Opioid Abuse Epidemic in TN: Where are we and what’s next?

David Reagan, MD PhD
Chief Medical Officer
Tennessee Department of Health
4/11/18
Morphine Milligram Equivalents per capita in 2015 by County (CDC)
Opioid Prescription Rates by County
TN, 2007-2011

Data source: Tennessee Department of Health; Controlled Substance Monitoring Database.
Likelihood of Long-Term Opioid Use United States, 2006–2015
More people become dependent on opioids earlier than thought

New Persistent Opioid Use After Minor and Major Surgery

80% minor, 20% major surgery
What % used opioids 90-180 days out?

Minor surgery risk ↑15 X
Major surgery risk ↑16 X

The incidence of new persistent opioid use was similar between the 2 groups (minor surgery, 5.9% vs major surgery, 6.5%; odds ratio, 1.12; SE, 0.06; 95% CI, 1.01-1.24). By comparison, the incidence in the nonoperative control group was only 0.4%. 
Postsurgical prescriptions for opioid naive patients and association with overdose and misuse

- Total duration of opioid use was the strongest predictor of misuse

- Each refill and additional week of opioid use was associated with an adjusted increase in the rate of misuse of 44.0% (p <0.001)

BMJ 2018;360:j5790
Amount of Opioids for Pain Dispensed in TN
2010 – 2017

Morphine Milligram Equivalents

<table>
<thead>
<tr>
<th>Year</th>
<th>Billions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>8.2</td>
</tr>
<tr>
<td>2011</td>
<td>9.0</td>
</tr>
<tr>
<td>2012</td>
<td>9.2</td>
</tr>
<tr>
<td>2013</td>
<td>8.9</td>
</tr>
<tr>
<td>2014</td>
<td>8.4</td>
</tr>
<tr>
<td>2015</td>
<td>7.9</td>
</tr>
<tr>
<td>2016</td>
<td>7.1</td>
</tr>
<tr>
<td>2017</td>
<td>6.2</td>
</tr>
</tbody>
</table>

33% Decrease
Other Results in Tennessee

- MME Dispensed to young adults has decreased by 51 to 74% from 2011 to 2017
- Number of pain clinics decreased 47% from 2014 to 2017
- MD and pharmacy shoppers decreased 76% from 2010 to 2017
- Strong actions against licensure for prescribing or diversion increased 141% from 2013 to 2017
National Safety Council, 2016

**6 KEY INDICATORS**

1. Mandatory Prescriber Education
2. Opioid Prescribing Guidelines
3. Eliminating Pill Mills
4. Prescription Drug Monitoring Programs (PDMPs)
5. Increased Access to Naloxone
6. Availability of Opioid Use Disorder (OUD) Treatment

**A ROADMAP FOR STRENGTHENING LAWS & REGULATIONS**

- **47 STATES** need to improve!
- **28 STATES** are “Failing”
- **4 STATES** are “Making Progress”
Drug Overdose Deaths Continue to Rise 2011 - 2016
Select Opioids Present In Overdose Deaths*

* Percentages for fentanyl and heroin are included in the opioid category
Accidental Addiction

“The disappointment smothers me completely. How could I allow myself to go back down the rabbit hole once again? The rush is exhilarating, yet is it worth the demise of self? I think not. Why do I do these things? The satisfaction is at a staggering low anymore and I am left with an even deeper void than which I started.

The decision is impulsive. As if I am an automaton programmed to fail. The needle is filled with lies and denial of which I readily accept but the question lingering constantly is Why?”

Corinne, quoted in Time magazine
Healthcare’s Role in the Market

The Market Triangle Model – Curbing the Market

✔ Healthcare

Treatment
Buyers

Control
Sellers

Potential Buyers

Prevention

Fulfilling The Brain’s Reward Center, Working Upstream to Keep the Brain from being Hijacked
Despite significant and increasing reductions in the number of morphine milligram equivalents dispensed in Tennessee, mortality resulting from overdose death continues to rise. This Strategic Map helps organize our efforts to reduce opioid misuse, abuse and overdose in Tennessee, with focus on areas within the purview of TDH. Activities in white italics are the highest priorities.

**Prevention through Education**
- Increase public education
- Increase education for healthcare workers & employers
- Decrease unintended pregnancy and neonatal abstinence syndrome
- Increase opportunities for healthy behavior adoption by youth

**Wise Data Collection and Use**
- Identify prescribing patterns that lead to adverse outcomes
- Provide information to inform action
- Acquire timely EMS and medical examiner data
- Use diverse data to describe the epidemic
- Integrate CSMD with electronic health records

**Regulation and Enforcement**
- Further accelerate regulatory oversight of inappropriate prescribing
- Strengthen collaboration with law enforcement

**Partnership**
- Promote syringe service programs
- Support DMHSAS efforts to increase treatment
- Support and inform anti-drug coalitions
- Assist communities by applying outbreak response methods to drug overdoses
# TN Together

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Treatment</th>
<th>Law Enforcement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place reasonable limits on supply and dosage of prescription opioids.</td>
<td>Ensure that all Tennesseans who need treatment have better access to recovery services and resources.</td>
<td>Increase funding to address unlawful sale and trafficking of opioids.</td>
</tr>
<tr>
<td>Increase public awareness through outreach campaign and targeted education.</td>
<td>Effectively target areas for resources through data, improved access and sharing.</td>
<td>Provide every Tennessee state trooper with Narcan for emergency treatment of overdoses.</td>
</tr>
<tr>
<td>Promote best practices in the medical community for pain management.</td>
<td>Expand treatment options and recovery programs, including those within the criminal justice system.</td>
<td>Update the schedule of controlled substances to better track, monitor and penalize the use and unlawful distribution of opioids.</td>
</tr>
</tbody>
</table>
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.

A healthcare practitioner may prescribe:

### Up to 3-day opioid prescription
- 180 MME total dosage
- No requirements before prescribing

### Up to 10-day opioid prescription
- 500 MME total dosage
- Requirements before prescribing:
  - Check the CSMD
  - Conduct a thorough evaluation of the patient
  - Document consideration of alternative treatments for pain and why an opioid was used
  - Obtain informed consent
  - Include the ICD-10 code in the patient’s chart and on the prescription

### Up to 20-day opioid prescription
- 850 MME total dosage
- For a more than minimally invasive procedure:
- Initial fill no more than half of total prescribed amount

### Up to 30-day opioid prescription
- 1200 MME total dosage
- After trial and failure or documenting contraindication of a non-opioid treatment, healthcare practitioner may prescribe for medical necessity

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
TN Healthcare Collaborative to Improve Pain Care

- “Collaborative space in Healthcare”
- Steering Committee began meeting in Aug 2017
- Turning the Tide on Opioid Abuse summit Nov 2017
  - Two day conference with 285 physicians, nurses, pharmacists
  - Patient and prescriber education, Perioperative pain management, ED pain management
- 501c3 being developed and staffed
- Using IHI / TIPQC improvement model
- One year funding in Governor’s budget proposal
Thank you!

David Reagan, MD PhD
Chief Medical Officer
Tennessee Department of Health
Opioid Abuse: One State, One Medical Center’s Response to Combat this Epidemic

J. L. Epps, MD
Who We Are

• Area’s only academic medical center with the following programs:
  – 228 physician residents and fellows
  – 14 fellowship programs
  – 11 pharmacy residents
  – 130 pharmacy students
  – 150+ medical students
  – 800+ nursing and ancillary healthcare students
  – Radiology technology program
  – Laboratory technology program
  – Chaplain residency program

• Knoxville’s only Magnet hospital

• Area’s only Level I Trauma Center

• Area’s only hospital based Aeromedical Service

• Regional Perinatal Center

• Level III Neonatal Intensive Care Unit (private rooms)

• Regional Hemophilia Program

• Regional Kidney and Pancreas Transplant Center

Colleges:
  - Graduate School of Medicine
  - Pharmacy
NASHVILLE, Tenn. (WKRN) October 27, 2016 – Seven people now face federal charges after an “extraordinary” number of drug overdoses earlier this year in the Murfreesboro area.

The outbreak happened in July when over a dozen overdoses were reported in a 24-hour period. At least two people died while at least six others were hospitalized.

The overdoses were the result of people ingesting a dangerous synthetic opioid called fentanyl. It’s commonly prescribed for pain management and is known for being **50 times more powerful than heroin and 100 times more powerful than morphine.**
Carfentanil – The most potent opioid used commercially – 10,000 times stronger than morphine – Elephant tranquilizer to blame for at least 8 Ohio deaths in Sept 2016

Moscow Theater Hostage Crisis (2002)
• After the murder of two female hostages, Spetsnaz operators pumped an undisclosed chemical agent into the building's ventilation system
• All 40 of the terrorists were killed, about 130 hostages died, including nine foreigners, due to poisoning by the gas
Chasing the Dragon

https://www.youtube.com/watch?v=lqdmWRExOkQ
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
Pathway Definition

Patient Care Pathway

A patient-centered, evidence-based care plan developed through a multi-disciplinary collaborative process, containing milestones that communicate and standardize the care of the patient across the entire healthcare continuum.
Pain Management: Standardization in the Midst of an Opioid Epidemic

Pain Scale
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Standardized Management of IV Drug Use – Associated Infections
– Plan of Care
– Withdrawal Management
– Addiction treatment
Dopamine and Addiction

Dopamine D2 Receptors are Lower in Addiction

Reward Circuits
Non-Drug Abuse

Drug Abuser
PET Scan in Addicts

- 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.


Science = Solutions
SPECT Brain Scan

Normal Brain

7 years Methadone use, some prior Heroin

“They Ain’t Right!”

(SPECT Brain scan from Brainplace.com, Dr. Daniel Amen)
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
• The admitting physician orders that the IVDU Plan of Care be instituted
• Search performed by security
• All patients will be placed in a specific and identifiable gown
• Personal property including clothing removed
• 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
• Initiation of Intravenous Drug Use Associated Infection Plan of Care
  – The admitting physician initiates the plan of care
  – Emphasized that the plan of care **ONLY BE APPLIED TO PATIENTS HOSPITALIZED WITH KNOWN IVDU INFECTIVE COMPLICATIONS**
    • Subsequently modified to include empyema from snorting cocaine
  – Pilot Project
    • 3W, 4W, 4S & 8E; now hospital wide by expansion to 5E & 10E
    • Initially with hospitalists only; now FP, House Staff Medicine & Trauma specialists
The admitting physician orders that the IVDU 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
Plan of Care for IVDU Infections: Search

- All searches are conducted by security
  - 98-99% of searches are ‘Administrative’ (done for the safety of the patient and the team members)
- Amnesty
  - Assurance that the search is being done for safety insures the ‘amnesty’ concept
- Search refusal procedure
  - Agreeing to the search is a part of the Patient Plan of Care
  - Refusal means that treatment will not occur
Plan of Care for IVDU Infections

• 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
• 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
• No access to personal cellular phone for the first week
  – Landline telephone access only from 0600 to 2000
  – 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
• 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
Demographics

<table>
<thead>
<tr>
<th>Gender</th>
<th>%</th>
<th>Race</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>46%</td>
<td>White</td>
<td>99%</td>
</tr>
<tr>
<td>Females</td>
<td>54%</td>
<td>Black</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>Other</td>
<td>0%</td>
</tr>
</tbody>
</table>

- Of all deaths in 2015 from opioid and heroin overdoses in Tennessee and nationwide, about 90 percent of the people were white.
- African Americans accounted for little more than 6 percent in Tennessee and 8 percent across the country (CDC).
# IVDU Contraband

<table>
<thead>
<tr>
<th>Search Results</th>
<th></th>
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<tbody>
<tr>
<td>No Contraband</td>
<td>58%</td>
</tr>
<tr>
<td>Contraband Found</td>
<td>28%</td>
</tr>
<tr>
<td>Refused Search</td>
<td>14%</td>
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</table>

<table>
<thead>
<tr>
<th>Contraband Found</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Pills/Medications</td>
<td>52%</td>
</tr>
<tr>
<td>Syringes/Needles</td>
<td>18%</td>
</tr>
<tr>
<td>Other Drug Paraphernalia</td>
<td>5%</td>
</tr>
<tr>
<td>Tobacco Products</td>
<td>5%</td>
</tr>
<tr>
<td>Unknown Substance/Residue</td>
<td>5%</td>
</tr>
<tr>
<td>Burnt Spoon/Cans</td>
<td>4%</td>
</tr>
<tr>
<td>Heroin</td>
<td>2%</td>
</tr>
<tr>
<td>Cut Straws</td>
<td>2%</td>
</tr>
<tr>
<td>Rubber Tourniquets</td>
<td>2%</td>
</tr>
<tr>
<td>Pipes</td>
<td>2%</td>
</tr>
</tbody>
</table>
### Insurance

<table>
<thead>
<tr>
<th>Insurance</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>Medicare</td>
<td>6%</td>
</tr>
<tr>
<td>Commercial</td>
<td>7%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>55%</td>
</tr>
<tr>
<td>Self Pay</td>
<td>27%</td>
</tr>
<tr>
<td>Other Agency</td>
<td>3%</td>
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</tbody>
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### Medicaid

<table>
<thead>
<tr>
<th>Medicaid</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Amerigroup</td>
<td>18%</td>
</tr>
<tr>
<td>BlueCare</td>
<td>31%</td>
</tr>
<tr>
<td>Medicaid Out of State</td>
<td>3%</td>
</tr>
<tr>
<td>TennCare UHC</td>
<td>22%</td>
</tr>
<tr>
<td>TennCare Pending</td>
<td>26%</td>
</tr>
</tbody>
</table>
## Project Results

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osteomyelitis</td>
<td>17%</td>
</tr>
<tr>
<td>Infective Endocarditis</td>
<td>26%</td>
</tr>
<tr>
<td>Soft Tissue Infection</td>
<td>35%</td>
</tr>
<tr>
<td>Sepsis</td>
<td>16%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
</tr>
<tr>
<td>No Infection</td>
<td>3%</td>
</tr>
</tbody>
</table>

- Pilot length: 219 days
- # of Patients: 234
- Addiction RX at D/C: 14%
- Readmission: 14%
## Pilot Results: LAMA

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Total #</th>
<th>LAMA</th>
<th>% LAMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osteomyelitis</td>
<td>39</td>
<td>9</td>
<td>23%</td>
</tr>
<tr>
<td>Infective Endocarditis</td>
<td>60</td>
<td>13</td>
<td>22%</td>
</tr>
<tr>
<td>Sepsis</td>
<td>38</td>
<td>25</td>
<td>66%</td>
</tr>
<tr>
<td>Epidural Abscess</td>
<td>2</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Soft Tissue Infection</td>
<td>82</td>
<td>30</td>
<td>37%</td>
</tr>
<tr>
<td>Endophthalmitis</td>
<td>2</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Empyema</td>
<td>2</td>
<td>1</td>
<td>50%</td>
</tr>
<tr>
<td>No Infection</td>
<td>9</td>
<td>2</td>
<td>22%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>234</strong></td>
<td><strong>80</strong></td>
<td><strong>34%</strong></td>
</tr>
</tbody>
</table>

LAMA = Left Against Medical Advice
• Failure to enforce the POC
  – as …….told Ms. XXXX that she had violated her patient care plane by not wearing her IVDA gown, having drug paraphernalia, drugs, leaving the floor, and having personal clothing items
  – …asked if she has used Opana during her stay in the hospital and Ms. XXXX said “yes”
After the way I was treated tonight at UT, I will be contacting a medical malpractice attorney. I am sick of being judged because of my history & will not stand for it any longer! In this world you have to stand and fight for what you believe in. I will speak out for myself & all recovering addicts! If anyone else has been treated poorly please message me as I will be contacting the lawyers on Monday. Our local news has been contacted already also.
<table>
<thead>
<tr>
<th></th>
<th>Physicians</th>
<th>Security</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Management</strong></td>
<td>80% Significant Improvement 20% Some Improvement</td>
<td>50% Significant Improvement 50% Some Improvement</td>
<td>62% Significant Improvement 28% Some Improvement 8% No Change 3% Slightly Worse</td>
</tr>
<tr>
<td></td>
<td><strong>100%</strong></td>
<td><strong>100%</strong></td>
<td><strong>90%</strong></td>
</tr>
<tr>
<td><strong>Patient Satisfaction</strong></td>
<td>25% Significant Improvement 25% Some Improvement 25% No Change 25% Significantly Worse</td>
<td>17% Significant Improvement 50% Some Improvement 33% No Change</td>
<td>23% Significant Improvement 31% Some Improvement 15% No Change 23% Slightly Worse 8% Significantly Worse</td>
</tr>
<tr>
<td><strong>Team Member Satisfaction</strong></td>
<td>80% Significant Improvement 20% Some Improvement</td>
<td>50% Significant Improvement 50% Some Improvement</td>
<td>55% Significant Improvement 35% Some Improvement 8% No Change 3% Slightly Worse</td>
</tr>
<tr>
<td><strong>Physician Satisfaction</strong></td>
<td>80% Significant Improvement 20% Some Improvement</td>
<td>50% Significant Improvement 33% Some Improvement 17% No Change</td>
<td>41% Significant Improvement 23% Some Improvement 28% No Change 8% Slightly Worse</td>
</tr>
</tbody>
</table>
### Positive Trends

<table>
<thead>
<tr>
<th>Type of Call</th>
<th>June 2017</th>
<th>July 2017</th>
<th>August 2017</th>
<th>September 2017</th>
<th>October 2017</th>
<th>November 2017</th>
<th>December 2017</th>
<th>January 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Drugs Encountered</td>
<td>1,901</td>
<td>1,598</td>
<td>817</td>
<td>501</td>
<td>505</td>
<td>591</td>
<td>229</td>
<td>171</td>
</tr>
<tr>
<td>Administrative Searches</td>
<td>26</td>
<td>20</td>
<td>27</td>
<td>63</td>
<td>78</td>
<td>52</td>
<td>68</td>
<td>65</td>
</tr>
<tr>
<td>Proactive Drug Patrols</td>
<td>225</td>
<td>253</td>
<td>362</td>
<td>705</td>
<td>691</td>
<td>477</td>
<td>906</td>
<td>1,185</td>
</tr>
<tr>
<td>K9 Usage</td>
<td>583</td>
<td>559</td>
<td>549</td>
<td>1,035</td>
<td>704</td>
<td>735</td>
<td>706</td>
<td>687</td>
</tr>
</tbody>
</table>

**Drugs Encountered**
- Prescription Pills
- Marijuana
- Cocaine
- Heroin
- Meth
- LSD
Positive Trends: Security

Monthly Total Number of Drugs Encountered by UTMC Security (2016-2018)
**Positive Trends: Relationships**

### PERSONAL ISSUES

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

*Comments (describe good or bad experience):* 

### OVERALL ASSESSMENT

<table>
<thead>
<tr>
<th></th>
<th><strong>very poor</strong></th>
<th>poor</th>
<th>fair</th>
<th>good</th>
<th><strong>very good</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How well staff worked together to care for you</td>
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<tr>
<td>2. Likelihood of your recommending this hospital to others</td>
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<td>3. Overall rating of care given at hospital</td>
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<tr>
<td>4. Answers given to your billing questions (if you had any)</td>
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</tbody>
</table>

*Comments (describe good or bad experience):* 

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