Lee Memorial Health System

Board of Directors’ Meeting & Quality & Education Full Board Meeting

Thursday
February 9, 2012
3:00 p.m.
AGENDA
QUALITY/EDUCATION
FULL BOARD OF DIRECTORS MEETING
February 9, 2012            3:00 p.m.
Lee Memorial Hospital – Boardroom, 2776 Cleveland Ave, Ft. Myers, FL 33901

1. CALL TO ORDER (Richard Akin, Board Chairman)
   Lee Memorial Health System Board of Directors Meeting

2. INVOCATION & PLEDGE OF ALLEGIANCE (Rev. Bill Miller, MDiv)

3. PUBLIC INPUT – Agenda Items: Any Public Input is limited to three minutes and
   a “Request to Address the Board of Directors” card must be completed
   and submitted to the Board Administrator prior to meeting.

4. RECOGNITION:
   A. Welcome: Daniel L. Fink, CAO, Children’s Hospital
   B. Retirement of Horace P. Dansby, M.D.
   C. Lee County Medical Society Award: Thomas Presbrey, M.D.

QUALITY/EDUCATION CHAIRMAN: STEVE BROWN, MD

5. CONSENT AGENDA (Accept)
   A. Risk Management Report 1st Qtr FY 2012

6. OPIOID ABUSE (Presentation)
   (Aaron Wohl, M.D., ER Physician & William Liu, M.D., Neonatal Pediatrics)

7. HOME PREVENTION (Presentation)
   (Neylayda Fonte, D.O. & Synthia R. Bultman, R.N.)

8. QUALITY PERFORMANCE INDICATORS, 4th QTR, FY 2011 (Accept)
   (Chuck Krivenko, MD, Chief Medical Officer & Becky Watt, System Director Decision Support)

9. HP CHILDRENS HOSPITAL INDICATORS, 4th Qtr FY 2011 (Accept)
   (Chuck Krivenko, MD, Chief Medical Officer & Becky Watt, System Director Decision Support)

10. OTHER ITEMS/ Date of the next QUALITY/EDUCATION BOARD OF DIRECTORS MEETING
    Thursday, April 12, 2012 – 3:00 p.m.

LMHS SYSTEM BUSINESS BOARD CHAIRMAN: RICHARD AKIN

11. PHYSICIAN LEADERSHIP COUNCIL (PLC) REPORT (Accept)
    (Tom Presbrey, M.D., PLC Chairman)

12. LMHS HEALTH PLAN PRESENTATION (Presentation)
    (Jon Cecil, Chief Human Resource Officer & Salvatore Lacagnina, D.O., Vice President
    Health & Wellness & Allison Thurau, System Director Compensation Benefits)

13. OLD BUSINESS

14. NEW BUSINESS
    A. Assistant Board Secretary Appointment (Approval)

15. BOARD OF DIRECTOR’S REPORTS

16. Date of the next MEETINGS
    Thursday, February 23, 2012 – 3:00 p.m. GOVERNANCE & FULL BOARD
    Lee Memorial Hospital – Boardroom, 2776 Cleveland Avenue, Fort Myers
    Also Convening as: Cape Coral Hospital Board of Directors (Provider # 10-0244);
    Lee Memorial Hospital Board of Directors (Provider # 10-0012);
    Gulf Coast Medical Center Board of Directors (Provider #10-0220)

17. ADJOURN (Richard Akin, Board Chairman)
LEE MEMORIAL HEALTH SYSTEM

Invocation Prayer

&

Pledge of Allegiance
PUBLIC INPUT – AGENDA ITEMS:

Any public input pertaining to items on the Agenda is limited to three minutes and a “Request to Address the Board of Directors” card must be completed and submitted to the Board Administrator prior to meeting.

Refer to Board Policy: 10:15E: Public Addressing the Board

Non-Agenda Item:
Individuals wishing to address the Board on an item NOT on the Agenda, the Board office must be notified of subject matter at least seven (7) days prior to the meeting to allow staff time to prepare and to insure the matter is within the jurisdiction of the Board.
LEEMEMORIALHEALTHSYSTEM
BOARDOFDIRECTORS

RECOGNITIONS:

A. Welcome: Daniel L. Fink, CAO Children’s Hospital

B. Retirement of Horace P. Dansby, M.D.

C. Lee County Medical Society – Award of Leadership & Professionalism: Dr. Tom Presbrey
WELCOME

LEE MEMORIAL HEALTH SYSTEM

Daniel L. Fink

Chief Administrative Officer
The Children’s Hospital
would like to recognize with sincere appreciation

Horace P. Dansby, M.D.

He was appointed to our hospitals as follows:
1973 - Lee Memorial Hospital
1974 - Southwest Regional Medical Center
1977 - Cape Coral Hospital
1990 – Gulf Coast Medical Center
1991 – HealthPark Medical Center
2009 – Gulf Coast Medical Center

The entire system wishes you health & happiness, and all the best in your future endeavors.
LEE COUNTY MEDICAL SOCIETY
HONORS FOUR PHYSICIANS FOR THEIR DEDICATION TO MEDICINE

Fort Myers, FL – January 20, 2012 --- The Lee County Medical Society has honored four Lee County Physicians for their outstanding contributions to medicine at the First Annual Medical Service Awards. The ceremony was held on Friday, January 20, 2012 at Edison State College.

Stephen Machiz, M.D. was presented with The Award for Citizenship & Community Service for outstanding leadership and public service above and beyond the call of duty as a practicing physician. This includes service within the local community and abroad.

Alexander M. Eaton, M.D. was presented with The Scientific Achievement Award in recognition of outstanding work in the areas of scientific medical research. This includes both basic science and clinical research.

Thomas G. Presbrey, M.D. received the Leadership & Professionalism Award. This award underscores the Lee County Medical Society’s continuing dedication to the principles of medical ethics and the highest standards of medical practice. Dr. Liu has remained active in organized medicine, is dedicated to the principles of medical ethics and dedicated to the highest standards of medical practice; he has made an outstanding contribution through active service in medical ethics activities.

SPCU (Surgical Progressive Care Unit) received the Award of Appreciation. As a non-physician member of the medical profession, nominees should have provided exemplary and a lasting contribution to their profession.

Further Information about the recipients:

Dr. Stephen Machiz is In 2002, Dr. Machiz suggested that the Fort Myers Downtown Rotary club start a fundraiser for themselves as well as the Children’s Hospital of Southwest Florida. Out of this idea grew a successful wine festival first called the Fort Myers Wine Fest and eventually the SWFL Wine & Food Fest. As a not-for-profit organization separate from the original Rotary called Southwest Florida Children’s Charities, Inc., the net proceeds grew from 20K for the first year to an amazing 1.6 million in 2011. Numerous charities have been supported through his work. This small community fundraiser blossomed into one of our area’s most prestigious special events. It was this charity work that was so deserving of recognition. As with other award winners, he is a Physician’s Physician. His devotion and dedication beyond his clinical years is an inspiration to all of us.

Dr. Alexander M. Eaton, in 1999 became an Associate Research Consultant for Duke University School of Medicine while maintaining his clinical practice. Apparently, in his spare time, he published a book titled “See Again! Reversing and Preventing Macular Degeneration. The following year, he was asked to serve on the Diabetes Advisory Council for the State of Florida by then Governor Jeb Bush. In 2002, he became the Director for Retina Health Center where he is working to the present day. In the past few years, he has continued to
provide academic presentations both in the states and overseas. More recently, he has been working with medical students from Tulane University measuring oxygen saturation in retinal tissues. One of his most outstanding achievements was helping to develop a genetic test to determine which patients would be at risk for steroid-induced glaucoma.

Dr. Eaton has done an exemplary job in pioneering medical research and educating his peers. For his past, ongoing and future research in the field of Ophthalmology, the second Ophthalmologist to win this award in as many years, the Committee decided to honor him. We are proud of his work; proud to have him in Southwest Florida and certainly wish him continued success.

**Dr. Thomas Presbrey** is the first and only chair of the Physician Leadership Council for the Lee Memorial Health System. While some of the work he has done involved unpopular decisions, they nevertheless needed to be solved and he was often there to assist. He has been leading for over five years playing a major role in the following:

- LMHS acquisition/consolidation of Southwest Florida Regional Medical Center and Gulf Coast Hospital
- Leading the efforts that eventually resulted in the rewriting of the medical staff by-laws.
- Providing regular, open and frank discussions with the LMHS Board.
- Providing improved communication between the LMHS Board and the Medical Executive Committee leaders.
- Helping to problem solve the most recalcitrant problems including emergency room call, subspecialty coverage and hospitalist issues. All the while, continuing to provide excellent quality care with his patients.

**Surgical Progressive Care Unit** of Gulf Coast Hospital, lead by the Nursing Director June Schneider, R. N., made an amazing transition.

The SPCU were originally trained to care for thoracic surgical patients. When the LMHS administration moved the Oncology Unit to the downtown hospital. With this move, most if not all the skilled nurses involved with the colorectal patients also moved to Lee downtown leaving a significant gap in care for an expanding number of colorectal surgical patients. LMHS Administration, in their infinite wisdom, offered the remaining cardiac nurses on the Surgical Progressive Care Unit as an alternative. The clinicians were concerned that nurses originally trained in cardiac medications and telemetry would not want to deal with, shall we say, “code brown” and feared a disaster in the making.

In fact, these nurses transitioned beautifully learning all the patient education materials and new care plans. In fact, some of the highest patient satisfaction scores have apparently come out of this unit.

These nurses exemplify the best in clinical care. They were asked to do something that was certainly out of their comfort zone. Rather than resist and complain, they decided to do the opposite and provide a new type of care to a new type of patient. The clinicians and patients alike are proud of your transition and the Annual Medical Service Awards Review Committee is proud of your accomplishments.

# # #

If you’d like more information about this topic, please contact Ann Wilke at 239-936-1645 or email awilke@lcmsfl.org.
February 1, 2012

Jim Nathan  
2776 Cleveland Avenue  
Fort Myers, FL 33901

Dear Mr. Nathan:

The Lee County Medical Society would like to thank you, Richard Akin, John Wiest, Drs. Larry Antonucci, Chuck Krivenko, Scott Nygaard and Donna Giannuzzi, RN. for the nomination of Thomas Presbrey, M.D., for the Award for Leadership and Professionalism. Dr. Presbrey was chosen as a recipient for this year.

We are delighted to be able to honor the doctors of Lee County. It takes someone like you to recognize a physician’s outstanding contribution to their community and to submit that physicians name and supporting information for the LCMS Awards Committee. The supporting documentation on the application with the doctor’s Curriculum Vitae gives the committee a better understanding of the candidate and of their accomplishments in the award category for which they have been nominated.

As this is our 2nd Annual Medical Service Award Program year, we are very excited and hope that you will nominate fellow physicians in the years to come.

Yours Truly,

Craig Sweet, M.D.  
Annual Medical Service Award  
Lee County Medical Society

Cs/vjs

Physicians Caring for our Community
QUALITY & EDUCATION
BOARD OF DIRECTORS
MEETING
Thursday, February 9, 2012

QUALITY/EDUCATION
CHAIRMAN:
Steve Brown, MD
CONSENT AGENDA (Accept)

A. Risk Management Report, 1st Quarter, Fiscal Year 2012
**DATE:** February 2, 2012  
**LEGAL SERVICE REVIEW?** YES___ NO___

**SUBJECT:** Quarterly Risk Management Report

**REQUESTOR & TITLE:** Mary McGillicuddy, Chief Legal Officer

**PREVIOUS BOARD ACTION ON THIS ITEM (IF ANY)**
( jusification and/or background for recommendations - internal groups which support the recommendation i.e. SLC, Operating Councils, PMTs, etc.)
Acceptance of Quarterly Risk Management Report for the previous quarter.

**SPECIFIC PROPOSED MOTION:**
Motion to Accept Quarterly Risk Management Report Q1FY12

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**LIST AND EXPLAIN ALTERNATIVES CONSIDERED**
Not Applicable

**FINANCIAL IMPLICATIONS**
Budgeted _____ Non-Budgeted _____
(including cash flow statement, projected cash flow, balance sheet and income statement)
No financial implications

**OPERATIONAL IMPLICATIONS**
(including FTEs, facility needs, etc.)
No operational implications

**SUMMARY**
Quarterly Risk Management Report including:
- Incident Reporting per 1,000 patient days
- Injury Occurrences per 1,000 patient days
- Categories of incident reports
- Risk Management participation in LMHS System Committees and Education
- Liability Claims
- Recommendations
QUARTERLY RISK MANAGEMENT REPORT TO THE BOARD
October-December 2011

The disclosure of this document and the contents herein does not constitute a waiver of any and all protections afforded Patient Safety Work Product under either Florida state or federal law including but not limited to those under the Patient Safety Quality Improvement Act of 2005 and implementing regulations.
The graph below shows incident reporting rates for the system for the past 24 months. During this time range, the reporting rate has displayed a marked increase. As will be shown in subsequent graphs, this can be attributed to increased reporting of Good Catch type events. The graphs on page 3 reflect the reporting rates for the four facilities individually.
The trend as depicted in these graphs indicates a decided rate growth over the last 24 months, and especially over the last five months. The ongoing increase is a favorable trend which may be attributed to recent patient safety initiatives. The last five months specifically may be due to the increased awareness generated by the Daily Safety Check-Ins, which were started on August 1st.
INJURY

The first graph shows the reporting rate and the injury rate for the four facilities during the quarter.

The second graph shows the percentage of reports without injury. Along with having an increase in the reporting rate, this graph shows that the reports received predominantly do not involve any injury.

Reporting of no injury incidents are highly encouraged so that “near misses” and potential areas of improvement can be identified. This information allows us to better understand where risks exist, and provides data used in our quality improvement activities throughout the system. Over 85% of the incident reports received involve no reported injury.

During this quarter, there were no reports to AHCA, as required by Florida law.
The graph to the right shows the rate for the categories of reported incidents from October through December 2011 at all four facilities. Rates are being utilized to be consistent with other system reporting. As indicated, the vast majority of these incidents did not involve any reported injury.

The top four categories are:

- **Treatment** & Testing category includes reports of IV infiltrates, Delays and Omissions, Patient Identification issues, etc
- **Other** category includes Exposures, Complaints, burns, skin breakdown, ER issues, AMAs, self-extubation, etc
- **Medication Errors**
- **Medication Good Catch**

70% of all reported occurrences fall within one of these four categories.
EDUCATION

Risk Management Educational Activities included:

• Risk Management Orientation for new hires
• Risk Management for New Nurses
• Incident Reporting for Spiritual Services
• How to handle claims relating to sexual misconduct for Administrative Supervisors
• Guest lecturer Edison College BS Program in Medical Ethics
Malpractice Claims
The first quarter of Fiscal Year 2012 ended with 52 open medical malpractice claims. The last quarter of FY 2011 concluded with 60 open claims. There were 8 new claims filed during the three months ending December 31, 2011, and 16 claims were closed.

While claims activity had been hovering around 60 open claims for the last few quarters, this quarter saw almost a 15% reduction in open claims. Some matters were closed during this quarter because the claimants abandoned the claim and the statutes of limitation passed.

The events giving rise to malpractice claims continue to differ widely in type.

Medical malpractice claims against the System continue to be closed on terms favorable to the Health System. The caps on damages under sovereign immunity increased as of October 1, 2011, from $100,000/$200,000 to $200,000/$300,000. This will apply to events occurring after that date, and should not be fully evident until about eighteen months to two years from now.
RISK MANAGEMENT ACTIVITIES

Continued participation in system committees including:

- Employee Safety and Wellness
- Ethics Committee
- Participated in various Intense Analysis Teams/ Common Cause Analysis Teams
- QSMC
- Heart Central Accountability Committee
- Patient Safety Red Rules Committee
- ISO Function flow Committee
- CCH Safety Tactical Committee
- Patient Care Service P&P Committee
- Patient Safety Transformation Committee
- Campus Specific ADE Work Groups
- System Quality & Conformance Committee
- Rapid response Team
- Daily Safety Check-In Calls
- Infusion Pump Team
- HP Code Blue committee
- Patient Safety Steering Committee
- Facility Quality Committee for all Hospitals
- DNV Training – Advanced Directives
- System Code Blue Committee
- Quality Management Patient Safety Committee
- Medication Safety Committee
RECOMMENDATIONS

• Monitor the 3M/SoftMed Risk Management System.
• Continue to track and trend incidents, provide summary data and work closely with various departments and committees engaged in performance improvement and patient safety activities.
• Continue to work with Education and Organizational Development and management staff to assure that all employees are meeting the annual education requirement for risk management and to provide a module for the Competency activities.
• Continue to utilize pre-litigation procedures to resolve meritorious claims in a timely manner.
• Continue development of specialized training materials for risk.
• Continue to collaborate with others in the health system with regard to patient safety initiatives.
NICU Nursing Internship Lecture Series
Neonatal Abstinence Syndrome (NAS)

William Liu, M.D.
The Children’s Hospital of Southwest Florida
What can we learn today?

Drugs pass to baby from the placenta.

After birth, baby suffers from withdrawal.
Neonatal Abstinence Syndrome due to maternal substance abuse

- Multiple causative agents: Polydrug exposure
- Exposures cross socio-economic, racial-ethnic and demographic lines
- Opioid addicted mother: Most well defined, with greatest medical consensus regarding need for treatment
- Difficult to measure true incidence: 3-50%?*
  - 160,000 babies annually?
  - Rate had been increasing from 1979-87, but had since decreased into 1990. This trend now appears to be reversing.

Total Admissions for NAS: HP + CCH

ICD-9 DX Code 779.5
Maternal Substance Abuse

- Nicotine
- EtOH
- Marijuana
- Sedative/Hypnotics-Depressants
  - Barbiturates (phenobarbital)
  - Benzodiazepine (Xanax, valium)
- Antidepressants
  - SSRI’s (Zoloft, Celexa, Paxil, Prozac)
- Stimulants
  - Methamphetamine
  - Cocaine
- Hallucinogen
  - Phenycyclidine (PCP, Angel Dust)
  - MDMA (Ecstasy)
Opioids

- Heroin
- Methadone
- Oxycodone
- Hydrocodone (e.g. Vicodin)
- Codeine
- Propoxyphene (Darvon)
- Meperidine (Demerol)
- Hydromorphone (Dilaudid)
- Morphine
- Fentanyl (Sublimaze)
- Butorphanol (Stadol)
- **Buprenorphine**
Neonatal Abstinence Syndrome

- Opioid exposure in utero exposes the growing fetus to the physiologic effects of these drugs:
  - Fetal demise
  - Fetal distress
  - Growth restriction
  - Prematurity
  - Perinatal asphyxia
  - Neonatal withdrawal
  - Heroin- increased risk for SIDS
- Long-term neurodevelopmental compromise
  - Cognitive and neurobehavioral deficits
Normal Fetal Brain Development

Synaptogenesis

Acute Signs of NAS: onset within days to weeks

**Central Nervous System**
- Excessive crying
- Sleeplessness
- Hyperactivity
- Tremors
- Hypertonia
- Apnea
- Myotonic jerks
- Seizures

**Other**
- Excessive sucking
- Poor feeding
- Emesis
- Loose or watery stools
- Sweating, yawning, sneezing
- Fever
- Mottling
- Nasal congestion
- Tachypnea
- Excoriation
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Finnegan Neonatal Abstinence Scoring Tool (FNAST)

Validated
High inter-rater reliability

NAS symptoms: Video
Treatment Goals

- Relieve signs and symptoms of withdrawal
- Improve feeding tolerance and growth
- Prevent respiratory instability and seizures
- Reduce mortality
- Improve neurodevelopment
Non-pharmacologic Treatment

• Soothing environment
  – Low light
  – Low noise levels
  – Decreased overall activity

• Soothing behaviors
  – Improve and support self-regulation
  – Swaddling, containment
Pharmacologic Treatments

- Paregoric
- Tincture of opium
- Clonidine
- Chlorpromazine
- Diazepam
- Phenobarbital
- Methadone
- Morphine
A standardized approach to treatment

Neonatal Withdrawal Syndrome Physician Guideline for Pharmacologic Management Information

1. Begin pharmacologic treatment when the FNAST score is 8 or greater in two consecutive scoring periods.

2. Starting Morphine Sulfate:
   A. Morphine Sulfate dilution is 0.4 mg/ml
   B. Starting dose: 0.1 ml (0.04 mg) PO every 3 hours with feeds.
   C. For infants with extreme withdrawal, initial scores may be excessive. Consider the following adjustment to the initial dose:
      i. Initial Finnegan Score 13-16: 0.2 ml (0.08 mg) x 1 dose
      ii. Initial Finnegan Score 17-20: 0.3 ml (0.12 mg) x 1 dose
      iii. Initial Finnegan Score 21-24: 0.4 ml (0.16 mg) x 1 dose
      iv. Initial Finnegan Score 25 or greater: 0.5 ml (0.20 mg) x 1 dose

3. Morphine Treatment – Escalation:
   A. Increase dose by 0.1 ml (0.04 mg) for each additional Finnegan Score greater than 8.
   B. Maximum dose of 1 ml (0.4 mg). Additional dosing should be at the discretion and determination of the attending physician.

4. Weaning Off Morphine:
   A. An infant is considered in control when the average score is less than 8 for a 2 day period.
   B. Following this 2 day period of control, wean Morphine by 0.05 ml (0.02 mg) per feed, every 24 hour period.

5. Re-Escalation:
   A. If the Finnegan scores again increase after attempted weaning, readjust dosage upward as follows:
      i. Finnegan Score 5-11: Increase by 0.02 – 0.03 ml (0.008 mg) per feed (this is the increase above the previous dose)
      ii. Finnegan Score 12-16: Increase by 0.05 ml (0.02 mg) per feed
      iii. Finnegan Score 17-20: Increase by 0.1 ml (0.04 mg) per feed

6. Consider Discontinuing Morphine:
   A. Patient is on Morphine at 0.05 ml (0.02 mg) or less per feed
   B. Finnegan score remain less than 8 for a 48 hour period
   C. NAS scoring should continue for 48-72 hours after Morphine is discontinued.

7. Toxicity:
   A. Babies receiving morphine should be closely monitored for signs of toxicity, including an apnea monitor.
   B. Overdosing may result in respiratory depression, abdominal distention, constipation and rarely urinary retention.
   C. Infant should be transferred to level 3 if acute dosing reaches 0.5 ml (0.2 mg) per dose.
   D. Maximum dosage should not exceed 2 mg/kg/day.
NAS recovery
Taking Care of a NAS Baby: It affects everyone

The impact on babies, parents and NICU staff
Rational Prescribing of Opioid Pain Relievers in the Emergency Department

Aaron Wohl, MD
Chairman, Department of Emergency Medicine
Lee Memorial and Health Park Hospital
Lee Memorial Health Systems, Ft. Myers, FL
Background

- Pain major symptom of many patients presenting to the ED (up to 42% of patients)
- Increased emphasis on treatment over last 2 decades
  - Joint commission declared pain the “fifth vital sign”
  - Patient satisfaction surveys covering pain management
  - Institute of Medicine report says we’re not doing well as providers
- Pain is real and relief is important and we are committed to assist in alleviating pain and suffering
  - Yet our duty as physicians to our community and patients is to empower patients to be responsible for the safe use of pain management and to educate about the dangers of misuse to minimize risk and improve the quality of pain care.
  - Why do I say this...?
Because we have a problem...

- CDC that indicates that “the abuse of prescription painkillers has reached epidemic proportions in the US”.
  - The White House office for national drug control policy reported that “prescription drug abuse, especially opioid abuse, is the fastest growing drug abuse problem in the US”.
- Startling rise in unintentional drug overdoses and related deaths since the 1990’s
  - 2007, 27,000 unintentional drug overdose deaths in the US, one death every 19 minutes
- Unintentional deaths involving Opioid Pain Relievers (OPR’s) specifically, rose from 2,900 deaths in 1999 to 14,800 in 2008
- Currently deaths from opioid analgesics are significantly greater in number than from cocaine and heroin combined
A startling problem

Figure 2: Unintentional drug overdose deaths by major type of drug, United States, 1999-2006

Source: National Vital Statistics System
Nearly three out of four prescription drug overdoses are caused by these prescription painkillers.
How Prescription Painkiller Deaths Occur

• Bind to receptors in the brain to decrease the perception of pain
  • Can create a strong feeling of euphoria, cause physical dependence, and in some people, lead to addiction
  • Also cause, heavy sedation and can slow down a person’s breathing

• Heavy sedation can be so severe that breathing stops, resulting in fatal overdose
  • About one-half of prescription painkiller deaths involved at least one other drug, including benzodiazepines, cocaine, and heroin. Alcohol is also frequently involved.
The epidemic has worsened over the last decade, and by 2008 drug overdose deaths were the second leading cause of injury death in the US following motor vehicle crashes...

- Drug overdose deaths 36,450 (most caused by prescription drugs)
- MVC’s 39,973

Traffic deaths were cut in half over the previous decade following...
- Highway safety
- Car improvements
- Seat belt laws
- Drunk driving laws

Source: National Vital Statistics System
The unprecedented rise in overdose deaths in the US parallels a 300% increase since 1999 in the sale of these strong painkillers.

- In an attempt to treat patient’s pain better, practitioners have greatly increased their rate of opioid prescribing over the past decade.
- Unfortunately, persons who abuse opioids have learned to exploit this new practitioner sensitivity to patient pain, and clinicians struggle to treat patients without overprescribing these drugs.
- By 2010, enough OPR’s were sold to medicate every American adult with a typical dose of 5 mg of hydrocodone every 4 hours for 1 month

The misuse and abuse of prescription painkillers was responsible for more than 475,000 ED visits in 2009, a number that nearly doubled in 5 yrs.
Rates of prescription painkiller sales, deaths and substance abuse treatment admissions (1999-2010)

**Abstract:** Therapeutic opioid use and abuse coupled with the nonmedical use of other psychotherapeutic drugs has shown an explosive growth in recent years and has been a topic of great concern and controversy. Americans, constituting only 4.6% of the world’s population, have been consuming 80% of the global opioid supply, and 99% of the global hydrocodone supply, as well as two-thirds of the world's illegal drugs. With the increasing therapeutic use of opioids, the supply and retail sales of opioids are mirrored by increasing abuse in patients receiving opioids, nonmedical use of other psychotherapeutic drugs (in this article the category of psychotherapeutics includes pain relievers, tranquilizers, stimulants, and sedatives, but does not include over-the-counter drugs), emergency department visits for prescription controlled drugs, exploding costs, increasing incidence of side effects, and unintentional deaths. However, all these ills of illicit drug use and opioid use, abuse, and non-medical use do not stop with adults. It has been shown that 80% of America's high school students, or 11 million teens, and 44% of middle school students, or 5 million teens, have personally witnessed, on the grounds of their schools, illegal drug use, illegal drug dealing, illegal drug possession, and other activities related to drug abuse. The results of the 2006 National Survey on Drug Use and Health showed that 7.0 million or 2.8% of all persons aged 12 or older had used prescription type psychotherapeutic drugs nonmedically in the past month, 16.387 million, or 6.6% of the population, had used in the past year, and 20.3%, or almost 49.8 million, had used prescription psychotherapeutic drugs nonmedically during their lifetime. Sadly, the initiates of psychotherapeutic drugs used for nonmedical purposes were highest for opioids. Therapeutic opioid use has increased substantially, specifically of Schedule II drugs. Apart from lack of effectiveness (except for short-term, acute pain) there are multiple adverse consequences including hormonal and immune system effects, abuse and addiction, tolerance, and hyperalgesia. Patients on long-term opioid use have been shown to increase the overall cost of healthcare, disability, rates of surgery, and late opioid use.
In 2008, there were 14,800 prescription painkiller deaths.

For every 1 death there are...

- 10 treatment admissions for abuse
- 32 emergency dept visits for misuse or abuse
- 130 people who abuse or are dependent
- 825 nonmedical users
More than 12 million people reported using prescription painkillers non-medically in 2010,
  - Use without a prescription or for the feeling they cause...euphoria or “getting high”.

Almost all prescription drugs involved in overdoses come from prescriptions originally; not from pharmacy theft.
  - Once they are prescribed and dispensed, prescription drugs are frequently *diverted* to people using them without prescriptions.
  - More than three out of four people who misuse prescription painkillers use drugs prescribed to someone else.
Where are they coming from...

People who abuse prescription painkillers get drugs from a variety of sources:

- Obtained free from friend or relative: 55%
- Prescribed by one doctor: 17.3%
- Bought from friend or relative: 11.4%
- Took from friend or relative without asking: 4.8%
- Got from drug dealer or stranger: 4.4%
- Other source: 7.1%
### Sources of Narcotic Analgesics

<table>
<thead>
<tr>
<th>Setting Type</th>
<th>% Distribution</th>
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<tbody>
<tr>
<td>Emergency department</td>
<td>39%</td>
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<tr>
<td>Primary care office</td>
<td>31%</td>
</tr>
<tr>
<td>Medical specialty office</td>
<td>13%</td>
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<tr>
<td>Surgical specialty office</td>
<td>10%</td>
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<tr>
<td>Hospital outpatient department</td>
<td>7%</td>
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...largest ambulatory source of administration and prescribing of opioid prescriptions for legitimate medical purposes.

Clearly, physicians write these prescriptions to benefit the patient, who enter the ED in a state of perceived need. Prescribing narcotics may seem like the kindest action to take. However, in viewing the bigger picture, we now understand that this is not always the case, and the system is overdue for some changes.....

Alarmingly up to 85% of the nations supply of illegally used Oxycodone reportedly originates in Florida.

- In the 2\textsuperscript{nd} half of 2008, the Top 50 doctors in the country dispensing Oxycodone were all in Florida.

- **9 million** oxycodone pills were prescribed by just 50 doctors in Florida in the 2\textsuperscript{nd} half of 2008.

- As many as **7 Florida residents reportedly die every day** as a result of prescription drug overdose.

What amount of concern would our community show if that many Dolphins were washing up on Florida’s shores daily?
The amount of prescription painkillers sold in states varies.

The quantity of prescription painkillers sold to pharmacies, hospitals, and doctors’ offices was 4 times larger in 2010 than in 1999.
Florida leading the way...

Drug overdose rates by state, 2008
Florida and “The Oxycontin Express”

- In October 2009, Vanguard TV released a 47 min video documentary highlighting Florida’s prescription drug problem associated with the incredible proliferation of illegitimate pain clinics or “pill mills”.
  - “Florida has become the painkiller capitol of the United States” and “South Florida is the Columbia of prescription drugs”.
  - The flight from Ft. Lauderdale to Huntington, West Virginia is know as “The Oxycontin Express”.

The US government is

- Tracking prescription drug overdose trends to better understand the epidemic.
- Educating health care providers and the public about prescription drug abuse and overdose.
- Developing, evaluating and promoting programs and policies shown to prevent and treat prescription drug abuse and overdose, while making sure patients have access to safe, effective pain treatment.
OK, It’s a Problem. What can we do about It?

- CDC encourages Health Care providers
  - Follow guidelines for responsible prescribing, including
    - Educate prescribers regarding the under-appreciated risks and frequently exaggerated benefits of high-dose opioid therapy.
    - **Screen and monitoring** for substance abuse and mental health problems.
    - Prescribing painkillers only when other treatments have not been effective for pain.
    - Prescribing only the **quantity of painkillers needed for** expected length of pain.
    - Using patient-provider “pain contracts” combined with urine drug tests for people using prescription painkillers long term.
    - Use **PDMPs to identify patients** who are improperly using prescription painkillers.....or those who aren't.
States can:

- Improve or start prescription drug monitoring programs (PDMPs)
- Pass, and enforce other laws to reduce prescription drug abuse, pill mills, and doctor shopping
- Encourage professional licensing boards to take action against inappropriate prescribing.
- Increase and fund access to substance abuse treatment.
- Use DMP, Medicaid, and workers’ compensation data to identify improper prescribing of painkillers.
What did Florida’s leaders do about it?

- Enacted the “Prescription Drug Bill” 7095
- Directed the DOH to declare a “Public Health Emergency”
- Enacted laws governing physicians, pain management clinics, pharmacies, and wholesale distributors to practice more responsibly, **helped initiate the FL PDMP.**
- Addressed counterfeit prescription pads, registration of those treating chronic pain and **Standards of Practice.**
Simply put, It’s the law....

- "Standards of Practice” defined by HB 7095
  - Requires registration for those doctors treating defined chronic non-malignant pain
  - Documentation requirements and risk assessment for drug-related behavior....
    - *office urine drug testing and monitoring*
  - Defined treatment plans including other treatment modalities with adjustment as needed (other than just narcotics)
  - Written **controlled substance agreement** between the physician and the patient outlining the patient’s responsibilities and expectations, including...
    - # and freq. of controlled substances to be used
    - reasons for drug therapy discontinuation and violations
    - Agreement that controlled substances shall be prescribed *by a single treating physician* unless otherwise authorized by the treating physician and documented in the medical record
  - Patient to be seen at **regular treatment intervals, not to exceed 3 months** to assess efficacy of treatment, progress, ensure controlled substance remains indicated..
In a similar notion, what do the “Pain Experts” say about treating chronic pain....

- The **American Society of Anesthesiologist Task force on pain management** cites narcotic prescriptions as the 9th item in a list of 12 possible solutions to treat chronic pain.
  - Yet in the ED narcotic administration and prescription are often the first and only methods used.

- The **American Academy of Pain Medicine** takes a defined approach to chronic pain patients:
  - comprehensive strategy, careful assessment, ongoing evaluation, clear lines of communication, boundaries and careful documentation.

- The **American Pain Society guidelines** recommend that “all patients on chronic opioid therapy should have a clinician who accepts primary responsibility for their overall medical care.”
  - Chronic pain is often multi-factorial and adequate treatment often includes antidepressants, psychotherapy, behavioral therapy and physical therapy.
The complex problem we face in the ED....

- Chronic pain care is very complex
  - ED’s lack the appropriate time and resources to sort out the problem
  - Doctors often opt for the quick solution of narcotics, hoping it will save time and hassle in an attempt to “satisfy” the patient.

- ED physicians often acquiesce to patient’s demands for narcotics
  - Might not be in the patient’s best medical interest or best clinical recommendations.
  - Chronic pain patients often return to the same ED multiple times a month with the same or related complaints.
  - Frequent prescription from ED is counter-therapeutic and can enable/reinforce addictive and abusive behaviors in some patients with chronic pain.

- Participating in this broken system is frustrating for physicians
  - Keeps patients in a cycle of pain and drugs
  - Enormous amount of resources diverted from patients with acute emergencies in our overburdened ED’s
What can our Emergency Departments do?

- Develop and foster voluntary guidelines consistent with new state laws designed to improve the safety of prescribing opiates.

- Intended to help Emergency Departments:
  - reduce the inappropriate use of opioid analgesics for chronic non-malignant painful conditions
  - continue to adequately and compassionately treat acute painful conditions
  - As we preserve the vital role and resources of the ED
NO, We are fortunate to have the frontline leadership of others...

Prescribing Pain Medication in the Emergency Department

“Recent data shows that health care providers are prescribing more opioid pain medicine. An unintended consequence of this prescribing has been an increase in overdose deaths, hospitalizations, and substance abuse treatment admissions. In addition, teens are using prescription opioid medication to get high. The cause of this public health problem and its solutions are complex.”

As part of the solution, WA-ACEP and the Washington State Department of Health convened an emergency department provider workgroup and created emergency department guidelines for opioid prescribing.

Our goal is to have a consistent, statewide message for patients in Washington State. Please hang the large poster (20 x 30) in your waiting room, and smaller posters (11 x 17) in exam or triage rooms.

- Washington Chapter of the American College of Emergency Physicians
- Sponsored by the Washington State Department of Health
- State Department of Social and Health Services
- State Hospital Association
- State council of the Emergency Nurses Association
Prescribing Pain Medication in the Emergency Department

Our emergency department staff understand that pain relief is important when someone is hurt or needs emergency care. However, providing pain relief is often complex. Mistakes or misuse of pain medication can cause serious health problems and even death. Our emergency department will only provide pain relief options that are safe and appropriate.

- Our main job is to look for and treat an emergency medical condition. We use our best judgment when treating pain, and follow all legal and ethical guidelines.
- We may ask you to show a photo ID (such as a driver’s license) when you check into the emergency department or receive a prescription for pain medication.
- We may ask you about a history of pain medication misuse or substance abuse before prescribing any pain medication.
- We may only provide enough pain medication to last until you can contact your doctor. We will prescribe pain medication with a lower risk of addiction and overdose when possible.

- For your safety, we do not:
  - Give pain medication shots for sudden increases in chronic pain.
  - Refill stolen or lost prescriptions for medication.
  - Prescribe missed methadone doses.
  - Prescribe long-acting pain medication such as OxyContin, MS Contin, fentanyl patches, or methadone for chronic, non-cancer pain.
  - Prescribe pain medication if you already receive pain medication from another doctor or emergency department. An exception may be made after a urine drug test or contact with your doctor or clinic.

If you would like help, we can refer you to a drug treatment program. Or you can call the Washington Recovery Help Line at **1-866-789-1511**.
Quality Collaborative of Northeast Florida Announces Pain Guidelines

- On behalf of the Quality Collaborative of Northeast Florida, Dr. Yank Coble, director of the Center for Global Health and Medical Diplomacy at the University of North Florida, and Capt. Lynn Welling, Naval Hospital Jacksonville commanding officer,
  - Announced the development of guidelines for treating chronic or recurrent pain designed to ensure patients get the most appropriate medication for their pain, while minimizing controlled substance dependence and abuse.
- Implement these guidelines in its emergency department on Saturday, Oct. 1.
- The Quality Collaborative of Northeast Florida, an initiative of the Center for Global Health and Medical Diplomacy at UNF, was formed last year and is comprised of 15 participating private- and public-sector health care organizations.
Quality Collaborative of Northeast Florida Announces Pain Guidelines

- The *Rational Prescribing of Controlled Substances Working Group* was formed to address the problem in the Florida region, bringing together organizations like Baptist Health of Northeast Florida, Brooks Health and Rehabilitation, Center for Global Health and Medical Diplomacy at UNF, Duval County Health Department, *Duval County Medical Society*, Emergency Resources Group, *Mayo Clinic Florida*, Memorial Health Care, *Naval Hospital Jacksonville*, *Orange Park Medical Center*, Riverside Spine, St. Luke’s Hospital, St. Vincent’s Healthcare, Titan Emergency Group and the *University of Florida at Shands*.

- LMHS requested permission to join this collaborative working group in order to provide such leadership for our community in SWFLA.
Tougher laws and new regulations targeting the state's pain clinics and rogue doctors are having an unintended consequence on Florida hospitals: More and more people are turning to the emergency room for painkillers.....

Emergency department doctors and nurses now find themselves treating hostile patients who are verbally and physically abusive. Some of those ... even make threats against hospital staff if they don't receive the drugs they want.
• The new plan calls for doctors to help educate patients about the dangers of abusing prescription drugs and addiction.

• Because emergency room physicians are unable to establish the long-term relationships with patients that are needed to properly treat chronic pain, they will also refer the patient to a primary care physician. The plan also calls for physicians to refer patients to community resources such as rehabilitation facilities, if they need help for prescription-drug addiction.

• Dr. Stacy E. Seikel, medical director at the Center for Drug Free Living, praised the new guidelines. "This was a monumental task," she said. "The policy is both appropriate and compassionate."
Is currently developing a clinical policy discussing the critical issues in the prescribing of opioids for adult patients in the ED

- Joint effort between the American College of Emergency Physicians, the Center for Disease Control and Prevention, and the Food and Drug Administration

- The aim is to provide evidence-based recommendations for prescribing opioids for adult ED patients with painful conditions while attempting to address the increasing frequency of adverse effects and abuse from this class of medications.
Our responsibility to our ED patients and the community

- Our responsibility as physicians is to “First, do no harm”.
  - Balance of a dual obligation to relieve pain and to protect susceptible patients from the consequences of abuse and addiction

- Indiscriminant administration and prescription of controlled substances by ED’s may lead to chemical dependence, addiction, dysfunction, disability, abuse and drug diversion and death in our community.
  - American Society of Addiction Medicine reports that teen addiction is often preceded by opioid prescriptions for legitimate medical purposes.
  - 11% of Florida high school students and 4% of Florida middle school students report the non-medical use of prescription analgesics.
Our ED physicians will continue to use their best judgment and resources including the FL PDMP and our hospital’s interconnected EMR’s when treating pain, while following legal and ethical guidelines.

This initiative is a first step as our ED physicians begin engage community resources to help connect patients with primary care physicians and legitimate pain management specialists for appropriate follow-up care.

Ultimately, our hope is to increase awareness to empower community leaders to gather more support for behavioral modification programs and addiction treatment programs.
Pain is real and pain relief is important when someone is hurt or needs emergency care.

- **Committed to alleviating pain and suffering in acutely painful conditions**
- Yet, chronic non malignant pain is best managed in the appropriate setting where monitoring and ongoing assessment can occur
  - as required by our new state law
  - Our ED’s are ill equipped to establish the long term relationship needed to appropriately treat and manage recurring pain and prevent life threatening side effects.
We take our mission to provide care for the community seriously and want to preserve our ED’s as a critical resource for the community we serve.

- Want to send a compassionate yet firm message to help reduce the number of those only seeking controlled substances for abuse, misuse and diversion purposes in our overburdened ED’s.

- At the same time, as patient and community advocates, our ED’s support efforts to alleviate pain and suffering.
  - Rationally
  - Responsibly
  - Respectfully
THE PROBLEM:

- According to The Centers for Disease Control and Prevention, abuse of prescription painkillers is a U.S. epidemic. Substance dependence, abuse and misuse are especially prevalent in Florida. On average seven Florida residents die each day from prescription overdoses. Our Emergency Department staff understands that pain relief is important when someone is hurt or needs emergency care. However, providing pain relief is often complex. Mistakes or misuse of pain medication can cause serious health problems or even death. Our emergency department will only provide you with pain treatment that we feel is safe and appropriate.

THE GUIDELINES:

- In order to provide you the safest, most effective and up-to-date medical care possible, LMHS and 15 other Florida institutions have adopted guidelines for prescribing pain medication in the Emergency Department (ED). Our intent is to raise awareness of a growing problem within our community and aim to reduce chemical dependence, addiction, abuse and drug diversion in Southwest Florida.
1) **We strive to coordinate the care of patients with chronic or recurrent pain conditions with primary care and specialist doctors.**
   - Management of chronic or recurrent pain is best accomplished by a single primary care provider or pain management specialist. Following your individualized care plan will optimize your treatment, while avoiding overuse of medications associated with abuse or addiction.

2) **One doctor should prescribe all your narcotic or controlled medications.**
   - We may prescribe narcotic pain medications on your first ED visit for an acutely painful condition. If you have already received a narcotic pain medication from another doctor or ED, we may treat your pain with non-narcotic pain medications.

3) **Certain chronic and recurrent pain conditions may not be adequately treated using narcotic medications as a mainstay of treatment.**
   - Many non-narcotic medications are useful in treating chronic pain. We avoid prescribing or administering many narcotic medications for chronic or recurrent pain, such as Dilaudid, Demerol, Morphine, Oxycontin, Vicodin and Percocet. These drugs are known to have the highest rates of abuse and addiction and may not be effective in many chronic pain conditions.
4) We will treat worsening of chronic or recurrent pain conditions with non-narcotic medications or we will prescribe pain medication with a lower risk of addiction and misuse when possible. We may only provide enough pain medication to last until you can contact your doctor.

5) We may access information about a patient’s controlled substance prescription history from Florida’s Prescription Drug Monitoring Program.
   ▪ We may ask you about a history of pain medication misuse or substance abuse and may use additional information, such as urine drug testing when deciding your pain treatment. This helps us understand if you have received controlled substances from multiple physicians and can help prevent serious interactions with other medications you might be taking. These measures help us to determine a more appropriate approach to your pain treatment.

6) Prescriptions for controlled medications may only be given to patients who present a valid, government issued photo identification.
   ▪ Before you receive a controlled medication prescription you may be asked to show a government-issued photo ID, such as a driver’s license. This is generally required for ED registration and pharmacies in order to improve patient safety.
7) *We will not replace lost or stolen prescriptions for controlled medications.*
   - We will not supply replacement prescriptions for controlled substances that were lost, destroyed or stolen. Patients misusing controlled substances frequently report their prescriptions were lost or have been stolen. Pain specialist routinely state in pain agreements that lost or stolen prescriptions will not be replaced.

8) *We will not prescribe or administer methadone.*
   - We will not provide replacement doses of methadone for patients who have missed a dose. Methadone is best used in coordination with a pain management specialist or primary care physician.
Emergency Department Guidelines to Reduce Prescription Drug Abuse

In collaboration with the Quality Collaborative of Northeast Florida and the Rational Prescribing of Controlled Substances Working Group

The Problem:
According to The Centers for Disease Control and Prevention, abuse of prescription painkillers is a U.S. epidemic. Substance dependence, abuse and misuse are especially prevalent in Florida. On average seven Florida residents die each day from prescription overdoses. Our Emergency Department staff understands that pain relief is important when someone is hurt or needs emergency care. However, providing pain relief is often complex. Mistakes or misuse of pain medication can cause serious health problems or even death. Our emergency department will only provide you with pain treatment that we feel is safe and appropriate.

The Guidelines:
In order to provide you the safest, most effective and up-to-date medical care possible, Lee Memorial Health System and 15 other Florida institutions have adopted guidelines for prescribing pain medication in the Emergency Department (ED). Our intent is to raise awareness of a growing problem within our community and aim to reduce chemical dependence, addiction, abuse and drug diversion in Southwest Florida.

1. **We strive to coordinate the care of patients with chronic or recurrent pain conditions with primary care and specialist doctors.**
   Management of chronic or recurrent pain is best accomplished by a single primary care provider or pain management specialist. Following your individualized care plan will optimize your treatment, while avoiding overuse of medications associated with abuse or addiction.

2. **One doctor should prescribe all your narcotic or controlled medications.**
   We may prescribe narcotic pain medications on your first ED visit for an acutely painful condition. If you have already received a narcotic pain medication from another doctor or ED, we may treat your pain with non-narcotic pain medications.

3. **Certain chronic and recurrent pain conditions may not be adequately treated using narcotic medications as a mainstay of treatment.**
   Many non-narcotic medications are useful in treating chronic pain. We attempt to avoid prescribing or administering many narcotic medications for chronic or recurrent pain, such as Dilaudid®, Demerol®, Morphine, Oxycontin®, Vicodin® and Percocet®. These drugs are known to have the highest rates of abuse and addiction and may not be effective in many chronic pain conditions.
4. **We will treat worsening of chronic or recurrent pain conditions with non-narcotic medications or we will prescribe pain medication with a lower risk of addiction and misuse when possible. We may only provide enough pain medication to last until you can contact your doctor.**

5. **We may access information about a patient’s controlled substance prescription history from Florida’s Prescription Drug Monitoring Program.**

   We may ask you about a history of pain medication misuse or substance abuse and may use additional information, such as urine drug testing when deciding your pain treatment. This helps us understand if you have received controlled substances from multiple physicians and can help prevent serious interactions with other medications you might be taking. These measures help us to determine a more appropriate approach to your pain treatment.

6. **Prescriptions for controlled medications may only be given to patients who present a valid, government issued photo identification.**

   Before you receive a controlled medication prescription you may be asked to show a government-issued photo ID, such as a driver’s license. This is generally required for ED registration and pharmacies in order to improve patient safety.

7. **We will not replace lost or stolen prescriptions for controlled medications.**

   We will not supply replacement prescriptions for controlled substances that were lost, destroyed or stolen. Patients misusing controlled substances frequently report their prescriptions were lost or have been stolen. Pain specialist routinely state in pain agreements that lost or stolen prescriptions will not be replaced.

8. **We will not prescribe or administer methadone.**

   We will not provide replacement doses of methadone for patients who have missed a dose. Methadone is best used in coordination with a pain management specialist or primary care physician.
LMHS Trauma Services
Injury Prevention

Syndi Bultman R.N., M.S., CEN
Injury Prevention Resource
Manager Trauma Services
239-336-6797
Our Purpose

Reduce the amount of unintentional injury and to promote a safe community
Our Mission

Trauma district is safe and free of preventable injuries
Mission Statement

Our mission is dedicated to reducing Lee County’s injury burden. Our goal is to promote effective approaches to injury prevention and control through education, advocacy, data collection and evaluation. In a collaborative effort with Lee County to address all injury, we strive to save lives, reduce costs, and improve the quality of life for Lee County residents and visitors.
What is Trauma?

Trauma is an injury caused by a physical force.

*Unintentional*—MVC, Falls, Poisoning, Drowning

*Intentional*—Suicide, Homicide, Assaults, Rape, Terrorists

Trauma kills more people between the ages of 1 and 44 than any other disease or illness.
Trauma is a Preventable Disease

Education is the Key to Preventing trauma
Injury Prevention

Bicycle safety
Child Passenger safety
High Risk Driver Program
Young Driver Program
G.A.T.E. (Youth Violence Prevention Program)
Sports Injury Prevention Program
(Concussion and Hyperthermia)
TNTT for school age children
Fatal Vision Goggles
Defensive Driving
Step Wise Lee Falls Prevention
Programs for mature adults
Take Care 1
Take Care 2
Individualized programs done for organizations on request
Boating safety Bonita Bay
Preventing workplace injuries Waste Management
What is a trauma center?
Injury Prevention Community Wide

Drug House Odyssey
Pediatric Injury Prevention Health Fair
3 D Month Event in Dec
Trauma Awareness Event May
Falls Awareness Event in September
Numerous community health fairs
Community Representation for Lee Memorial Trauma Services

Chairperson of Lee County Injury Prevention Coalition and Executive Board
State Department of Health Injury Prevention Advisory Council
Florida State Department of Health Senior Falls Prevention Coalition
Prevention subgroup
Policy sub group
Executive Board Drug Free Coalition of Southwest Florida
Board of Directors Pine Manor Association
Liaison for Lee Memorial Trauma Center
Lee County Community Traffic Safety Team
Bike/Walk Lee
MPO Bicycle Pedestrian Coordinating Committee
Youth Prevention Coalition
Injury prevention contacts

March 2003-2004 reached 17,118 people
March 2004-2005 reached 304,056
March 2005-2006 reached 290,912
March 2006-2007 reached 228,595
March 2007-2008 reached 76,255
March 2008-2009 reached 79,401
March 2009-2010 reached 473,986
March 2010-March 2011 reached 844,684
Step Wise Lee Falls Prevention

Presentations since 2010---- 110
2011----2,390

Media Contacts-----280,000

Health Fairs---- 40

CAN program (Community Assistance Network) with United Way

Fire Departments: 
Ft. Myers Shores
Bonita Springs
Estero
South Trail
Iona-McGregor
Lehigh
Fort Myers Fire Dept

Police:
Lee County Sheriff
Fort Myers Police
### Falls Stats from 2008-2011

Falls over 65 from 10/1/2008 to 9/30/2009
- 549 patients
- 3% ETOH on board
- 25 Deaths

Falls over 65 from 10/1/2009 to 9/30/2010
- 468 patients
- 4% ETOH on board
- 23 Deaths

Falls over 65 from 10/1/2010 to 9/30/2011
- 446 patients
- 5% ETOH on board
- 29 Deaths

#### Falls Age 64+

<table>
<thead>
<tr>
<th>Year</th>
<th># patients</th>
<th>%w/ETOH</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-09</td>
<td>549</td>
<td>3%</td>
<td>25</td>
</tr>
<tr>
<td>2009-10</td>
<td>468</td>
<td>4%</td>
<td>23</td>
</tr>
<tr>
<td>2010-11</td>
<td>446</td>
<td>5%</td>
<td>29</td>
</tr>
</tbody>
</table>

**Fall Trends 2008-11**

-103 (10% reduction)  2% increase  +6 deaths 11% increase
CAN Referrals

Referrals

January 2011
February 2011
March 2011
April 2011
May 2011
June 2011
July 2011
August 2011
September...
October 2011
November...
December...
Cost Savings

Based on national non fatal injury cost of $39,782

Savings of $4,097,546.00
G.A.T.E.
(Gang Awareness Training Education)

33 presentations with 721 participants

Have 57 trained in GATE

Media coverage 20,000

42 RSO in school system

Will become part of curriculum next year

Bonita Springs
Pine Manor
Harlem Lakes
Charleston Park
High Risk Driver Program

High Risk Driver Program is court ordered

Started Jan 2007

Total to date Dec 2011 4,551 participants

5 repeats

after one to one and a half years

2 repeats

After three years
Young Driver Program

Started 2008

Due to response from High Risk Driver advertised in monthly newsletter press releases

Have you Heard

Now have several Judges mandating juveniles to this program
2011 Contacts

<table>
<thead>
<tr>
<th>Activity</th>
<th>Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRD</td>
<td>436</td>
</tr>
<tr>
<td>YDP</td>
<td>38</td>
</tr>
<tr>
<td>TNTT Drivers Ed</td>
<td>297</td>
</tr>
<tr>
<td>Defensive Driving</td>
<td>202</td>
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<tr>
<td>Helmet Tours</td>
<td>20</td>
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<tr>
<td>Sports Injury Prevention</td>
<td>45</td>
</tr>
<tr>
<td>Drug House Odyssey</td>
<td>2,217</td>
</tr>
<tr>
<td>Step Wise Lee Falls Prevention</td>
<td>2,390</td>
</tr>
<tr>
<td>Total Health Fairs</td>
<td>48</td>
</tr>
<tr>
<td>Participants reached at Health Fair</td>
<td>31,701</td>
</tr>
<tr>
<td>Total Media Contacts</td>
<td>1,121,360</td>
</tr>
<tr>
<td>Total contacts for 2011</td>
<td>1,158,706</td>
</tr>
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</table>
Funding
Questions
**DATE:** 2/1/2012  
**LEGAL REVIEW:** Yes ___ No _X_

**SUBJECT:** 4th Quarter FY 2011 (Jul – Sep 2011) System Organizational Performance Measure Indicators

**REQUESTOR & TITLE:** Dr. Krivenko, Chief Medical Officer/Clinical & Quality Services

**PREVIOUS BOARD ACTION ON THIS ITEM (IF ANY)**  
(Justification and/or background for recommendations – internal groups which support the recommendation i.e. SLC, Operating Councils, PMTs, etc.)

The System Quality Safety and Management Council reviewed and approved several of the indicators within the system Organizational Performance Measure presentation on January 11, 2012.

**SPECIFIC PROPOSED MOTION:**

Accept the system Organizational Performance Measure Indicators: 4th Quarter Fiscal Year 2011 (Jul – Sep 2011).

<table>
<thead>
<tr>
<th>PROS TO RECOMMENDATION</th>
<th>CONS TO RECOMMENDATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**LIST AND EXPLAIN ALTERNATIVES CONSIDERED**

N/A

**FINANCIAL IMPLICATIONS**  
Budgeted _____ Non-Budgeted ____  
(including cash flow statement, projected cash flow, balance sheet and income statement)

N/A

**OPERATIONAL IMPLICATIONS**  
(including FTEs, facility needs, etc.)

N/A

**SUMMARY**

_The disclosure of this report and the contents herein does not constitute a waiver of any and all protections afforded Patient Safety Work Product under the Patient Safety Quality Improvement Act of 2005 and implementing regulations._
System BOD Performance Measure Indicators

4th Quarter FY 2011
July - September 2011
Clinical Decision Support
<table>
<thead>
<tr>
<th>LMHS</th>
<th>VBP PROGRAM SCORECARD</th>
<th>FY2011 QTR 1</th>
<th>FY2011 QTR 2</th>
<th>FY2011 QTR 3</th>
<th>FY2011 QTR 4</th>
<th>FISCAL YEAR</th>
<th>MEAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEART ATTACK</td>
<td>ASPIRIN AT DISCHARGE (AMI-2)</td>
<td>99.3%</td>
<td>98.0%</td>
<td>97.5%</td>
<td>96.0%</td>
<td>98.2%</td>
<td>98.6%</td>
</tr>
<tr>
<td></td>
<td>FIBRINOLYTIC THERAPY RECEIVED WITHIN 30 MINUTES OF HOSPITAL ARRIVAL (AMI-7A)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>80.8%</td>
</tr>
<tr>
<td></td>
<td>PRIMARY PCI RECEIVED WITHIN 90 MINUTES OF HOSPITAL ARRIVAL (AMI-8A)</td>
<td>90.0%</td>
<td>70.0%</td>
<td>72.4%</td>
<td>55.6%</td>
<td>74.4%</td>
<td>90.6%</td>
</tr>
<tr>
<td>HEART FAILURE</td>
<td>DISCHARGE INSTRUCTIONS RECEIVED (HF-1)</td>
<td>61.0%</td>
<td>70.5%</td>
<td>55.2%</td>
<td>69.6%</td>
<td>63.4%</td>
<td>69.5%</td>
</tr>
<tr>
<td></td>
<td>EVALUATION OF LVEF FUNCTION (HF-2)</td>
<td>97.9%</td>
<td>97.4%</td>
<td>99.0%</td>
<td>100.0%</td>
<td>98.3%</td>
<td>97.9%</td>
</tr>
<tr>
<td></td>
<td>ACE/ARBS FOR LYSO (HF-3)</td>
<td>95.4%</td>
<td>85.2%</td>
<td>88.0%</td>
<td>75.0%</td>
<td>67.5%</td>
<td>84.8%</td>
</tr>
<tr>
<td>PNEUMONIA</td>
<td>PNEUMOCOCCAL VACCINATION (PN-2)</td>
<td>91.5%</td>
<td>94.3%</td>
<td>91.5%</td>
<td>97.2%</td>
<td>93.1%</td>
<td>93.5%</td>
</tr>
<tr>
<td></td>
<td>BLOOD CULTURE PRIOR TO ADMINISTRATION OF FIRST ANTIBIOTIC(S) (PN-3A)</td>
<td>96.2%</td>
<td>100.0%</td>
<td>92.3%</td>
<td>88.9%</td>
<td>95.4%</td>
<td>93.5%</td>
</tr>
<tr>
<td></td>
<td>BLOOD CULTURE PERFORMED PRIOR TO ADMINISTRATION OF FIRST ANTIBIOTIC(S) (PN-3B)</td>
<td>91.6%</td>
<td>92.0%</td>
<td>92.9%</td>
<td>91.7%</td>
<td>92.1%</td>
<td>92.2%</td>
</tr>
<tr>
<td></td>
<td>INITIAL ANTIBiotic SELECTION FOR CAP IN IMMUNOCOMPETENT PATIENT (PN-5)</td>
<td>87.0%</td>
<td>91.1%</td>
<td>66.7%</td>
<td>94.4%</td>
<td>88.8%</td>
<td>92.5%</td>
</tr>
<tr>
<td></td>
<td>INFLUENZA VACCINATION (IN-7)</td>
<td>84.8%</td>
<td>93.0%</td>
<td>N/A</td>
<td>N/A</td>
<td>88.5%</td>
<td>N/A</td>
</tr>
<tr>
<td>HEALTHCARE-ASSOCIATED INFECTION</td>
<td>PROPHYLACTIC ANTIBIOTIC(S) ONE HOUR BEFORE INCISION (SOP-INF-1A)</td>
<td>96.6%</td>
<td>93.6%</td>
<td>94.0%</td>
<td>97.2%</td>
<td>94.9%</td>
<td>97.1%</td>
</tr>
<tr>
<td></td>
<td>SELECTION OF ANTIBIOTIC GIVEN TO SURGICAL PATIENTS (SOP-INF-2A)</td>
<td>91.8%</td>
<td>90.7%</td>
<td>90.9%</td>
<td>91.9%</td>
<td>91.2%</td>
<td>97.6%</td>
</tr>
<tr>
<td></td>
<td>PROPHYLACTIC ANTIBIOTIC(S) STOPPED WITHIN 24 HOURS AFTER SURGERY (SOP-INF-3A)</td>
<td>92.0%</td>
<td>91.2%</td>
<td>88.8%</td>
<td>89.8%</td>
<td>90.8%</td>
<td>96.5%</td>
</tr>
<tr>
<td></td>
<td>CARDIAC SURGERY PATIENTS WITH CONTROLLED 6AM POSTOPERATIVE SERUM GLUCOSE (SOP-INF-4)</td>
<td>94.1%</td>
<td>93.5%</td>
<td>98.8%</td>
<td>91.3%</td>
<td>95.1%</td>
<td>93.9%</td>
</tr>
<tr>
<td>SURGICAL CARE IMPROVEMENT</td>
<td>SURGERY PATIENTS ON A BETA BLOCKER PRIOR TO ARRIVAL WHO RECEIVED A BETA BLOCKER DURING THE PERIOPERATIVE PERIOD (SOP-CARD-2)</td>
<td>91.5%</td>
<td>87.6%</td>
<td>88.4%</td>
<td>84.0%</td>
<td>88.6%</td>
<td>93.8%</td>
</tr>
<tr>
<td></td>
<td>SURGERY PATIENTS WITH RECOMMENDED VENOUS THROMBOEMBOLISM PROPHYLAXIS ORDERED (SOP-VTE-1)</td>
<td>87.2%</td>
<td>82.7%</td>
<td>93.3%</td>
<td>95.4%</td>
<td>90.0%</td>
<td>94.7%</td>
</tr>
<tr>
<td></td>
<td>SURGERY PATIENTS WHO RECEIVED APPROPRIATE VENOUS THROMBOEMBOLISM PROPHYLAXIS WITHIN 24 HOURS PRIOR TO SURGERY TO 24 HOURS AFTER SURGERY (SOP-VTE-2)</td>
<td>84.7%</td>
<td>77.2%</td>
<td>88.8%</td>
<td>94.4%</td>
<td>86.1%</td>
<td>93.1%</td>
</tr>
<tr>
<td><strong>AVERAGE OF ABOVE CORE MEASURES</strong></td>
<td>90.0%</td>
<td>89.2%</td>
<td>89.8%</td>
<td>91.3%</td>
<td>89.9%</td>
<td>92.6%</td>
<td></td>
</tr>
</tbody>
</table>
Data:

- **Indicator Description:** Monthly monitor of the health system’s rolling 12 month Serious Safety Event Rate (SSER) and number of serious safety events (SSEs)
- **Formula:** \( \left( \frac{\text{rolling 12 month number of serious safety events}}{\text{rolling 12 month average patient days}} \right) \times 10,000 \)
- **Goal:** \( \leq 0.2 \text{ SSEs / 10,000 adjusted patient days} \)
- **Why track:** Safety events cause increased risk and dissatisfaction among patient populations and increased cost to the health system and patient.

**Current Status:**

**1st Quarter FY12**

- **System:** 0.141 SSEs / 10,000 adjusted patient days (7 SSEs / 497,315 adjusted patient days)
- **Cape:** 0.194 SSEs / 10,000 adjusted patient days (2 SSEs / 103,256 adjusted patient days)
- **HealthPark:** 0.000 SSEs / 10,000 adjusted patient days (0 SSEs / 144,460 adjusted patient days)
- **Lee:** 0.186 SSEs / 10,000 adjusted patient days (2 SSEs / 107,755 adjusted patient days)
- **Gulf Coast:** 0.156 SSEs / 10,000 adjusted patient days (2 SSEs / 128,366 adjusted patient days)

**Governing Body:**

- System Quality & Safety Management Council
## Performance Measures
### Fourth Quarter Fiscal Year 2011 (Jul - Sep 2011)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>MEASURE</th>
<th>CURRENT QUARTER</th>
<th>PRIOR QUARTER</th>
<th>FISCAL YTD RATE</th>
<th>PREFERENCE</th>
<th>TARGET</th>
<th>CURRENT QUARTER PERFORMANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Outcomes</strong></td>
<td><strong>Acute Care</strong>&lt;br&gt;Overall Mortality Rate (excludes the HP Children’s Hospital pediatric &amp; newborn populations)</td>
<td>1.40%</td>
<td>1.32%</td>
<td>1.54%</td>
<td>Lower</td>
<td>1.53%</td>
<td>***</td>
</tr>
<tr>
<td></td>
<td><strong>Acute Care - Medicare Acute MI 30-Day Readmissions</strong></td>
<td>26.0%</td>
<td>20.0%</td>
<td>23.0%</td>
<td>Lower</td>
<td>19.9%</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td><strong>Acute Care - Medicare Congestive Heart Failure 30-Day Readmissions</strong></td>
<td>21.9%</td>
<td>25.7%</td>
<td>23.2%</td>
<td>Lower</td>
<td>24.7%</td>
<td>***</td>
</tr>
<tr>
<td></td>
<td><strong>Acute Care - Medicare Pneumonia 30-Day Readmissions</strong></td>
<td>20.1%</td>
<td>16.3%</td>
<td>16.0%</td>
<td>Lower</td>
<td>18.3%</td>
<td>*</td>
</tr>
</tbody>
</table>

**KEY:**
* Stars assigned on Current Quarter values
* *Worse than Expected*
** As Expected +/- 5% variance
*** Better than Expected
## Performance Measures
### Fourth Quarter Fiscal Year 2011 (Jul - Sep 2011)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>MEASURE</th>
<th>CURRENT QUARTER</th>
<th>PRIOR QUARTER</th>
<th>FISCAL YTD RATE</th>
<th>PREFERENCE</th>
<th>TARGET</th>
<th>CURRENT QUARTER PERFORMANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Outcomes</td>
<td>Acute Care &amp; Rehab - Severity II Medication Errors Per 10,000 Days (excludes the HP Children's Hospital pediatric &amp; newborn populations)</td>
<td>2.2</td>
<td>2.1</td>
<td>2.6</td>
<td>Lower</td>
<td>≤ 3 errors</td>
<td>***</td>
</tr>
<tr>
<td></td>
<td>Acute Care - Patient Falls Per 1,000 Days/ED Visits</td>
<td>2.30</td>
<td>1.99</td>
<td>2.10</td>
<td>Lower</td>
<td>3.50</td>
<td>***</td>
</tr>
<tr>
<td></td>
<td>Acute Care &amp; Rehab - Hospital Acquired Pressure Ulcers Stage II &amp; Above</td>
<td>0.83%</td>
<td>2.51%</td>
<td>2.10%</td>
<td>Lower</td>
<td>2.40%</td>
<td>***</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Acute Care - Elective Surgery Surgical Site Infections</td>
<td>PENDING</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- ICU Central Line Blood Stream Infections Per 1,000 Central Line Days</td>
<td>1.43</td>
<td>0.23</td>
<td>0.47</td>
<td>Lower</td>
<td>Long-Term ≤ 3 CLBSIs Short-Term 0 CLBSIs</td>
<td>***</td>
</tr>
<tr>
<td></td>
<td>- ICU Ventilator Associated Pneumonia Infections Per 1,000 Ventilator Days</td>
<td>0.00</td>
<td>0.00</td>
<td>0.08</td>
<td>Lower</td>
<td>≤ 3 VAPs</td>
<td>***</td>
</tr>
<tr>
<td></td>
<td>- ICU Urinary Tract Infections Per 1,000 Foley Catheter Days</td>
<td>1.14</td>
<td>1.37</td>
<td>1.58</td>
<td>Lower</td>
<td>≤ 4 UTIs</td>
<td>***</td>
</tr>
</tbody>
</table>

**KEY:** Stars assigned on Current Quarter values | * Worse than Expected | ** As Expected +/- 5% variance | *** Better than Expected
## Performance Measures
### Fourth Quarter Fiscal Year 2011 (Jul - Sep 2011)

<table>
<thead>
<tr>
<th>CATEGORY</th>
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<th>FISCAL YTD RATE</th>
<th>PREFERENCE</th>
<th>TARGET</th>
<th>CURRENT QUARTER PERFORMANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Efficiency</strong></td>
<td><strong>Acute Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Unadjusted Average Length of Stay (excludes the HP Children's Hospital pediatric &amp; NICU populations)</td>
<td>4.40 days</td>
<td>4.46 days</td>
<td>4.41 days</td>
<td>Lower</td>
<td>4.60 days</td>
<td>***</td>
</tr>
<tr>
<td></td>
<td><strong>Acute Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Medicare Unadjusted Average Length of Stay</td>
<td>5.20 days</td>
<td>5.05 days</td>
<td>5.06 days</td>
<td>Lower</td>
<td>≤ 5.45 days</td>
<td>***</td>
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<tr>
<td></td>
<td><strong>Acute Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>- System Delay Days Per 1,000 Acute Care Days (excludes the HP Children's Hospital pediatric &amp; newborn populations)</td>
<td>31</td>
<td>26</td>
<td>29</td>
<td>Lower</td>
<td>&lt; 30</td>
<td>**</td>
</tr>
<tr>
<td><strong>Timeliness</strong></td>
<td><strong>Emergency Department</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- &quot;Left Before Evaluated&quot; Incidents</td>
<td>1.3%</td>
<td>1.4%</td>
<td>1.7%</td>
<td>Lower</td>
<td>≤ 2%</td>
<td>***</td>
</tr>
<tr>
<td><strong>Patient Satisfaction</strong></td>
<td><strong>HCAHPS</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Overall Hospital Rating</td>
<td>64.5%</td>
<td>61.6%</td>
<td>61.5%</td>
<td>Higher</td>
<td>68.0%</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td><strong>HCAHPS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Likelihood To Recommend</td>
<td>70.5%</td>
<td>66.9%</td>
<td>68.0%</td>
<td>Higher</td>
<td>N/A</td>
<td>*</td>
</tr>
</tbody>
</table>

**KEY:** Stars assigned on Current Quarter values

* Worse than Expected
** As Expected +/- 5% variance
*** Better than Expected
WHAT WAS THE SYSTEM’S OVERALL MORTALITY RATE FOR ACUTE CARE?

LIMITS BASED ON 1ST 24 DATA PTS: UCL = 2.19, Mean = 1.63, LCL = 1.08 (1 - 24) (mR = 2)

UCL
Mean
Target
LCL

PERCENT THAT EXPIRED

12/13/2011 4:08:10 PM
WHAT PERCENT OF MEDICARE PATIENTS WITH AMI WERE READMITTED WITHIN 30 DAYS?

LIMITS BASED ON 1ST 24 DATA PTS: UCL = 44.61, Mean = 23.22, LCL = 1.84 (1 - 24) (mR = 2)
WHAT PERCENT OF MEDICARE PATIENTS WITH CHF WERE READMITTED WITHIN 30 DAYS?

LIMITS BASED ON 1ST 24 DATA PTS: UCL = 31.70, Mean = 23.37, LCL = 15.05 (1 - 24) (mR = 2)
WHAT PERCENT OF MEDICARE PATIENTS WITH PNEUMONIA WERE READMITTED WITHIN 30 DAYS?

LIMITS BASED ON 1ST 24 DATA Pts: UCL = 27.79, Mean = 16.28, LCL = 4.78 (1 - 24) (mR = 2)
WHAT WAS THE SYSTEM RATE OF SEVERITY II MED ERRORS FOR ACUTE CARE & REHAB?

LIMITS BASED ON 1ST 24 DATA PTS: UCL = 6.01, Mean = 2.73, LCL = -0.54 (not shown) (1 - 24) (mR = 2)
WHAT WAS THE SYSTEM RATE OF PATIENT FALLS FOR ACUTE CARE & ED?

LIMITS BASED ON 1ST 24 DATA PTS: UCL = 2.99, Mean = 2.26, LCL = 1.53 (1 - 24) (mR = 2)
Beginning March 2004, the Hospital Acquired Pressure Ulcers indicator includes data from Southwest Florida Regional Medical Center and Gulf Coast Hospital / Gulf Coast Medical Center.

Beginning June 2010, the Acute Care & Rehab Pressure Ulcer indicator includes only Stage II and greater pressure ulcers. Data prior to June 2010 is inclusive of all pressure ulcers.
WHAT WAS THE SYSTEM'S ICU CENTRAL LINE INFECTION RATE?

LIMITS BASED ON 1ST 24 DATA PTS: UCL = 3.65, Mean = 1.33, LCL = -1.00 (not shown) (1 - 24) (mR = 2)
WHAT WAS THE SYSTEM'S ICU URINARY TRACT INFECTION RATE?
LIMITS BASED ON 1ST 24 DATA PTS: UCL = 5.82, Mean = 2.65, LCL = -0.53 (not shown) (1 - 24) (mR = 2)
WHAT WAS THE SYSTEM'S UNADJUSTED AVERAGE LENGTH OF STAY FOR ACUTE CARE?

1ST LIMITS FROM 10/07 - 9/08: UCL = 4.47, Mean = 4.25, LCL = 4.02 (1 - 12) (mR = 2)

2ND LIMITS FROM 10/08 - 9/09: UCL = 4.54, Mean = 4.36, LCL = 4.19 (13 - 24) (mR = 2)

3RD LIMITS FROM 10/09 - 9/10: UCL = 4.56, Mean = 4.31, LCL = 4.06 (25 - 36) (mR = 2)
WHAT WAS THE SYSTEM’S MEDICARE UNADJUSTED AVERAGE LENGTH OF STAY FOR ACUTE CARE?

1ST LIMITS FROM 10/07 - 9/08: UCL = 5.37, Mean = 5.11, LCL = 4.85 (1 - 12) (mR = 2)

2ND LIMITS FROM 10/08 - 9/09: UCL = 5.62, Mean = 5.25, LCL = 4.89 (13 - 24) (mR = 2)

3RD LIMITS FROM 10/09 - 9/10: UCL = 5.42, Mean = 4.99, LCL = 4.56 (25 - 36) (mR = 2)
WHAT WERE THE NUMBER OF ACUTE CARE DELAY DAYS FOR THE SYSTEM?*

LIMITS BASED ON 1ST 24 DATA PTS: UCL = 58.16, Mean = 33.91, LCL = 9.65 (1 - 24) (mR = 2)
WHAT PERCENT OF SYSTEM EMERGENCY DEPARTMENT PATIENTS LEAVE BEFORE EVALUATED?

LIMITS BASED ON 1ST 24 DATA PTS: UCL = 3.79, Mean = 1.87, LCL = -0.05 (1 - 24) (Mr = 2)

PERCENT THAT LEAVE BEFORE EVALUATED

1/3/2012 5:28:30 PM
WHAT WAS THE SYSTEM AVERAGE LENGTH OF STAY FOR PATIENTS DISCHARGED FROM THE EMERGENCY DEPARTMENT?
WHAT % OF SYSTEM HCAHPS OVERALL
HOSPITAL RATING SCORES WERE "9" & "10"?

PERCENT "9" & "10" SCORES

Target
Data:

- **Indicator Description:** Measure of three LMH, HP*, & CCH Acute Care & Rehab medication error indicators based upon the incident’s outcome severity. Status of these indicators for 4th Quarter FY11:

  - **Acute Care & Rehab – Outcome Severity III Medication Errors**
    - Combined: 0.0 errors / 10,000 patient days (0 Severity III errors / 54,032 days)
    - CCH = 0.0 errors / 10,000 patient days (0 Severity III errors / 16,468 days)
    - HP* = 0.0 errors / 10,000 patient days (0 Severity III errors / 17,269 days)
    - LMH & Rehab = 0.0 errors / 10,000 patient days (0 Severity III errors / 20,295 days)

  - **Acute Care & Rehab – Outcome Severity II Medication Errors**
    - Combined: 2.6 errors / 10,000 patient days (14 Severity II errors / 54,032 days)
    - CCH = 1.8 errors / 10,000 patient days (3 Severity II errors / 16,468 days)
    - HP* = 2.3 errors / 10,000 patient days (4 Severity II errors / 17,269 days)
    - LMH & Rehab = 3.4 errors / 10,000 patient days (7 Severity II errors / 20,295 days)

  - **Acute Care & Rehab – Outcome Severity I Medication Errors**
    - Combined: 73.7 errors / 10,000 patient days (398 Severity I errors / 54,032 days)
    - CCH = 57.7 errors / 10,000 patient days (95 Severity I errors / 16,468 days)
    - HP* = 84.0 errors / 10,000 patient days (145 Severity I errors / 17,269 days)
    - LMH & Rehab = 77.9 errors / 10,000 patient days (158 Severity I errors / 20,295 days)

*The Acute Care & Rehab – Medication Errors indicator excludes the HP Children’s Hospital pediatric & newborn populations as defined by Risk Management & Pharmacy

- **Formula:** \( \left( \frac{\text{total Acute Care & Rehab medication errors by incident severity}}{\text{total Acute Care & Rehab patient days}} \right) \times 10,000 \)

- **Goals:**
  - Severity III Outcome = 0 errors / 10,000 patient days (internal goal)
  - Severity II Outcome = ≤ 3 errors / 10,000 patient days (internal goal)
  - Severity I Outcome = No goal established

- **Why track:** Potential patient complications and safety issues may result from medication errors. Federal safety regulation requirement

**Governing Body:**

- System Quality & Safety Management Council and ADE Task Force
MEDICATION ERROR DEFINITIONS

**Outcome**

- A. Potential
- B. Avoided Error
- C. No Harm
- D. Monitoring
- E. Treatment
- F. Increased LOS
- G. Permanent Harm
- H. Near Death
- I. Fatal Error

**Severity**

- I
- II
- III
Data:

- Indicator Description: Measure of three Gulf Coast Medical Center medication error indicators based upon the incident’s outcome severity. Status of these indicators for 4th Quarter FY11:
  - Acute Care – Outcome Severity III Medication Errors
    GCMC = 0.0 errors / 10,000 patient days (0 Severity III errors / 25,017 days)
  - Acute Care – Outcome Severity II Medication Errors
    GCMC = 1.2 errors / 10,000 patient days (3 Severity II errors / 25,017 days)
  - Acute Care – Outcome Severity I Medication Errors
    GCMC = 92.3 errors / 10,000 patient days (231 Severity I errors / 25,017 days)

- Formula: ([total Acute Care medication errors by incident severity / total Acute Care patient days] * 10,000 days)

- Goals:
  - Severity III Outcome = 0 errors / 10,000 patient days (internal goal)
  - Severity II Outcome = ≤ 3 errors / 10,000 patient days (internal goal)
  - Severity I Outcome = No goal established

- Why track: Potential patient complications and safety issues may result from medication errors. Federal safety regulation requirement

Governing Body:

- System Quality & Safety Management Council and ADE Task Force
MEDICATION ERROR DEFINITIONS

**Outcome**

<table>
<thead>
<tr>
<th>A. Potential</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Avoided Error</td>
<td>II</td>
</tr>
<tr>
<td>C. No Harm</td>
<td></td>
</tr>
<tr>
<td>D. Monitoring</td>
<td></td>
</tr>
<tr>
<td>E. Treatment</td>
<td></td>
</tr>
<tr>
<td>F. Increased LOS</td>
<td></td>
</tr>
<tr>
<td>G. Permanent Harm</td>
<td>III</td>
</tr>
<tr>
<td>H. Near Death</td>
<td></td>
</tr>
<tr>
<td>I. Fatal Error</td>
<td></td>
</tr>
</tbody>
</table>

**Severity**

- I: Potential
- II: Avoided Error
- III: No Harm
- IV: Monitoring
- V: Treatment
- VI: Increased LOS
- VII: Permanent Harm
- VIII: Near Death
- IX: Fatal Error

---

**SWFRMC & GCH data combined through Jan-09 with GCMC data collection initiated Feb. 18, 2009.**

---

**WHAT WERE THE NUMBER OF SEVERITY III MEDICATION ERRORS AT GCMC?**

**LIMITS BASED ON 1ST 24 DATA PTS: UCL = 9.31, Mean = 2.85, LCL = -3.61 (1 - 24) (sd = 2)**

---

**WHAT WERE THE NUMBER OF SEVERITY II MEDICATION ERRORS AT GCMC?**

**LIMITS BASED ON 1ST 24 DATA PTS: UCL = 0.00, Mean = 0.00, LCL = 0.00 (1 - 24) (sd = 2)**
DATE: 2/1/2012

LEGAL REVIEW: Yes ___ No _X_

SUBJECT: 4th Quarter FY 2011 (Jul – Sep 2011) HP Children’s Hospital Organizational Performance Measure Indicators

REQUESTOR & TITLE: Dr. Krivenko, Chief Medical Officer/Clinical & Quality Services
Dr. Salman, Pediatric Hematology/Oncology

PREVIOUS BOARD ACTION ON THIS ITEM (IF ANY)
(justification and/or background for recommendations – internal groups which support the recommendation i.e. SLC, Operating Councils, PMTs, etc.)

The System Quality Safety and Management Council reviewed and approved the indicators within the HP Children’s Hospital Organizational Performance Measure presentation on January 11, 2012.

SPECIFIC PROPOSED MOTION:
Accept the HP Children’s Hospital Organizational Performance Measure Indicators: 4th Quarter Fiscal Year 2011 (Jul – Sep 2011).

PROS TO RECOMMENDATION
N/A

CONS TO RECOMMENDATION
N/A

LIST AND EXPLAIN ALTERNATIVES CONSIDERED
N/A

FINANCIAL IMPLICATIONS
Budgeted ____ Non-Budgeted ____
(including cash flow statement, projected cash flow, balance sheet and income statement)

N/A

OPERATIONAL IMPLICATIONS
(including FTEs, facility needs, etc.)

N/A

SUMMARY

The disclosure of this report and the contents herein does not constitute a waiver of any and all protections afforded Patient Safety Work Product under the Patient Safety Quality Improvement Act of 2005 and implementing regulations.
HP Children’s Hospital
BOD Performance Measure Indicators

4th Quarter FY 2011
July - September 2011
Clinical Decision Support
## HP Children’s Hospital Performance Measures
Fourth Quarter Fiscal Year 2011 (Jul - Sep 2011)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>MEASURE</th>
<th>CURRENT QUARTER</th>
<th>PRIOR QUARTER</th>
<th>FISCAL YTD RATE</th>
<th>PREFERENCE</th>
<th>TARGET</th>
<th>CURRENT QUARTER PERFORMANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Outcomes</td>
<td><strong>HP Children's Hospital Acute Care - Newborn Overall Mortality Rate (including NICU)</strong></td>
<td>0.73%</td>
<td>1.17%</td>
<td>0.63%</td>
<td>Lower</td>
<td>3.62%</td>
<td>***</td>
</tr>
<tr>
<td></td>
<td><strong>HP Children's Hospital Acute Care - Pediatric Overall Mortality Rate</strong></td>
<td>0.11%</td>
<td>0.10%</td>
<td>0.12%</td>
<td>Lower</td>
<td>0.53%</td>
<td>***</td>
</tr>
<tr>
<td>Safety Outcomes</td>
<td><strong>HP Children's Hospital - Severity II Medication Errors Per 10,000 Days</strong></td>
<td>0.0</td>
<td>0.0</td>
<td>0.3</td>
<td>Lower</td>
<td>≤ 3 errors</td>
<td>***</td>
</tr>
<tr>
<td>Efficiency</td>
<td><strong>HP Children's Hospital NICU Acute Care - Unadjusted Average Length of Stay</strong></td>
<td>22.04 days</td>
<td>17.86 days</td>
<td>21.96 days</td>
<td>Lower</td>
<td>25.7 days</td>
<td>***</td>
</tr>
<tr>
<td></td>
<td><strong>HP Children's Hospital Pediatric Acute Care - Unadjusted Average Length of Stay (excluding normal newborns)</strong></td>
<td>3.32 days</td>
<td>3.57 days</td>
<td>3.46 days</td>
<td>Lower</td>
<td>4.7 days</td>
<td>***</td>
</tr>
</tbody>
</table>

**KEY:** Stars assigned on Current Quarter values  
* Worse than Expected  
** As Expected +/- 5% variance  
*** Better than Expected
### HP Children’s Hospital Performance Measures
Fourth Quarter Fiscal Year 2011 (Jul - Sep 2011)

**ORGANIZATIONAL**

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>MEASURE</th>
<th>CURRENT QUARTER</th>
<th>PRIOR QUARTER</th>
<th>FISCAL YTD RATE</th>
<th>PREFERENCE</th>
<th>TARGET</th>
<th>CURRENT QUARTER PERFORMANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>HP Children’s Hospital Acute Care - Elective Surgery</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td><strong>Surgical Site Infections</strong></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td><strong>HP PICU - Central Line Blood Stream Infections Per 1,000 Central Line Days</strong> (Rolling 12 Month Rate)</td>
<td>0.0</td>
<td>1.3</td>
<td>0.0</td>
<td>Lower</td>
<td>≤ 2.2 CLBSIs</td>
<td>***</td>
</tr>
<tr>
<td></td>
<td><strong>HP PICU - Central Line Blood Stream Infections Per 1,000 Central Line Days</strong> (Rolling 12 Month Rate)</td>
<td>2.4</td>
<td>3.1</td>
<td>2.4</td>
<td>Lower</td>
<td>≤ 2.1 CLBSIs</td>
<td>*</td>
</tr>
<tr>
<td></td>
<td><strong>HP PICU - Ventilator Associated Pneumonia Infections Per 1,000 Ventilator Days</strong> (Rolling 12 Month Rate)</td>
<td>0.0</td>
<td>1.7</td>
<td>0.0</td>
<td>Lower</td>
<td>≤ 1.1 VAPs</td>
<td>***</td>
</tr>
<tr>
<td></td>
<td><strong>HP NICU - Ventilator Associated Pneumonia Infections Per 1,000 Ventilator Days</strong> (Rolling 12 Month Rate)</td>
<td>0.7</td>
<td>1.4</td>
<td>0.7</td>
<td>Lower</td>
<td>≤ 1.2 VAPs</td>
<td>***</td>
</tr>
<tr>
<td></td>
<td><strong>HP PICU - Urinary Tract Infections Per 1,000 Foley Catheter Days</strong></td>
<td>0.0</td>
<td>0.0</td>
<td>3.6</td>
<td>Lower</td>
<td>≤ 4.2 UTIs</td>
<td>*</td>
</tr>
</tbody>
</table>

**KEY:** Stars assigned on Current Quarter values
* Worse than Expected
** As Expected +/- 5% variance
*** Better than Expected
WHAT WAS THE HP CHILDREN'S HOSPITAL'S NEWBORN* OVERALL MORTALITY PERCENTAGE FOR ACUTE CARE?

LIMITS BASED ON 1ST 24 DATA PTS: UCL = 2.03, Mean = 0.61, LCL = -0.82 (not shown) (1 - 24) (mR = 2)

PERCENT THAT EXPIRED

Target

UCL

Mean

12/6/2011 1:18:42 PM
WHAT WAS THE HP CHILDREN'S HOSPITAL'S PEDIATRIC* OVERALL MORTALITY PERCENTAGE FOR ACUTE CARE?

LIMITS BASED ON 1ST 24 DATA PTS: UCL = 0.99, Mean = 0.22, LCL = -0.56 (not shown) (1 - 24) (mR = 2)
WHAT WERE THE NUMBER OF NEWBORN & PEDIATRIC SEVERITY II MED ERRORS AT HP THE CHILDREN'S HOSPITAL?

LIMITS BASED ON 1ST 24 DATA PTS: UCL = 10.96, Mean = 2.42, LCL = -6.12 (not shown) (1 - 24) (mR = 2)
WHAT WAS THE CHILDREN'S HOSPITAL'S NICU* UNADJUSTED AVERAGE LENGTH OF STAY FOR ACUTE CARE?

1ST LIMITS FROM 10/07 - 9/08: UCL = 47.39, Mean = 27.17, LCL = 6.95 (1 - 12) (mR = 2)

2ND LIMITS FROM 10/08 - 9/09: UCL = 43.07, Mean = 25.25, LCL = 7.44 (13 - 24) (mR = 2)

3RD LIMITS FROM 10/09 - 9/10: UCL = 35.63, Mean = 23.54, LCL = 11.45 (25 - 36) (mR = 2)
WHAT WAS THE CHILDREN'S HOSPITAL'S PEDIATRIC UNADJUSTED AVERAGE LENGTH OF STAY FOR ACUTE CARE?

1ST LIMITS FROM 10/07 - 9/08: UCL = 4.00, Mean = 3.54, LCL = 3.09 (1 - 12) (mR = 2)
2ND LIMITS FROM 10/08 - 9/09: UCL = 4.69, Mean = 3.84, LCL = 2.99 (13 - 24) (mR = 2)
3RD LIMITS FROM 10/09 - 9/10: UCL = 4.74, Mean = 3.51, LCL = 2.28 (25 - 36) (mR = 2)
HOW MANY HP PICU PATIENTS ACQUIRED CENTRAL LINE INFECTION?

[Graph showing number of central line infections per month from Oct-09 to Sep-11.]

- Oct-09: 0
- Nov-09: 0
- Dec-09: 0
- Jan-10: 0
- Feb-10: 0
- Mar-10: 0
- Apr-10: 1
- May-10: 1
- Jun-10: 0
- Jul-10: 1
- Aug-10: 0
- Sep-10: 0
- Oct-10: 0
- Nov-10: 0
- Dec-10: 0
- Jan-11: 0
- Feb-11: 0
- Mar-11: 0
- Apr-11: 0
- May-11: 0
- Jun-11: 0
- Jul-11: 0
- Aug-11: 0
- Sep-11: 0

Total: 5 central line infections
HOW MANY HP NICU PATIENTS ACQUIRED CENTRAL LINE INFECTION?
How many HP PICU patients acquired ventilator-associated pneumonia?
HOW MANY HP NICU PATIENTS ACQUIRED
VENTILATOR ASSOCIATED PNEUMONIA?

VAP INFECTION CASES

HOW MANY HP PICU FOLEY CATHETER PATIENTS ACQUIRED URINARY TRACT INFECTION?
ADJOURNMENT
QUALITY & EDUCATION PORTION

LEE MEMORIAL HEALTH SYSTEM
BOARD OF DIRECTORS

DATE OF THE NEXT REGULARLY SCHEDULED MEETING

Quality & Education FULL BOARD MEETING

Thursday, April 12, 2012
3:00pm

Lee Memorial Hospital - Boardroom
2776 Cleveland Ave, Ft. Myers, FL 33901
Lee Memorial Health System
BOARD OF DIRECTORS
MEETING
Thursday, February 9, 2012

BOARD CHAIRMAN:
Richard Akin
PLC Chairman Report to the Board 2/9/2012

Recent Meetings

TCH MEC – 1/17  GCMC MEC – 1/9
HPMC MEC – 1/10  LMH MEC – 1/11
CCH MEC – 1/12

❖ Multiple Campus MEC Common Themes and Issues

❖ STEMI Call--The Emergency Room Medical Directors have met with the cardiologists to discuss this call system, and what process is used for patients who may need intervention but do not meet STEMI criteria. The Cardiology section is addressing this problem System wide.

❖ The CME and Medical Library assessment was reviewed at all sites. Many feel they do not know how to utilize all the resources the Library has to offer. The Library Staff will be asked to make presentations to the FMECs.

❖ At The Children's Hospital a new CAO started January 30th.

❖ At the Healthpark a physicians concern hotline is going to be set up modeled after the one at GCMC.

❖ At Cape Coral there was discussion concerning the Centers of Excellence model and how it may be affecting where EMS takes patients.

Thank you for your attention.

Tom Presbrey, M.D.
PLC Chairman
DATE:  Feb 9, 2012

NAME OF SERVICE:  LMHS Employee Health Plan and Wellness Initiatives

PERSON(s) RESPONSIBLE & TITLE:

Alison Thurau, System Director Human Resources,
Salvatore Lacagnina D.O. VP Health and Wellness
and Jon Cecil, Chief Human Resource Officer

PREVIOUS BOARD ACTION ON THIS ITEM (IF ANY)

Each year in early summer as part of the LMHS fiscal year budget process the Board approves the compensation and benefits programs. One of the benefit programs that is approved is the LMHS Employee Health Plan. For fiscal years 2011 & 2012, a continued focus on employee and family health and wellness was designed into the Plan.

SUMMARY/COMMENTS

The LMHS Employee Health Plan came in under budget for FY 2011 due to many efforts through plan management, pharmaceutical management, and health and wellness initiatives. This update will detail the plan outcomes including data mining, claims management, claims outreach, chronic disease management and health and wellness programs.
Lee Memorial Health Plan
Focus on Wellness
Board Presentation - 2012

Health Plan Model
Health Plan Model

Demographic Information

• Average Age: 46
• Average percentage of female employees: 80%
• Percentage of employees electing dependent coverage: 60%
• Percentage of employees waiving coverage: 15%
Benefits for You and Your Family
to focus on Wellness

- Eligibility
- Medical Insurance
- Dental Insurance
- Vision Insurance
- Disability Insurance
- Life & Accident Insurance
- Retirement Plans
- Flexible Spending Accounts
- Employee Assistance Program
- Wellness
- Paid Time Off
- Additional Benefits
- Primary Care Physician Referral
- Important Contacts

• Health Plan - $70 million
• Dental
• Vision
• Disability
• Life & AD&D
• 401(b), 457(b), Roth
• Flex Spending Accounts
• Paid Time Off
• Optionals
Health Plan Operations Model

Wellness Programs
- Employee Health Clinics
- Wellness Coaches
- Lee Health Solutions
- Wellness Fitness Centers
- RT Asthma Program

Benefits

Mail Order Pharmacy
- 340(b) Pricing
- Retails to Open in 2012 on site at LMHS

Health Plan Committee
**Message:** Our goal is to optimize the health, wellness and productivity of LMHS employees and their families while managing future benefit plan costs for LMHS and its employees, offering competitive benefits and maintaining employee satisfaction and retention.

**Critical Success Factors:**

- Optimize health
- Satisfy and Retain Employees
- Manage our budget
Health Plan Strategy

Step I - Success Factors:

• Use of one provider - LMHS saves costs. Labs, X-rays, MRI, CAT Scans only at LMHS – Today 98% utilization LMHS.

• Focus on Employee Engagement – Encourage employees to optimize their health.

  • Designed Health Bucks - $150 on VISA upon completion of a well defined wellness exam with lab work. Labs to be completed first.

  • Educated Employees on LMHS Wellness Programs - $150 for LMHS Wellness Programs.

Results: 1500 employees (20%) out of 7500 participated
Need to focus on preventing the 85% of healthy individuals who represent 15% of the cost from becoming unhealthy through a progressive Plan Design with strong wellness components.

ROI – 2-3 years – Savings projected $3- $4 million
On behalf of Lee Memorial Health System, congratulations on taking this crucial first step in building a healthier future. As an employee enrolled in the LMHS Health Plan, you have taken your first step to wellness. One of the benefits included in the LMHS Health Plan this year is a wellness exam with no copay. Inside the front cover of your Benefits Enrollment Booklet you will find a description of your wellness exam and a lab slip to get your Lab work completed at a LMHS Lab.

As you begin your journey to better health, the following are the steps towards a healthier future:

Step one: is to get the Lab work completed.
Step two: is to make an appointment with your physician in our network for your wellness exam.
Step three: is to have a detailed conversation with your physician regarding your Lab work and wellness exam results.

Please note: If you prefer, as a courtesy to your physician, you can call 1-239-573-4508 and make an appointment to have your wellness exam with Sal Lacagnina, D.D., our LMHS VP of Health and Wellness. Results will be sent to your physician and continuing care will be with your physician.

In addition, as a fourth step in your journey to better health, you will receive mailed confidentially to your home a Wellness Report with the results of your wellness exam to keep for your records and to use to create a Wellness Action Plan.

Once you have your exam, you can make an appointment with one of our LMHS Wellness Coaches to develop your Wellness Action Plan. To make an appointment with a Wellness Coach, just call 1-239-573-4508. In addition, we have an on-site EAP counselor who can work in conjunction with your Wellness Coach on behavior changes to support your Wellness Action Plan. Use the same telephone number to make an appointment with an EAP counselor.

What are Healthy Bucks and How Do I Qualify?
Healthy Bucks are $150 that are loaded on a VISA card for you to use for LMHS wellness programs that have been designated as Healthy Bucks eligible programs. You qualify to receive this VISA card when you (the employee) complete your wellness exam between January 1, 2011, and December 31, 2011. After the LMHS Benefits group is notified that the exam is completed, the VISA card will be mailed to your home address. The $150 can be used for you or your family members as long as they are for LMHS designated Healthy Bucks programs.
Health Plan Strategy

Step II: Success Factors

Increase participation and focus through data mining and plan design.

- Installed Verisk Data Mining Tool – Loaded and analyzed two years of data.

- Plan Design:
  - To maintain same premiums for 2012 as 2011 employee wellness exam with no co-pay must be completed by 12/31/2011.
  - Healthy Choice Premiums – 20% lower than Tobacco Users and those without wellness exams.

Results: Today (97%) all but 200 covered employees have completed a wellness exam.
Verisk Health
Sightlines™ Medical Intelligence
Clinical Analysis
Lee Memorial Health System
## Disease – Top Findings

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence Per 1000</th>
<th>VH Norm</th>
<th>PMPY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>214</td>
<td>70</td>
<td>$10,673</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$8,593</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>197</td>
<td>92</td>
<td>$8,223</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$7,153</td>
</tr>
<tr>
<td>Diabetes</td>
<td>116</td>
<td>52</td>
<td>$14,018</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$11,187</td>
</tr>
<tr>
<td>Asthma</td>
<td>60</td>
<td>21</td>
<td>$9,250</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$7,642</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>75</td>
<td>27</td>
<td>$17,501</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>20,475</td>
</tr>
<tr>
<td>Depression</td>
<td>31</td>
<td>7</td>
<td>$11,499</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$11,256</td>
</tr>
</tbody>
</table>
Plan Design - Action Taken: Added LMHS Asthma Program at no charge and moved Asthma and Pulmonary Specialists to lower co-pay
Depression

Added an onsite Personal and Family Counselor.

- Part of our Employee Assistance Program
- Located at CCH but can travel to other facilities
- Assist employees and families who are suffering from stress and depression.
Tool Influenced Plan Design

Awareness Campaign Around Top Six Disease Groups and Added Claims Outreach

Memo to Leaders – Information in HYH - Tables Outside Cafes’ - Educational Material

• Presentations in Department/Unit

• TPA Outreach Calls to Individuals with Greatest Care Gaps – focus education

• Wellness Coaches through WEBTPA will be provided with lists and able to make follow up appointments
Primary Diagnosis Cancer

Prevalence: Breast – Colorectal- Lung- Urinary Tract – Prostate Cancer
Plan Design Case Outreach

Potential Cancer Screenings – Postcards Mailed – Referral to Wellness Coaches

- Mammo: 522
- Colonoscopy: 2677
- Pap: 3073
- PSA: 1175
LMHS health plan cost per employee for the most recent three fiscal years. According to Mercer $9723 PEPY Gross is average for Hospitals with PPO plans.
### LMHS Historic NET Medical Program Cost Summary

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
<th>Estimated 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>LMHS Total Annual NET Medical Program Cost</td>
<td>$55,040,884</td>
<td>$56,434,705</td>
<td>$62,116,411</td>
</tr>
<tr>
<td>Annual Differential</td>
<td>$2,379,156</td>
<td>$1,393,821</td>
<td>$5,681,706</td>
</tr>
<tr>
<td>Percentage Differential</td>
<td>4.5%</td>
<td>2.5%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Average Number of Members Enrolled</td>
<td>13,705</td>
<td>14,125</td>
<td>15,646</td>
</tr>
<tr>
<td>Average Annual NET Medical Plan Cost/Member</td>
<td>$4,016</td>
<td>$3,995</td>
<td>$3,970</td>
</tr>
<tr>
<td>Percentage Differential</td>
<td>4.6%</td>
<td>-0.5%</td>
<td>-0.6%</td>
</tr>
</tbody>
</table>

**Mercer Survey Hospital Medical PPO Trends (500+EE's)**

- 2009: 4.8%
- 2010: 5.9%
- Estimated 2011: 3.6%

**Mercer Survey Large Employer Medical PPO Trends (500+EE's)**

- 2009: 6.0%
- 2010: 8.4%
- Estimated 2011: 3.6%
What is Included in our Total Costs?

- Admin Fee TPA
- UR, Large Case Management
- Verisk Health Data Mining & Physician Profiler
- Mercer Actuarial Study and Reporting
- Reinsurance Contract
- Medical Claims
- RX Retail
- RX LMHS Mail Order Pharmacy
- Diabetic, Pre-Diabetic & Weight Loss Programs
- Smoking Cessation & Asthma Programs
## Mercer National Survey Results PPO Plan Design

<table>
<thead>
<tr>
<th></th>
<th>Mercer Survey Results</th>
<th>2010 LMHS</th>
<th>Hospitals 500+</th>
<th>Health Services 500+</th>
<th>National 500+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Visits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median Physician Visit Copay</td>
<td>$25</td>
<td>$20</td>
<td>$20</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>Median Specialist Visit Copay</td>
<td>$60</td>
<td>$35</td>
<td>$35</td>
<td>$35</td>
<td>$35</td>
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<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single / Family</td>
<td>$350 / $1,050</td>
<td>$350 / $850</td>
<td>$500 / $1,000</td>
<td>$400 / $1,000</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Deductible</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median Hospital Stay Deductible</td>
<td>$100/day to $500</td>
<td>$250</td>
<td>$250</td>
<td>$250</td>
<td>$250</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Median Coinsurance</td>
<td>10%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Out-of-Pocket</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median Individual Out-of-Pocket (includes deductible)</td>
<td>$2,850</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
<td></td>
</tr>
</tbody>
</table>

**Co-insurance is below market at 10% compared with 20% - however to increase this would increase bad debt. Bad Debt and charity care was over $1 million dollars.**
Critical Success Factors 2013:

Two Plan Designs to prepare for Exchanges.

- Recommendation will be presented when finalized.
Health & Wellness Team

- Lee Health Solutions
- Wellness Center of Cape Coral & Lee Center for Rehab and Wellness
- Employee Health/Nurse Practitioner Clinic
- Wellness Coaches
- Employees and Dependents
Health & Wellness Coaching

Its not just counseling!
Health/Wellness Coach

• Using “Motivational Interviewing” techniques the Coach guides the individual to discover his/her own personal ambivalence to healthy behaviors.

• Example: husband dies unexpectedly and wife loses all motivation to stay healthy.
• Engages the individual in order to activate the person’s own internal motivation to change.

• Example: the overweight person who decided she wanted to horse back ride again.
Traditional Patient Teaching

• Provides educational material intended to make the individual knowledgeable about their specific health problems.

• The health care provider tells the individual what they need to do to become and stay healthy but unless the person internalizes this behaviors do not change.
Address the Ambivalence

The Health Coach approach involves the following:

- Active listening
- Working from the patient’s agenda
- Identifying the patient’s beliefs and values
- Eliciting change talk
- Recognizing the patient’s readiness to change and capitalizing on this
The medically educated health coach is able to identify health risk factors:

- Review medical problems and identify care gaps
- To develop action plans to decrease risk factors and close the gaps
- To develop action plans for healthy eating, regular physical activity, stress management, etc.
The health coach tracks success metrics for the individuals and holds them accountable to the action plans and goals that are jointly developed and agreed upon.

The coach is also a liaison with others on the health care team.

And becomes a trusted health care advocate for the individual.
• DP – Came to me for weight loss but was so stressed about situation at home there was no way to focus on that. We came up with some strategies to begin to work on that gave her focus and hope. Recommended EAP but preferred to work with me on concrete goals that made her life easier. Is now exercising on regular basis and has begun to lose weight.

• KO. Came to me for weight loss. It had been one year since her husband died. Was still struggling with this but didn’t want to go to EAP – wanted concrete goals to work on. Has changed her attitude towards food, is now exercising and is losing weight even while in another state helping her daughter who is going through chemo for lung CA; the same cancer that took her husband.

• RA – went from 205 to 165 pounds; BMI is now normal and is exercising at Fitness on the Move regularly. Has changed the way he is eating and has now become that example that he wanted to be for his church. His goal is to help others accomplish this.

• TH and MH. Came to me as a couple to work on weight loss. He has lost over 20 pounds and she has lost over 15. They are eating so much healthier and are both exercising regularly which is quite an accomplishment for her with the health problems she has.
• The results from the biometrics are clear. Well over 50% of the employed population of the LMHS have BMI's that are abnormal and over 30% are obese and we have many employees that are morbidly obese by definition.

• Morbid obesity = BMI > 40.

• Dealing with obesity is a sensitive issue but one that needs to be addressed.

• Being overweight is associated with all the major chronic illnesses including diabetes, hypertension, elevated cholesterol, depression, etc; and studies show that the longer a person is overweight the shorter the life span.

• We need to involve physicians and focus on this issue through our wellness initiatives.
Physician Collaboration

LMHS Wellness Program
Employees by BMI Range

From 1/1/2011 to 12/1/2011, 5002 Employees Participated
Diabetes – Physician Collaboration and Referral to Wellness Coaches

- Diabetes
- Type II - no comp.
- Type II with comp
- Type I
Physician Collaboration

- Engagement of LPG, LCC and community physicians
- Physicians and Health Care Providers need to provide a clear message regarding the importance of preventive medicine and need to be part of the Health and Wellness team.
- Preferred providers should be identified by using tools such as the Verisk Physician profiler.
- All team members will rally around a common goal of improving the continuum of care so as to
- Improve clinical outcomes and help individuals become and stay healthy.
Physician Collaboration: Coding and Billing

• Physicians and Health Care providers play a vital role in the collection of accurate data.

• If the claim is not coded properly we cannot track and trend chronic illnesses accurately.

• Bad data in means bad reports out.

• Plans are to meet with LPG, LCC and community physicians to work on improving the accuracy of the diagnostic codes.
Community Involvement

- Many community businesses are now involved in the LMHS Employee Health Clinics.
- City of Cape Coral and the City of Fort Myers
- We are in discussion with the School Board.
Wellness Activities

- “Walk with the Leaders”, the “Hump Day Hustle” and “A Walk in the Park”

- On site exercise programs – Zumba & Yoga

- “Healthy Me, Healthy Lee Fitness Challenge”

- On site Wellness Champions

- Wellness Centers
OLD BUSINESS
NEW BUSINESS

Motion to Approve appointment of Donald Brown (Board Member) as Assistant Board Secretary (Approval)
BOARD OF DIRECTORS’ REPORTS
DATE OF THE NEXT REGULARLY SCHEDULED MEETING:
GOVERNANCE & FULL BOARD MEETING

ALSO CONVENING AS: CAPE CORAL HOSPITAL BOARD OF DIRECTORS (PROVIDER #10-0244); LEE MEMORIAL HOSPITAL BOARD OF DIRECTORS (PROVIDER #10-0012); GULF COAST MEDICAL CENTER BOARD OF DIRECTORS (PROVIDER #10-0220)

Thursday, February 23, 2012
3:00pm

Lee Memorial Hospital Boardroom
2776 Cleveland Ave, Ft. Myers, FL 33901