy
  - No visitation will be allowed upon admission
  - Visitation and the number of visitors are re-evaluated after one week by the nurse manager
  - Process to allow visitation to be earned
    - When (if at all)?
    - Who?
    - How many?
- When (if) visitation is allowed, restrict visiting hours to 9:00 AM to 6:00 PM 7 days per week

Modifications of DUAI POC

- If the patient's medical condition warrants transfer to the intensive care unit (ICU), the expectations and guidelines of the plan of care will continue both in the ICU and upon return to the acute care floor
  - Visitors may be allowed while in the ICU at nurse manager and physician discretion
  - However visitors will not be allowed to personal belongings to the patient or into the ICU room
- Participation in all prescribed treatments, including, but not limited physical therapy, specialist consults, and skilled nursing facility placement when deemed appropriate is a mandated tenet of the POC
- POC is not initially implemented in the ICU upon admission
  - EMTALA

Modifications of DUAI POC

- No access to personal cellular phone for the first week
  - Landline telephone access
  - Access to personal cellular phone after the first week at the discretion of the nursing unit leadership
    - Makes access to drug sources more difficult
- Allow supervised trips outside with the unit's nurse manager, clinical nurse specialist, or team leader after three weeks of hospitalization to a location to be determined by leadership staff based upon cooperative behavior
    - 0900 – 1600 as unit staffing allows
    - Family and visitors will not be allowed to accompany

Contraband Found: DUAI

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Contraband	#	%
Prescription Pills/Medications	918	50%
Syringes/Needles	337	18%
Unknown Substance/Residue	99	5%
Other Drug Paraphernalia	88	5%
Burnt Spoon/Cans	79	4%
Rubber Tourniquets/Ties	53	3%
Cut Straws	42	2%
Pipes	31	2%
Stolen Medical Supplies	28	2%
Heroin	28	2%
Knives	26	1%
Meth	17	1%
Marijuana	12	1%

- Contraband Found or Search Refused @ 41%

Project Results

Diagnosis	%
Osteomyelitis	14%
Infective Endocarditis	26%
Soft Tissue Infection	36%
Sepsis	17%
Other	3%
No Infection	3%

- Pilot length: 549 days
- # of Patients: 723
- Addiction RX at D/C: 12%
- Readmission: 22%
- Race
  - 99% Caucasian
  - 1% African American
- Gender
  - 48% Male
  - 52% Female

Left Against Medical Advice

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Diagnosis	Total #	LAMA	%LAMA
Osteomyelitis	100	32	32%
Infective Endocarditis	189	82	43%
Sepsis	127	71	56%
Epidural Abscess	3	0	0%
Soft Tissue Infection	258	96	37%
Endophthalmitis	8	3	38%
Empyema	3	1	33%
No Infection	35	10	29%
Total	723	295	41%

Left Against Medical Advice

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DUAI	
Abiding By Plan/Discharged Properly	60%
Signed Plan Then Later Left AMA	25%
Refused to Sign Plan at Admission – Left AMA	13%
Pt Discharged for Not Abiding By Plan	2%

Pilot Results: LAMA LOS

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Diagnosis	Agree (d)	LAMA (d)
Osteomyelitis	17.2	6.2
Endocarditis	21.1	6.0
Sepsis	8.1	2.7
Soft Tissue	5.3	3.4

LAMA = Left Against Medical Advice

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Larry Graham, MD on UTMC DUAI POC

- President of Mercy Health's Behavioral Health Institute in Ohio
  - "**When COPD patients smoke, we don't discharge them**. We educate them, try to get buy-in and offer smoking substitutes. If we're not creating no-visitor rules for those patients, we shouldn't do it for patients with chemical dependencies."
  - "If a patient or guest has brought in drugs and we're aware of it, the team has to **sit down with the patient and say, '*This can't keep going* on because it puts everyone at risk.** What do we need to do that would be helpful to you?' I can't say we never discharge a patient, but we haven't had to do it very often."
  - "It's essential to educate staff to **reduce *biased and stigmatizing attitudes* toward drug-addicted patients**, which …….produces policies like UTMC's."

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- Dr. David Kasick
  - Leads a team of consulting psychiatrists working with medical and surgical teams at Ohio State University Medical Center
  - “If patients feel they are being restricted, they may leave and relapse. We try to work with them on **being safe in the least restrictive way**, ***not one size-fits-all***.”
- Dr. Timothy Lahey
  - Infectious disease specialist and ethicist at Dartmouth-Hitchcock Medical Center
  - “This is a super-frustrating area of clinical care and I can't judge someone for taking a command-and-control approach. But I think it's ***misguided***.”

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- Arthur Caplan
  - Director of medical ethics at the NYU School of Medicine
  - "…***doesn't see it as an ethical way to treat patients*** outside of mental health settings."
- Martin Green
  - Immediate past president of the International Association for Healthcare
  - "I'm not saying it's the wrong thing to do, but it's a new one on me. The patient is in a hospital, not a jail. It may be a ***violation of that person's human rights***."

The Joint Commission

THE UNIVERSITY OF TENNESSEE MEDICAL CENTER

Did you contact Complainant?

Complaint Summary:

http://www.modernhealthcare.com/article/20180707/NEWS/180709961?CSAuthResp=1%3A873688472576271%3A180148%3A1024%3A24%3Aapproved%3A3A604214089ADABCDC68925596D24D6A

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In response to the media article above, the leadership of The Joint Commission has the following questions:

1. What organization specific data was utilized to make the decision to establish and implement the IV Drug Use Associated Infection Plan of Care.
2. What data was used to determine each level of restriction?
3. What alternatives were considered that were less restrictive to the patient's rights?
4. When is this policy implemented in relationship to patient status (ED, outpatient, OBS, Inpatient)?
5. Is there risk of EMTALA with the implementation of this program?
6. What data is collected to evaluate the effectiveness of this program in addition to the data collected from the first line item?
7. How is the patients mental health evaluated based on the possibility of closure from family support and contact and room confinement for a long period of time coupled with potential of mental effects of withdrawal?
8. Going through each restriction implemented, how was the decision made based on data to implement that restriction to the level it was implemented?
9. Is the patient allowed to leave the room they are designated within? Is the patient in the room alone with the perception they cannot leave the room?
10. If yes to either of these it is seclusion according to CMS and would require the components of seclusion to be done.
11. How is patient perception evaluated?
12. How have alterations in perception of quality of care been addressed?
13. How did the organization make the determination that each of these standards and elements of performance were still provided with the implementation of the policy as part of the analysis conducted from the leadership standards above?

Not Alone

- Adopted by the other hospital systems in our region
  - Covenant
  - Tennova
- Presentations and visits from multiple other institutions across the country
  - Temple University Hospital in Philadelphia (727 beds)
  - The Christ Hospital in Cincinnati (527 beds)
  - Abbott Northwestern Hospital in Minneapolis (627 beds)
  - Vanderbilt University Medical Center (626 beds)

Not Alone

- Wake Forest
  - We have a ***significant issue with patients who are intravenous drug (illicit) abusers, who repeatedly break behavioral contracts*** including leaving the floor with PICC lines in place. Our behavioral contract includes ***a sitter, pain medicine consult, visitor restriction, and psychiatry consult*** to evaluate for IVC.
    The next reasonable step would be to discharge the patient; however, the primary providers may not feel the patient is safe, medically, to discharge the patients.
    1. In these cases, ***does anyone have an administrative discharge process***?
    2. If so, who discharges the patient?
    3. What happens if the patient returns to the ED?

Not Alone

- University of Kentucky
  - We have ***grappled with similar issues***. We have revised our discharge policy to ***administratively discharge*** any patient who remains off the floor/out of room/unavailable for care after 2 hours or more. For patients who are frequently out of their rooms with recurrently positive urine drug screens and/or disruptive or threatening, we engage the physician and care team to determine whether the patient is deriving any benefit from continued inpatient therapy. If the patient is stable, we often recommend discharge. Some of our hospitalists have shied away from discharging a stable disruptive and/or noncompliant patient out of fear of potential liability; in the end, when the decision whether to discharge a patient is a medical one, we defer to the professional's judgment. However, often when such patients are confronted with their conduct, coupled with a ***behavioral agreement which limits mobility, visitors, and medications, many patients will leave against medical advice***. Finally, when the patients return to the ED - whenever that may be- we recommend that our providers comply with the legal obligations under EMTALA, to wit: triage, screen for an emergency medical condition, and stabilize and treat. Thereafter, *the provider may make a determination* regarding disposition based on his/her professional judgment

	Physicians	Security	Nurses
Overall Management	80% Significant Improvement 20% Some Improvement **100%**	50% Significant Improvement 50% Some Improvement **100%**	62% Significant Improvement 28% Some Improvement 8% No Change 3% Slightly Worse **90%**
Patient Satisfaction	25% Significant Improvement 25% Some Improvement 25% No Change 25% Significantly Worse	17% Significant Improvement 50% Some Improvement 33% No Change	23% Significant Improvement 31% Some Improvement 15% No Change 23% Slightly Worse 8% Significantly Worse
Team Member Satisfaction	80% Significant Improvement 20% Some Improvement	50% Significant Improvement 50% Some Improvement	55% Significant Improvement 35% Some Improvement 8% No Change 3% Slightly Worse
Physician Satisfaction	80% Significant Improvement 20% Some Improvement	50% Significant Improvement 33% Some Improvement 17% No Change	41% Significant Improvement 23% Some Improvement 28% No Change 8% Slightly Worse

Positive Trends: Relationships

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PERSONAL ISSUES	very poor 1	poor 2	fair 3	good 4	very good 5
1. Staff concern for your privacy	O	O	O	O	●
2. How well your pain was controlled	O	O	O	O	●
3. Degree to which hospital staff addressed your emotional needs	O	O	O	O	●
4. Response to concerns/complaints made during your stay	O	O	O	O	●
5. Staff effort to include you in decisions about your treatment	O	O	O	O	●
6. Staff sensitivity to the inconvenience that health problems and hospitalization can cause	O	O	O	O	●
7. Extent to which staff checked your ID bracelet before giving you medications	O	O	O	O	●

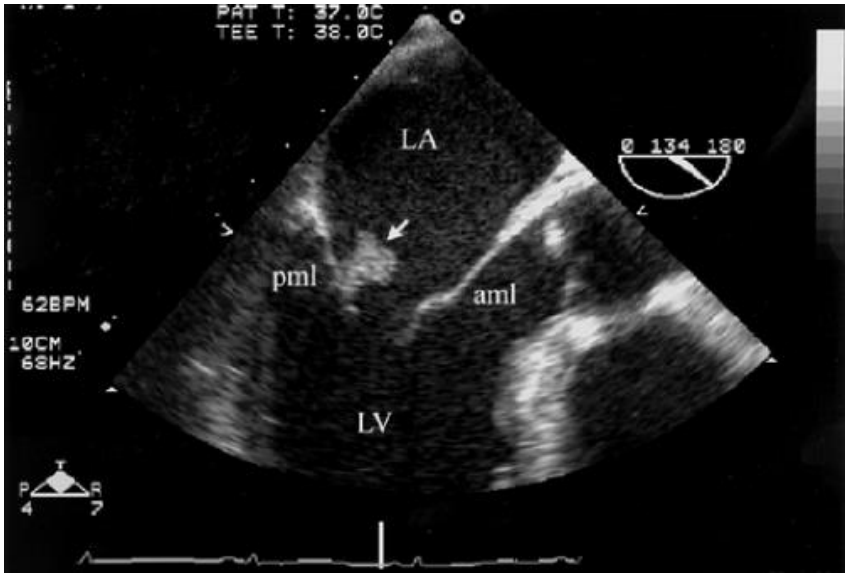
Comments (describe good or bad experience): _____

OVERALL ASSESSMENT	very poor 1	poor 2	fair 3	good 4	very good 5
1. How well staff worked together to care for you	O	O	O	O	●
2. Likelihood of your recommending this hospital to others	O	O	O	O	●
3. Overall rating of care given at hospital	O	O	O	O	●
4. Answers given to your billing questions (if you had any)	O	O	O	O	●

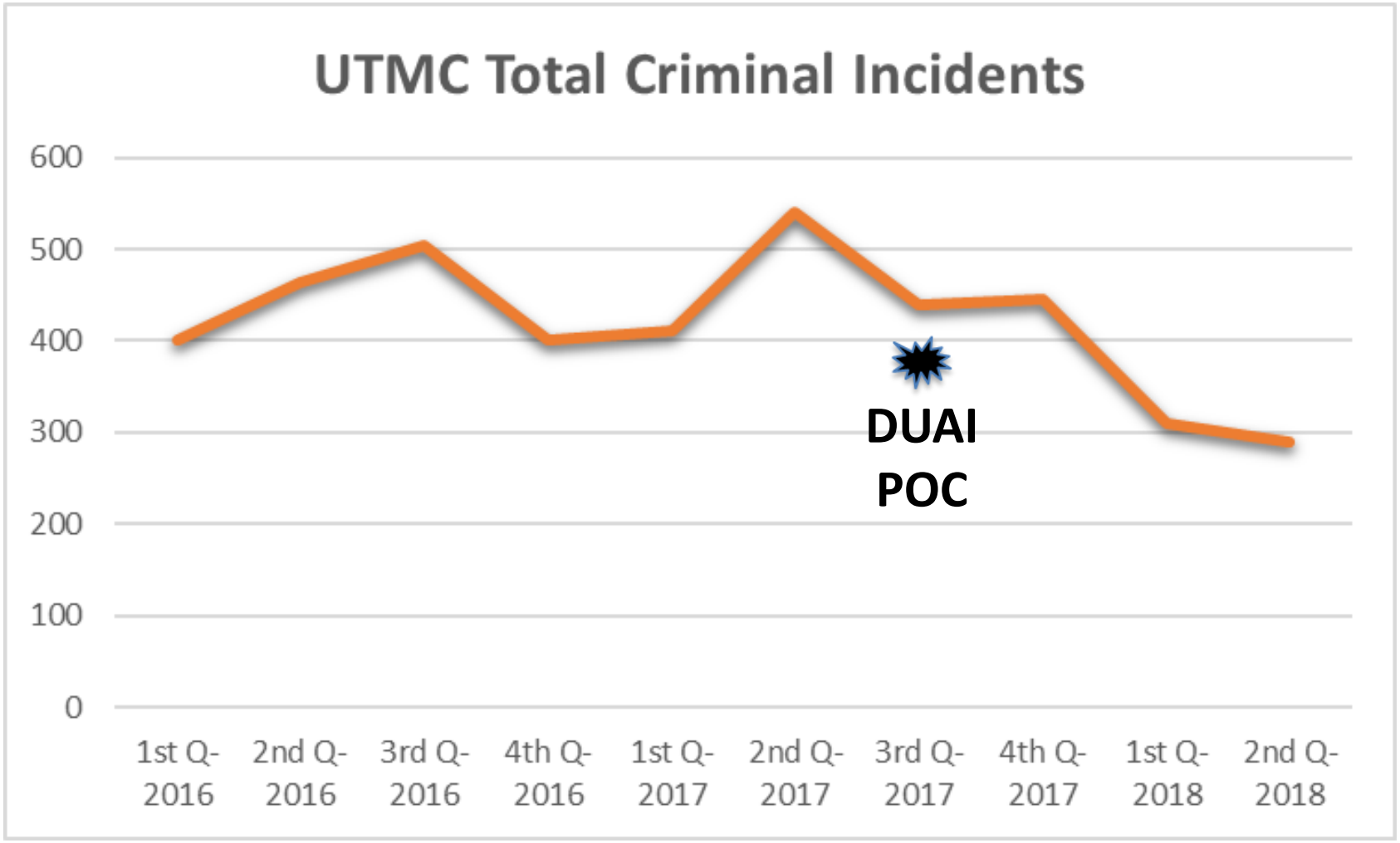
Comments (describe good or bad experience): _____

UTMC Experience: Endocarditis

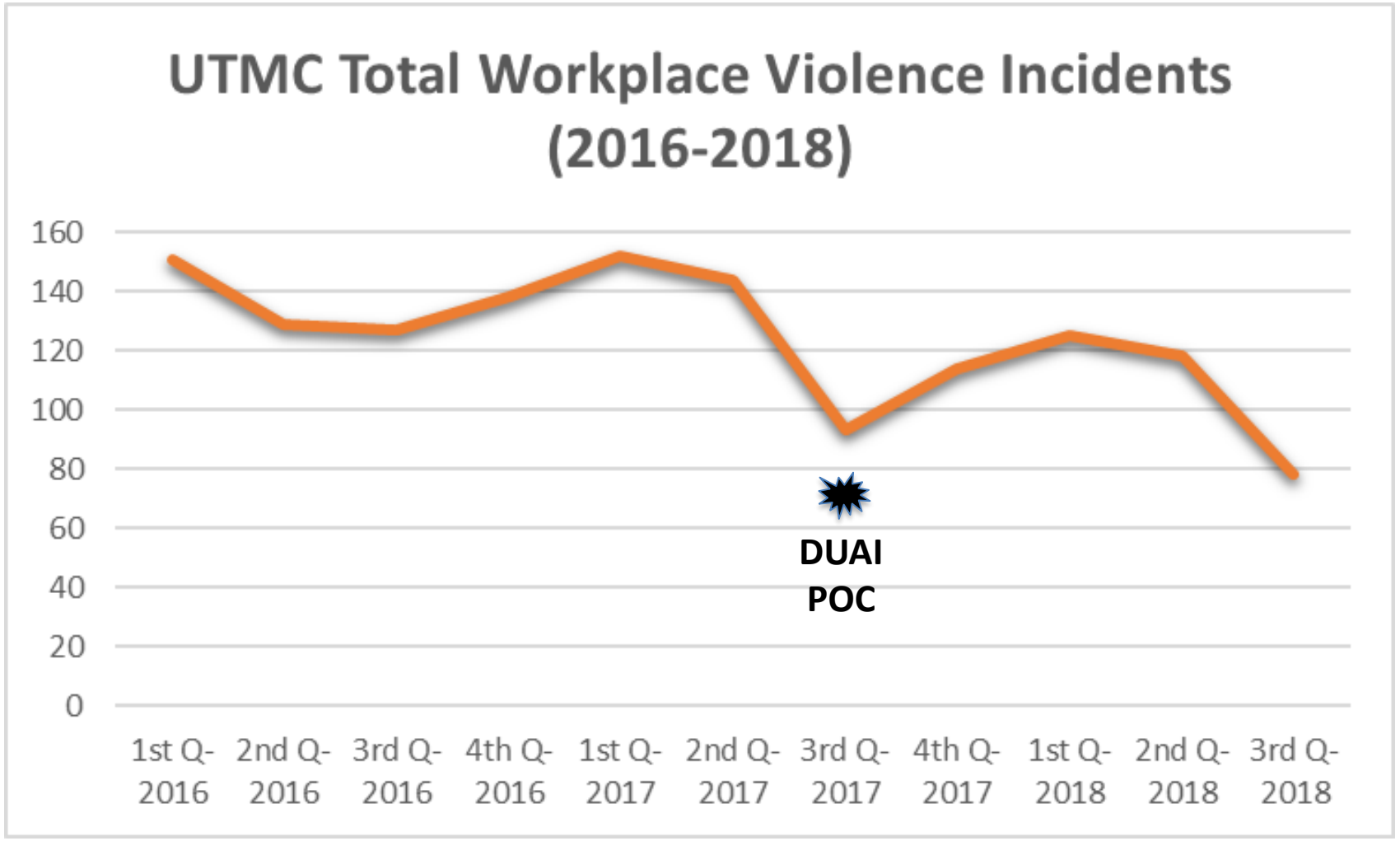
- >95% of endocarditis at UTMC is due to IV drug use
- More difficult to separate the causes of sepsis, soft tissue infection & osteomyelitis



Group	Number	LAMA	Re-Admission	Died
8/15/2016 - 8/14/2017 Endocarditis	126	15%	10%	13%
8/15/2017 - 7/09/2018 Endocarditis	104	39%	19%	1%
8/15/2017 - 7/09/2018 Pilot Total	413	41%	19%	1.4%


UTMC Total Criminal Incidents
600
500
400
300
200
100
0
DUAI
POC
1st Q-2016
2nd Q-2016
3rd Q-2016
4th Q-2016
1st Q-2017
2nd Q-2017
3rd Q-2017
4th Q-2017
1st Q-2018
2nd Q-2018

Workplace Violence



Drugs Encountered by UTMC Security (Number)

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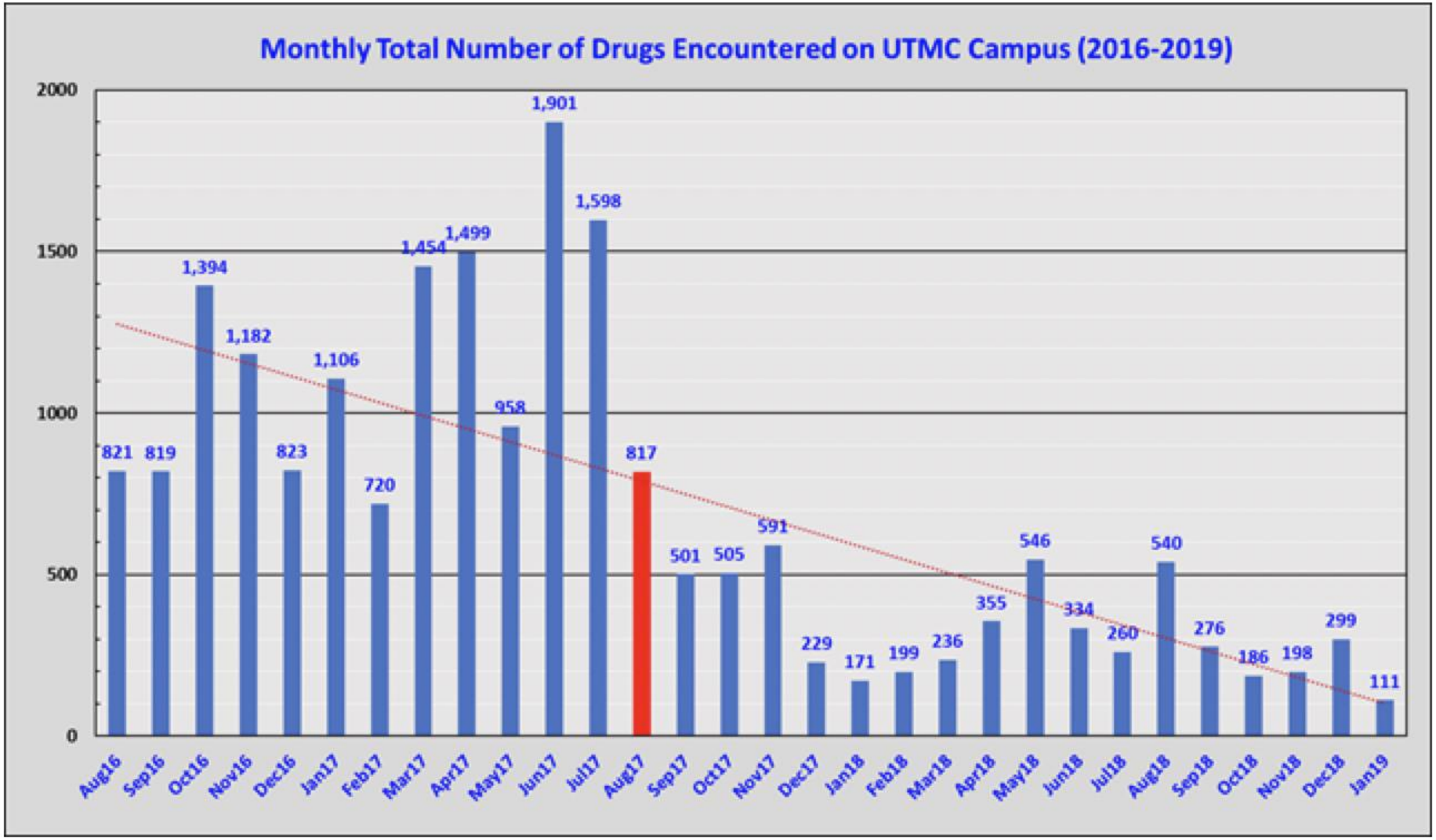

Improvement in Patient and Team Member Safety: Overall

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- UTMC Total Criminal Incidents – (Assaults/Drug Incidents/Thefts/Burglaries/Vandalisms Totals
  - Decreased 36.56% from 2017 through 2018
- Drugs Encountered
  - Decreased 75.0%
- Drugs Paraphernalia and Weapons Encountered
  - Decreased Slightly from 2017 to 2018
- Deaths from Illicit Drug Overdose while Hospitalized
  - Three overdoses
  - 2 Deaths
  - Drugs obtained from family (mother) or 'friends'

In Each Case, the DUAI Was NOT IMPLMENTED

Questions?