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The Source

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ON THE COVER: Valerie Norton, M.D., and J. Michael Worsey, M.D.

Photography by Ian Cummings

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Sharing a Patients-first Mission

My thoughts continue to be with the thousands of lives impacted by the Las Vegas shooting and the devastation here and abroad brought on by the recent hurricanes, storms and earthquakes. Those affected by the latter, along with thousands of volunteers, are working tirelessly to rebuild homes, schools, businesses and the vast infrastructure of their communities. While worldwide events and media attention at times feel doomed to favor what divides us, I'd like to reflect on the virtuous efforts that do exist—and that are evidenced even more profoundly in times of crisis.

HealthTrust is most grateful and proud of the commitment of our supplier and distributor communities. They, along with many members of the HealthTrust team, sprang into readiness and response mode—available to assist members 24/7 over the course of two-plus weeks in September—before, during and after Hurricanes Harvey and Irma. I also want to acknowledge the work ethic of employees in countless other member facilities in the path of these events whose clinicians, administrators and supply chain managers put patients before their own hardships and kept their facilities operational and ready to care for patients.

Cyber Risk Management

Malware, ransomware, wannacry … today's cyber attackers are no longer satisfied with simply "looking around" a victim's digital property—instead, these sophisticated hackers have found ways to tap into PHI and settings on medical devices and impact entire network structures within seconds or minutes. Scan the headlines and daily we read of yet another institution, healthcare or otherwise, that has fallen prey.

"As hackers increasingly take advantage of historically lax security on embedded devices," Wired.com says, "defending medical instruments has taken on new urgency on two fronts. There's a need to protect patients, so that attackers can't hack an insulin pump to administer a fatal dose. And, vulnerable medical devices also connect to a huge array of sensors and monitors, making them potential entry points to larger hospital networks."

"I WANT TO ACKNOWLEDGE THE WORK ETHIC OF EMPLOYEES IN COUNTLESS OTHER MEMBER FACILITIES IN THE PATH OF THESE EVENTS WHOSE CLINICIANS, ADMINISTRATORS AND SUPPLY CHAIN MANAGERS PUT PATIENTS BEFORE THEIR OWN HARDSHIPS AND KEPT THEIR FACILITIES OPERATIONAL AND READY TO CARE FOR PATIENTS."

To help prevent or, in a worst-case scenario, remediate impacts from medical device attacks, HealthTrust convened representatives of its supplier community and hospital membership to hear from industry experts and one another. More than 400 attendees took part in this GPO industry-first meeting over the course of 1.5 days, that featured experts from the Food and Drug Administration, the MDISS (Medical Device, Innovation, Safety and Security Consortium), and NH-ISAC (National Health Information Sharing & Analysis Center).

The goal of the summit was to reach a consensus agreement surrounding solution methods for risk management and recovery, including the impact on the future of product development and product lifecycle, how to report security vulnerabilities, timelines for implementing short- or long-term fixes, the roles and responsibilities of suppliers and health department officials, and any obstacles that could prevent execution. Summit discussions will be analyzed, resulting in new requirements for HealthTrust's RFP process and vendor scoring, and the addition of risk and remediation contract language for any

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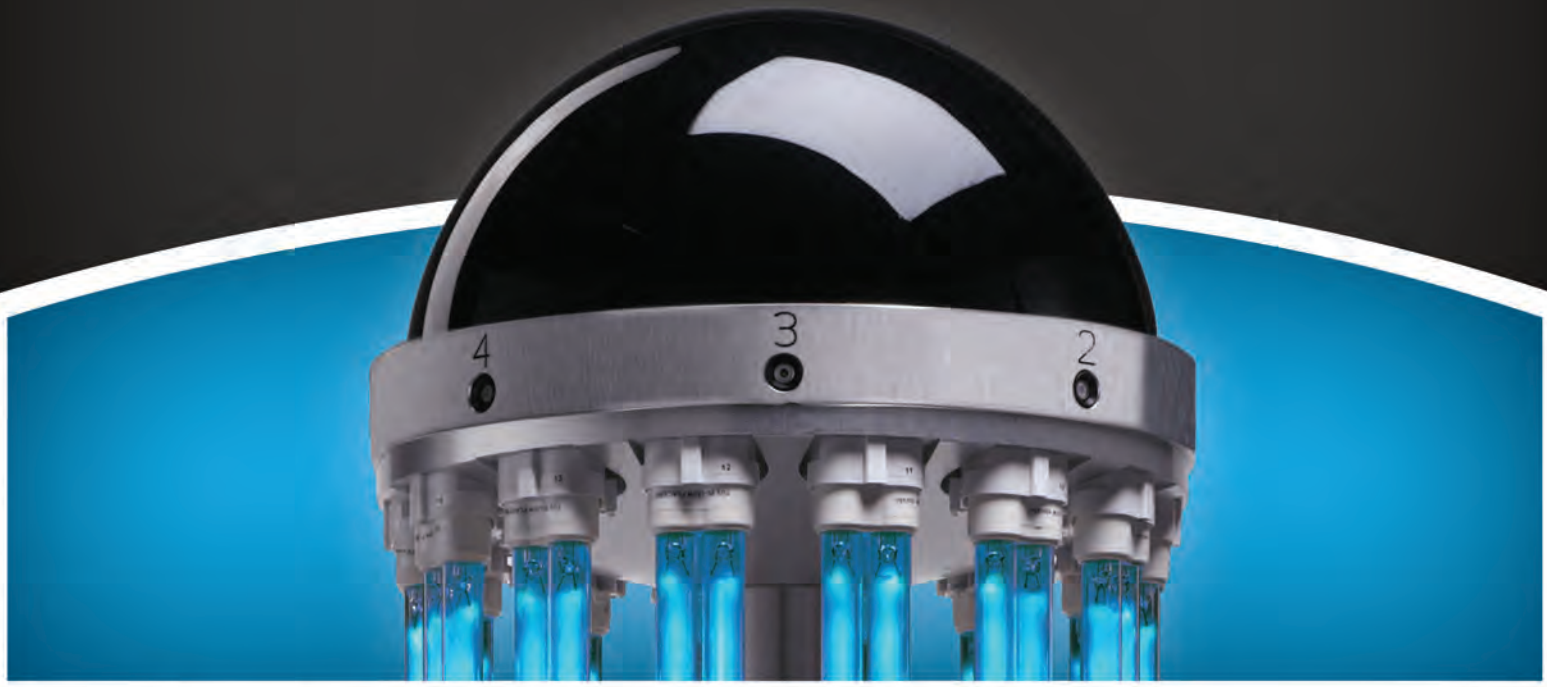

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Why Healthcare Needs a Course Correction

Hurricanes Harvey, Irma and Maria have understandably dominated headlines in recent weeks, and exhausted the resources and stamina of healthcare facilities in the path of their destruction. Based on meteorological norms, the trio of storms were calamitous in size and impact—including over 100 deaths. Recovery efforts will be going on for months, if not years.

Sadly, when measured by the number of lives lost, the human toll of hurricanes pales in comparison to the current opioid crisis. At least four times as many people die each year from an overdose than perished in the Great Galveston Hurricane of 1900, the worst on record with 8,000 deaths. Rates of chronic use and mortality have grown increasingly grim since the Centers for Disease Control and Prevention first declared opioid abuse an epidemic in 2012.

Few physicians are signing up to treat opioid dependence, and there is little evidence to guide clinicians in the process of opioid tapering to reduce abuse potential. Discontinuing opioids abruptly, including medications used to treat dependence, can cause withdrawal symptoms that addicts will go to extraordinary means to avoid. For some addicts in storm-ravaged Houston, this included successive days of walking to and from a detox center surrounded by water—a 10-mile round trip.

The number of opioid prescriptions written each year has quadrupled in less than two decades, without a resulting change in pain reported by Americans. Nearly 2 million people suffer from prescription opioid disorder (POD), with the highest and fastest-growing rates of diagnoses of POD among Medicare beneficiaries (more than 6 per 1,000) and Medicaid beneficiaries (8.7 per 1,000). Statistics like these have become a wake-up call for providers that a course correction is needed to turn the tide on this deadly epidemic.

As was shared in the last issue of *The Source*, health systems that met in Nashville in April for the HealthTrust Perioperative Pain Management Collaboration Summit walked away mindful of the significant role providers play in the opioid epidemic as a result of their pain management practices—notably the overprescribing of opioid drugs.

Summit participants are embracing the curative actions they can take—from launching a perioperative opioid stewardship program, investigating current prescribing patterns, and educating patients and staff about narcotic risks and alternatives, to seeking senior leadership support for new approaches to pain management. (*See stories on pages 66 and 70.*) One of these health systems is literally traveling region by region to its hospitals, raising staff awareness of the very real connection between patients having surgery and developing an opioid addiction.

SUMMIT PARTICIPANTS ARE EMBRACING THE CURATIVE ACTIONS THEY CAN TAKE—FROM LAUNCHING A PERIOPERATIVE OPIOID STEWARDSHIP PROGRAM, INVESTIGATING CURRENT PRESCRIBING PATTERNS, AND EDUCATING PATIENTS AND STAFF ABOUT NARCOTIC RISKS AND ALTERNATIVES, TO SEEKING SENIOR LEADERSHIP SUPPORT FOR NEW APPROACHES TO PAIN MANAGEMENT.

Healthcare as a whole trails multiple other industries—including retail, hospitality and financial services sectors—when it comes to treating data as a strategic asset.

Co-facilitator of the HealthTrust summit—**Michael Schlosser**, M.D., MBA, FAANS, chief medical officer, HCA National Group and vice president, clinical excellence and surgical services at HCA—has personally responded to an invitation to join the Opioid Stewardship Action Team of the Washington, D.C.-based National Quality Forum. The newly convened group is tasked with developing an opioid stewardship playbook to help healthcare practitioners better manage their patients' pain while reducing their risk for addiction. Available in March 2018, it will build on current public- and private-sector efforts to address the opioid epidemic, focusing on improving clinicians' prescribing practices and advancing quality measures that support prescribers. The playbook will also identify strategies and tactics for managing the care of individuals who are at high risk of becoming opioid dependent.

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Coordination Counts in AMI Care

How Hospitals Are Building In-sync Teams to Treat AMI—and Where There's Room for Improvement

The mortality rate of patients with undetected acute myocardial infarction (AMI) is at least twice that of patients who are accurately diagnosed. Prompt, accurate diagnosis is critical. The key, according to the Society of Chest Pain Centers (SCPC), is to "reduce time to treatment during the critical early stages of a heart attack, when treatments are most effective, and to better monitor patients when it is not clear whether they are having a coronary event."

Hospitals achieve the best outcomes when they establish evidence-based protocols to rapidly diagnose and treat AMI. These protocols should be deployed by a diverse team of professionals, including physicians in emergency medicine and cardiology, nurses, and quality improvement leaders. Every step of the process must be carefully thought out and implemented correctly, efficiently and in a timely manner.

The practice of medicine "has become a team sport, beyond any one physician or one person," explains **Raymond Rodriguez**, M.D., a board-certified interventional cardiologist who serves as medical director of Mount Sinai Cardiology in the Keys of Florida, an assistant professor of medicine at the Columbia University Division of Cardiology at Mount Sinai Medical Center in Miami, and a HealthTrust physician advisor. "You need an evidence-based protocol and a coordinated team in order to deliver the best outcomes."

Door-to-balloon Time: The Critical Metric

An accurate history, physical exam and electrocardiography (ECG) are typically the first steps in any AMI protocol. ECGs performed by paramedics in the field are helpful for early notification to the hospital.

"I would like to see paramedics focus on getting patients into the hospital as fast as possible and the ED doctors focus on getting patients to the cath lab quickly," says **Richard Heuser**, M.D., chief of cardiology, St. Luke's Medical Center and Phoenix Heart Center in Phoenix. "Classic ST-elevation on ECG is the diagnostic marker of STEMI. With NSTEMI, diagnosis is a little more challenging. ECG, patient history of presentation, ongoing pain, or unstable vital signs will indicate which patients need to go to the cath lab."

Even an ECG may not be as valuable as hospitals think. "The ECG represents an instantaneous moment in time; therefore, a single ECG may not accurately represent the entire picture," says **Felix Lee**, M.D., medical director of the cardiac cath lab at HCA's Good Samaritan Hospital in San Jose, California. Lee also serves as cardiovascular service line medical director for HealthTrust and physician lead for HealthTrust's recent Collaborative Summit on Managing AMI Patients. (*See the recap story on page 14.*)

For NSTEMI, troponin is the biomarker of choice when the ECG doesn't tell the whole story. The goal is to get the results of these tests and get the patient to the cath lab as swiftly as possible for diagnostic coronary angiography, percutaneous coronary intervention (PCI) or other therapy to follow.

Critical diagnostics can be performed in the ambulance or in the emergency department (ED). "Health systems decide their protocol," Heuser says. "Some systems have the paramedic in the ambulance or in the field to administer the ECG, and possibly measure troponins. These are sent to the hospital so doctors have the information prior to the patient's arrival."

Rodriguez's goal is to get the ECG within 10 minutes of the patient coming to the ED and have a door-to-troponin within 60 minutes of patient presentation. "Timeliness matters, and has to be a part of every ED's protocol, especially with AMI, since time is muscle, which is life," Rodriguez says. "Every staff member—from greeters and registrants to nurses and physicians—should be working to get these vital pieces of information in a very timely fashion."

Matthew Bilodeau, M.D., Ph.D., an interventional cardiologist practicing with Lutheran Medical Group in Fort Wayne, Indiana, and a HealthTrust physician advisor, agrees that hospitals should have a standardized chest pain protocol—whether it's a facility like Lutheran that has a cath lab or an outside hospital where patients receive thrombolytic therapy with the intention to transfer them as soon as possible.

Lutheran's protocol stresses rapid transfer to the cath lab once the patient arrives, and metrics are tracked closely. The ED avoids administering any diagnostic or intervention that could delay transfer to definitive treatment, which is almost 100 percent PCI-based. The hospital rarely uses thrombolytics, except in situations where either the patient's condition prevents transfer in a timely manner or the receiving facility is located too far away.

Life-saving New Technologies

At Lutheran, interventional coronary care has expanded, based on new technologies known to improve outcomes. Bilodeau explains, "We're fortunate to have access to technologies that are really coming of age, such as percutaneous ventricular assist devices, for patients who present with cardiogenic shock or out-of-hospital cardiac arrest."

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"Patients who are resuscitated, usually in the field, and find their way to the cath lab may then be eligible for additional care coordination aimed at protecting them from the brain injury that sometimes follows these kinds of events," Bilodeau explains. "We use newer technologies, including a hypothermia protocol, which we have readily available in the cath lab for more rapid and effective cooling of patients, as well as for rewarming them when the protocol is complete."

Bilodeau is pleased that Lutheran has these technologies available for specific patient populations that are at highest risk for mortality. "Evidence seems to support both improved outcomes and survival to discharge, as well as quality of life down the road," he says.

On the near horizon are noninvasive sensors to help physicians diagnose AMI much earlier. These sensors, which are not ECG-driven but rely on other physiological measurements, such as heart-type fatty acid-binding protein (or H-FABP), could change the dynamic of who makes the diagnosis. Many emergency departments and chest pain centers already use computers capable of continuous ST segment monitoring.

The Challenges

According to Bilodeau, one of the biggest challenges is reducing unnecessary delays in care by integrating the ED with the local emergency medical system, especially with AMI referrals from outside hospitals. "Sometimes there's a delay in transferring the patient because an ambulance isn't available or stationed at the hospital, and some of those hospitals are not even that far from us," he says.

Team readiness is another critical factor. Heuser suggests that 15 minutes after the hospital receives a call, half of the team should be at the hospital waiting for the patient. He believes this process could probably reduce door-to-balloon time on a normal case by 20–30 minutes. "We perform quality assurance reviews on all AMI cases, including any door-to-balloon times greater than 90 minutes," Heuser reports.

For Rodriguez, the huge gaps are in prevention and outreach. "Hospitals need to become more welcoming and familiar places, not the places people go to only if near death. We can do a better job of educating people about AMI symptoms so they'll recognize when they should come to the hospital." ●

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Rethinking Heart Attacks

HealthTrust Convenes Collaborative Summit to Explore Opportunities for Improving Patient Management Across the Care Continuum

Member leaders from five health systems attended HealthTrust's recent Collaborative Summit for Managing AMI Patients. Small-group intensives were followed by lively, full-room discussions.

Five healthcare systems from within the HealthTrust membership recently gathered in Nashville, Tennessee to brainstorm ideas for improving the management of patients with AMI (acute myocardial infarction)—aka, heart attack. The Collaborative Summit for Managing AMI Patients, held over two days in mid-September, replicated the successful, accelerated learning format utilized earlier this year to help members improve their perioperative pain management practices, says event organizer **David Osborn**, Ph.D., senior vice president of inSight Advisory Services for HealthTrust.

Small-group intensives and individual visioning exercises were followed by report-outs and lively, full-room discussions on assigned topics specific to acute care, post-acute care, initiative implementation, and measuring and evaluating success. Attendees left with actionable steps they could take back home to move their health system toward a more effective approach to AMI patient management.

V. Seenu Reddy, M.D., medical director for HealthTrust, started off day one with a recap on the current state of AMI care that is characterized by variation across geographies. The scope of cardiovascular disease is immense. In the United States, a heart attack kills someone every 40 seconds, making it the leading cause of death. Access to care issues may be partially responsible for disparities in incidence rates, says Reddy, and opportunities to improve patient care lie squarely with hospitals. Heart attacks and coronary heart disease are among the 10 most expensive hospital principal discharge diagnoses.

Summit Participants

The following HealthTrust members sent teams of physicians, pharmacists, nurses, and administrative, clinical and service line leaders to the summit:

- **Community Health Systems** – Franklin, Tennessee
- **HCA Far West Division | Good Samaritan Hospital** – San Jose, California
- **RCCH HealthCare Partners** – Brentwood, Tennessee
- **Scripps Health** – San Diego, California
- **Trinity Health** – Livonia, Michigan

Key Themes Emerge

Summit attendees divided into working groups on day one to scan reference materials, develop an "ideal" AMI program, discuss physician engagement and alignment strategies, and determine appropriate ways to measure and evaluate success. The readings included clinical research on AMI care, professional guidelines, and articles related to post-acute care, program implementation, physician engagement, and data and analytics.

On day two, interdisciplinary efforts by the five health systems jumpstarted the creation of institution-specific action plans. Overall, six key takeaways emerged from the summit for improving AMI patient management across the care continuum:

- ***Enhance processes and workflows to improve care delivery and outcomes.*** For example, hospitals can partner with local emergency medical services (EMS) providers to educate and reinforce electrocardiography (ECG) interpretation skills. They should ensure that patients' first contact person in the emergency department (ED), if nonclinical, is educated on both typical and atypical AMI symptoms, and that checklists are utilized throughout the course of a hospitalization. Better protocols and assessments could be developed for patients at risk for poor outcomes. Organizations could also address any barriers to prompt delivery of care, such as delays in getting laboratory test results.

  Patients need to be tracked into the post-acute setting for a minimum of 90 days. Post-acute care goals should include referral to cardiac rehabilitation to reduce the risk of readmission. Follow-up calls within seven days of discharge can address patient concerns related to medications, activity, diet and pain.

- ***Hardwire change wherever possible to create meaningful, sustainable results.*** This would include changes to order sets, protocols and decision support systems. Use of standardized checklists will help ensure workflows are followed for every patient. The system of care, not just the decisions of individual providers, need to be addressed.

  Education is needed across the board: staff on standardized order sets, protocols and checklists; post-acute providers to align patient messaging and increase utilization of cardiac rehabilitation; and primary care physicians (PCPs) on their patients' event and the protocol for smoothing their transition from inpatient to post-acute care.

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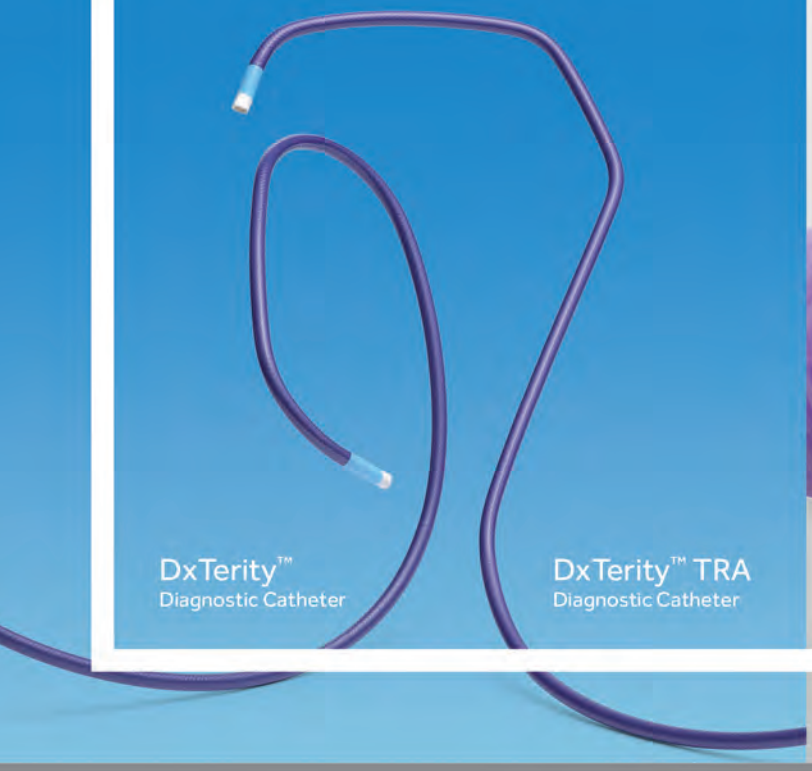

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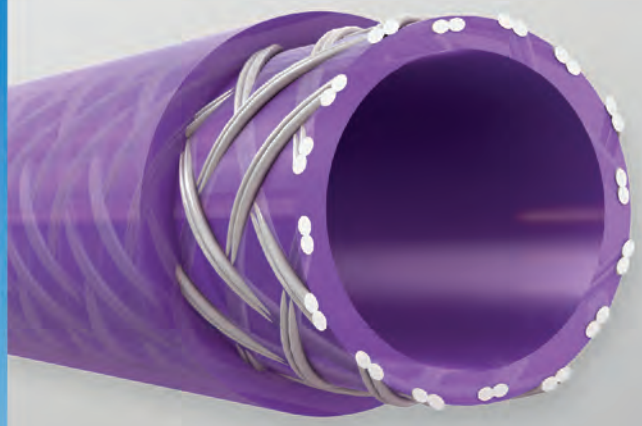

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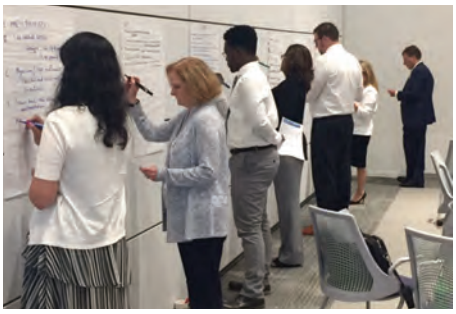
Electronic health records can be utilized to maintain order sets. Compliance with order sets and protocols needs to be measured. Hospitals can build physician trust in ECGs taken in the field, by doing a comparative study of results based on who did the testing.

• ***Broaden improvement efforts beyond hospitals so change is sustainable at all points in the care continuum.*** Health systems should lead the way, but all providers—regardless of care site—must be engaged in efforts to change behaviors and outcomes. Education needs to begin at admission and continue post-discharge, and there should be a standardized process for handing off patients to a PCP or other post-acute provider.

Among the to-dos for hospitals: begin cardiac rehab before patients are discharged; educate staff on standardized orders and protocols; include pharmacists in discharge planning and teaching to address medications, side effects and potential problems with noncompliance; and educate PCPs, as well as patient families, about the importance of medication and cardiac rehabilitation compliance. Community education efforts should include how to recognize the signs and symptoms of an AMI.



On day two, summit attendees began creating institution-specific action plans that focused on enhancing the care of AMI patients.

Post-acute providers need to be aligned with and reinforce patient education concerning behavior change (e.g., exercise, nutrition and stress management) throughout the post-acute care process. They also should implement multiple education methods.

• ***Focus on metrics that provide the most opportunity for improving patient outcomes and systems of care.*** Measures are needed for both ST-elevation myocardial infarction (STEMI) and non-STEMI patients. Registry and case mix data can help identify weaknesses in processes and outcomes. Multiple metrics are important to improving outcomes, including

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door-to-balloon time (speed of getting AMI patient to a cath lab for percutaneous coronary intervention).

Benchmarking performance to other regional and national facilities can identify strengths and weaknesses. Physicians, nurses and staff need to be involved in selecting the appropriate metrics to track for maximum impact. Among the rules of thumb: Don't focus on too many metrics, opt for the actionable ones, know your audience and be aware of unintended consequences.

• ***Develop the business case for health system resources to manage the care of AMI patients.*** Addressing this challenge will lead to better clinical outcomes, including fewer readmissions and complications, as well as higher patient and caregiver satisfaction levels, and reduced cost of care. Justification for the targeted investment should cover the financial implications, including penalties for hospital-acquired conditions and readmissions.

• ***Make some quick changes to create positive results and momentum.*** Clinical and administrative leadership should be educated on the opportunity to enhance care, to gain their support and advocate for the resources needed to achieve it. Initiatives that start small often gain the steam necessary for expansion based on early, positive results. Providers need to identify changes that can be made in the short term that will be impactful—scheduling patients for cardiac rehab at discharge, for example, and educating family members on the importance of medication and cardiac rehab compliance.

Immediate Steps

On the final day of the summit, all participants worked to define the goals, strategy and barriers for their respective health systems. Based on their outlines, they then shared with all other attendees the specific, immediate actions they could take at their organizations within the next 30 days.

For some, an important first step was to do a gap analysis to identify areas of opportunities. For example: What do patient readmission rates look like at 30, 60 and 90 days? How often are patients being referred to cardiac rehab? Are there significant medication compliance issues?

Developing AMI care checklists and creating or expanding the use of standardized order sets across hospitals were among summit participants' other goals for the first 30 days following the event. ●

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A Step Beyond

HealthTrust Residency Program Prepares Pharmacy Leaders for the Future

"The demand for trained pharmacy professionals has increased in past years," according to the American Association of Colleges of Pharmacy (AACP), "due to the rapid growth of the healthcare and pharmaceutical industries, and the growing elderly population. The number of pharmacists in healthcare services is also growing, as pharmacists become more actively involved in drug therapy decision-making for patients of all ages." To prepare the next generation of leaders, HealthTrust established the nation's first corporate-based training program for rising pharmacy leaders nearly four years ago.

The one-of-a-kind program trains potential pharmacy leaders early in their careers by placing them in residence for one year at HealthTrust's headquarters in Nashville, Tennessee. Pharmacists with such experience have greater opportunities for mobility within the profession, according to the AACP.

When it comes to non-clinical training in areas such as budget development, financial reporting and negotiating pharmaceutical contracts, most doctorate-level pharmacy curriculums fall short. And, healthcare administration residency programs tend to focus more on facility-based operations and management. As a result, open leadership positions are likely to be filled by either the most senior pharmacy practitioner willing to try their hand at the role or by an existing manager from an unrelated discipline.

Early career exposure to critical business functions—how to manage limited healthcare resources and the role of value-based purchasing and declining reimbursements—provides these future leaders with real-world experience related to the economic realities of modern medicine.

Working in a corporate healthcare environment is the best way to understand how and why pharmacy sourcing and strategic business decisions are made. With that in mind, HealthTrust, in partnership with the University of Tennessee College of Pharmacy, launched a residency program with a specialty focus on corporate pharmacy leadership to adequately prepare these future leaders.

HealthTrust annually offers a postgraduate "year-two" residency (PGY-2) for a participant who has already completed a doctorate in pharmacy (six to eight years) as well as a first-year general practice residency (PGY-1) at a hospital or other pharmacy practice site.

During their year at HealthTrust, PGY-2 residents have the opportunity to interact with clinical advisory boards made up of corporate leaders in areas such as pharmacy, nursing, laboratory and radiology. This experience is similar to the type of multidisciplinary exchanges that happen at a committee level within a hospital or other healthcare setting. Residents also gain experience working with pharmacy suppliers engaged in the request for proposal process, participating in meetings and live demos showcasing product features.

As part of the residency, participants also join an accelerated version of HealthTrust's leadership development program, which includes public speaking opportunities, a personality assessment, human resources classes and discussions with key executives.

"The ultimate goal is to successfully prepare residents for future employment so our program is designed to go beyond a traditional pharmacy learning experience," says **Vincent Jackson**, PharmD, vice president of HealthTrust's pharmacy services group. "In addition to leadership training, residents also benefit from the unique networking and learning opportunities that come from working with a diverse range of subject matter experts and service line leaders within a total spend management organization such as HealthTrust, as well as from exposure to corporate pharmacy leaders, clinicians, supply chain professionals and healthcare executives at member healthcare systems throughout the United States."

Vincent Jackson

HealthTrust's Corporate Pharmacy Leadership Program has been accredited by the American Society of Health-System Pharmacists (ASHP), certifying that it meets established standards and criteria for residency training programs. ●

HealthTrust will be accepting applications for its 2018–2019 PGY-2 residence through Jan. 19, 2018. Applications should be submitted through the PhORCAS process.

Where Are They Now?

2014–2015 HealthTrust PGY-2 Resident

Nicolle Rychlick, PharmD, was hired by HealthTrust when a position opened in the pharmacy services group for a clinical integration director. She also leads the activities of HealthTrust's Pharmacy Advisory Board.

2015–2016 HealthTrust PGY-2 Resident

Bradley Bruce, PharmD, was hired by HCA as a senior consultant in the regulatory compliance support area.

2016–2017 HealthTrust PGY-2 Resident

Brittany Berry, PharmD, was hired by HealthTrust when a position opened in the pharmacy services group for a portfolio director.

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1. Prevantics Clinical Compendium. PDI, Orangeburg, NY. 2012.
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PATIENT CARE ENVIRONMENT OF CARE **INTERVENTIONAL CARE**

Journey to Walk Again Inspired Innovation

For people with neurological injuries or disorders, there's often no such thing as full recovery—most will live with the condition for the rest of their life. Because of this, the assistance needed extends far beyond outpatient care and the occasional doctor's visit. Most neuro patients are left to navigate complex treatment paths alone, along with a slew of unanswered questions—from finding a support group to applying for a service dog.

After a spinal cord injury in 2004, **Jessica Harthcock** found herself asking hundreds of questions. At age 17, she was practicing gymnastic maneuvers for the springboard diving team. Despite every trick having gone smoothly that evening, on her final attempt, Harthcock landed on her head and heard a crunch in her neck.

Doctors diagnosed her with complete paralysis at the T3-4 level, meaning that Harthcock lost all sensation and motor ability from her chest down. As a diver and dancer, she knew what it meant to work hard and push her body. Despite doctors' diagnoses that she'd never walk again, she immersed herself in rehabilitation and activity-based, weight-bearing therapies as though learning a new athletic feat. She was determined to regain the use of her legs.

"No one walks alone," the motto of Utilize Health, is also a promise the company makes to walk beside its members through the entirety of their recovery, or throughout the path of learning to make the best out of life living with a condition.

While therapy was physically exhausting, the greater deterrent was finding the right rehabilitation centers, care professionals and resources. Driving or flying all over the United States, Harthcock and her family sought specialized treatments. Though persistent at her therapy, the lack of support from some physicians was draining. Months into her journey to regain motor control, one doctor told her she basically needed to accept her lot in life and move on.

WITH THE SAME PERSISTENCE THAT PUSHED JESSICA HARTHCOCK THROUGH THOUSANDS OF HOURS OF PHYSICAL AND OCCUPATIONAL THERAPY, SHE AND HER TRAINER-TURNED-HUSBAND LAUNCHED UTILIZE HEALTH.

As Harthcock shuttled between facilities, the seeds of an idea took root. There had to be a better, more streamlined path to recovery.

First Steps

Twenty-two months after her injury, Harthcock saw the first sign of recovery. A twitch in her right thigh progressed into a controlled twitch and, eventually, voluntary muscle movement. Three years post-injury, she took her first step as a paraplegic.

Harthcock had accomplished the very thing doctors told her she couldn't do, and it propelled her even further. She thought about all the other patients with neurological conditions who were struggling toward recovery alone—or worse, who never had an opportunity to start. With the same persistence that pushed Harthcock through thousands of hours of physical and occupational therapy, she and her trainer-turned-husband **Adam Harthcock** launched Utilize Health.

Through both personal advocates and digital tools assisting with medical, social and environmental needs, Utilize Health is pioneering neurological care coordination to help its members make sense of treatment options. The company also tracks outcomes, aiding members in maximizing their potential for recovery and helping to lower hospital readmission rates and the overall cost of care.

"No one walks alone" is more than the motto of Utilize Health. It is also a promise the company makes to walk beside its members through the entirety of their recovery, or throughout the path of learning to make the best out of life living with a condition. With support from digital tools and a personal concierge service, the company simplifies care coordination.

As the Harthcocks built Utilize Health, they started with the why. Advocating for patients with neurological conditions and improving the quality of their lives has always informed the how and the what.

For Jessica Harthcock, the near impossibility of navigating a complex healthcare and neuro-rehab system pushed her to innovate—just as a traumatic, unforeseen injury forced her to give everything she had to the recovery process. "Eventually, I found a really good team who delivered exceptional care, but they were all in different places," she says. Utilize Health aggregates data and offers a "facilities finder" so patients can locate essential information in one place.

Filling in the Gaps With Patient Advocates

In the early years after her injury, Harthcock discovered that every neuro patient she met was missing a point person, someone

Continued on page 24

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Continued from page 22

to do the essential work of coordination. Harthcock was fortunate because her mom had a flexible work schedule that enabled her to sit on hold for an hour with an insurance company or to arrange the multitude of necessary appointments and evaluations. "Without her, I'd still be sitting in a wheelchair," Harthcock adds.

A concierge service, which Harthcock calls the heartbeat of Utilize Health, was born because most patients don't have someone who can drop everything to arrange fragmented logistics. These specialty neuro-rehab clinicians are employed by Utilize Health and have at least eight years of field experience at two or more care settings. They offer one-on-one assistance to members with anything they might need—from finding accessible housing to applying for a service animal.

Utilize Health's specialty neuro-rehab clinicians offer one-on-one assistance to members with anything they might need—from finding accessible housing to applying for a service animal.

"Our advocates know exactly what to expect when working with these patients," says **Carrie Redmon**, director of care coordination. "They're ready to face any challenge to help maximize the potential for recovery."

Patients' experience with Utilize Health is often life-changing in terms of better outcomes. And, health plans appreciate the significant cost savings of coordinated care. While Utilize Health has to date partnered primarily with health plans, it is now investigating how the program can impact the bottom line for hospitals, including HealthTrust member facilities. ●

Utilize Health hopes to partner with a HealthTrust member facility to pilot its program sometime in the new year. To learn more, contact Jessica Harthcock at jessica@utilizehealth.co or visit www.utilizehealth.co.

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Indications and Usage

NUWIQ® is a Recombinant Antihemophilic Factor [blood coagulation factor VIII (Factor VIII)] indicated in adults and children with Hemophilia A for on-demand treatment and control of bleeding episodes, perioperative management of bleeding, and for routine prophylaxis to reduce the frequency of bleeding episodes. NUWIQ® is not indicated for the treatment of von Willebrand Disease.

Important Safety Information

NUWIQ® is contraindicated in patients who have manifested life-threatening hypersensitivity reactions, including anaphylaxis, to the product or its components. The most frequently occurring adverse reactions (>0.5%) in clinical trials were paresthesia, headache, injection site inflammation, injection site pain, non-neutralizing anti-Factor VIII antibody formation, back pain, vertigo, and dry mouth. Development of Factor VIII neutralizing antibodies (inhibitors) may occur.

Please see accompanying Brief Summary of Prescribing Information for Additional Important Information.

References: 1. Sandberg H, et al. Thromb Res 2012; 130:808-817. **2.** Casademunt E, et al.. Eur J Haematol 2012; 89:165-176. **3.** Kannicht C, et al. Thromb Res 2013; 131:78-88. **4.** Valentino LA, et al. Haemophilia 2014; 20:1-9.

Date of preparation: 9/2017. NUW-016-CAD-r

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HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use NUWIQ safely and effectively. See full prescribing information for NUWIQ.

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NUWIQ is a recombinant antihemophilic factor [blood coagulation factor VIII (Factor VIII)] indicated in adults and children with Hemophilia A for:

- On-demand treatment and control of bleeding episodes
- Perioperative management of bleeding
- Routine prophylaxis to reduce the frequency of bleeding episodes

NUWIQ is not indicated for the treatment of von Willebrand Disease.

DOSAGE AND ADMINISTRATION

For intravenous use after reconstitution

- Each vial of NUWIQ is labeled with the actual amount of Factor VIII potency in international units (IU).
- Determine dose using the following formula for adolescents and adults:

  Required IU = body weight (kg) x desired Factor VIII rise (%) (IU/dL) x 0.5 (IU/kg per IU/dL)

- Dosing for routine prophylaxis:

Subjects	Dose (IU/kg)	Frequency of infusions
Adolescents [12-17 yrs] and adults	30-40	Every other day
Children [2-11 yrs]	30-50	Every other day or three times per week

- Frequency and duration of therapy depends on severity of the FVIII deficiency, location and extent of bleeding, and patient's clinical condition.

DOSAGE FORMS AND STRENGTHS

NUWIQ is available as a white sterile, non-pyrogenic, lyophilized powder for reconstitution in single-use vials containing nominally 250, 500, 1000 or 2000 IU Factor VIII potency.

CONTRAINDICATIONS

NUWIQ is contraindicated in patients who have manifested life-threatening hypersensitivity reactions, including anaphylaxis, to the product or its components.

WARNINGS AND PRECAUTIONS

- Hypersensitivity reactions, including anaphylaxis, are possible. Should symptoms occur, discontinue NUWIQ and administer appropriate treatment.
- Development of Factor VIII neutralizing antibodies (inhibitors) may occur. If expected plasma Factor VIII activity levels are not attained, or if bleeding is not controlled with an appropriate dose, perform an assay that measures Factor VIII inhibitor concentration.
- Monitor all patients for Factor VIII activity and development of Factor VIII inhibitor antibodies.

ADVERSE REACTIONS

The most frequently occurring adverse reactions (>0.5%) in clinical trials were paresthesia, headache, injection site inflammation, injection site pain, non-neutralizing anti-Factor VIII antibody formation, back pain, vertigo, and dry mouth.

USE IN SPECIFIC POPULATIONS

Pediatric Use: Lower recovery, shorter half life and faster clearance in children aged 2 - ≤12 years. Higher doses and/or a more frequent dosing schedule for prophylactic treatment should be considered in pediatric patients aged 2 to 5 years.

PATIENT COUNSELING INFORMATION

Advise patients to read the FDA-approved patient labeling (Patient Information and Instructions for Use).

Because hypersensitivity reactions are possible with NUWIQ , inform patients of the early signs of hypersensitivity reactions, including hives, generalized urticaria, tightness of the chest, wheezing, hypotension, and anaphylaxis. Advise patients to stop the injection if any of these symptoms arise and contact their physician, and seek prompt emergency treatment.

Advise patients to contact their physician or treatment center for further treatment and/or assessment if they experience a lack of clinical response to Factor VIII replacement therapy, as this may be a manifestation of an inhibitor.

Advise patients to consult with their healthcare provider prior to traveling. While traveling, patients should be advised to bring an adequate supply of NUWIQ based on their current treatment regimen.

To report SUSPECTED ADVERSE REACTIONS, contact Octapharma USA Inc. at 1-866-766-4860 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Revised September 2015

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Safe & Sustainable

Reprocessing SUDs is a path to environmental stewardship

A growing demand for sustainability strategies is evident in the U.S. healthcare ecosystem, according to a September 2017 survey from Johnson & Johnson Medical Devices Companies (JJMDC). The survey of 92 executives and clinicians at large U.S. health systems found that nine out of 10 clinicians and health system executives agree that sustainability provides long-term cost savings. The majority also agree that sustainability provides additional benefits, such as protecting the environment (76 percent), improving patient care (73 percent), and increasing the ability to manage risk and regulatory performance (68 percent). Nearly all (95 percent) believe that environmental sustainability contributes to the value of care delivered in their health system.

More hospitals are discovering that reprocessing single-use devices (SUDs), or disposable devices, is often an affordable method for environmental sustainability and resource conservation—without compromising healthcare outcomes or patient safety. SUD reprocessing methods must meet the FDA's 510(k) approval process, and hospitals that use such devices are finding clinical outcomes and patient benefits equivalent to that of original equipment manufacturers (OEMs).

"TALK WITH YOUR NATIONAL ACCOUNT REPRESENTATIVES ABOUT BEST PRACTICES FOR STARTING A REPROCESSING PROGRAM, SETTING PROGRAM GOALS AND ONGOING TRACKING. REQUEST ANNUAL BUSINESS REVIEWS TO MONITOR PROGRESS AND IDENTIFY ADDITIONAL SAVINGS OPPORTUNITIES."

—**Kathy Demaray**, HealthTrust vice president of GPO Operations and the Supply Chain Board

Why It's Safe

Hospital-based reprocessing handles instruments and reusable devices, which undergo meticulous cleaning, inspection, packaging and sterilization.

Third-party reprocessing providers handle disposable devices and perform under strict FDA oversight.

"SUD reprocessing is inherently different than in-house reprocessing," explains **Bill Scott**, senior marketing director for Stryker's Sustainability Solutions division (**HealthTrust Contract No. 4673**). "There are different regulatory requirements for each device."

Hospitals that use SUD reprocessing send their devices to a third-party reprocessing supplier where devices are received, sorted, cleaned and inspected. Each one is individually tested, packaged and sterilized before the product is released for buy-back to the hospital.

"Our devices have been inspected multiple times at our plant and run through terminal sterilization just like the new product," says **Frank Czajka**, president of Medline ReNewal (**HealthTrust Contract No. 4670**).

"We test every device we work on," Czajka says. "That's in contrast to a typical production run where an OEM tests between 1 percent and 4 percent of its new products," he says. "Each of our devices is inspected between eight and 10 times before it leaves our plant for use at a facility."

JJMDC recently announced its Care-Advantage Sustainability capability, which includes reprocessing through Sterilmed, across a broad spectrum of categories to include both JJMDC as well as non-JJMDC reprocessed single-use devices.

"We can provide health systems with a broad portfolio of sustainably sourced medical devices to help them meet their commitment to environmental stewardship efficiently and cost effectively," says **Melinda Thiel**, vice president, customer marketing and solutions at JJMDC.

In addition to cost savings, reprocessing SUDs diverts medical devices from landfills. Sterilmed (**HealthTrust Contract No. 4672**) collects and ships devices at no cost to the facility, reducing operating room waste disposal costs by up to 70 percent. ●

Visit the sustainability page of the HealthTrust member portal for more information on contracted reprocessing suppliers.

'*Primum non nocere*: First, Do No Harm'

Executive Insights on Sustainability in Healthcare

Reducing the environmental footprint of a hospital or healthcare facility can have a direct and positive impact on patient care as well as on the well-being of its employees. And, with some exceptions, products and services that promote sustainable healthcare can also save money. Purchasing from suppliers that require sustainable manufacturing furthers a culture of responsibility, thus sharing a goal with hospitals that all related efforts benefit or, at the very least, do no harm to the environment. The question for a hospital, suggests *Becker's Hospital Review*, should not be, "Why should we practice sustainability in healthcare?" but instead, "Why shouldn't we?"

Transitioning a healthcare facility from a presumably chemical-laden, waste-generating environment to a finely tuned green operation can seem overwhelming, especially when cost and reimbursement concerns, and patient safety and satisfaction, continually rank higher on the priority list. Knowing these are the realities of today, *The Source* asked executives at two of HealthTrust's member organizations to offer their insights related to sustainability in healthcare. Our interviewees are **Bob Beyer**, vice president of supply chain services at Hospital Sisters Health System (HSHS), based in Springfield, Illinois, and **Robert Garrett**, co-CEO of Hackensack Meridian Health, based in Edison, New Jersey.

Why is healthcare sustainability a priority for your facility/health system?

Beyer: As a faith-based organization rooted in the teachings of St. Francis of Assisi, our commitment to healthcare sustainability and reverence for the earth are a part of our core values and belief system.

Garrett: Sustainability is directly in line with the fundamental mission of Hackensack Meridian Health to maintain and improve health, whether through innovations in care or by reducing exposure to potentially harmful chemicals. Our hospitals are energy- and resource-intensive by the nature of their operations. We do not want to contribute to environmental problems, but to utilize resources efficiently, reduce waste and reinvest the savings into providing high-quality patient care—creating a healthier environment for patients and team members.

Describe sustainability initiatives you are particularly passionate about and why.

Beyer: Although all of our sustainability initiatives are important to HSHS, we're particularly passionate about waste streams management and charity donations of capital equipment. Our sister organization, Hospital Sisters Mission Outreach, focuses on waste streams management by distributing unwanted supplies and equipment to healthcare organizations and missions in the developing world.

Garrett: The safer chemicals initiative, which has been the foundation of our sustainability program for years, continues to be a major source of pride for the entire network. Hackensack University Medical Center is home to the Deirdre Imus Environmental Health Center, whose mission is to identify, control and ultimately prevent toxic exposures in the environment that can threaten our children's health. The improvements here have included the switch to purchasing green cleaning products and furniture that is not treated with toxic, flame-retardant chemicals. We have also partnered with our utility provider to install energy-efficient lighting and chillers as well as LED lighting in parking garages.

How did your green team obtain your buy-in or that of other executives, colleagues and physicians?

Beyer: In addition to being a major component of our organization's core values, it is simply the right thing to do. Our leadership and colleagues know they are making a difference for our health system and communities by supporting these efforts.

Garrett: By illustrating that each initiative was in line with our strategic priorities to provide the optimal patient experience and the best outcomes, and to ensure our teams are working in a healthy, pleasant environment. Additionally, these efforts result in cost savings through more efficient practices, which is an essential part of our mission.

Continued on page 30

Reducing inefficiencies, raising effectiveness – *that is the sum of care.*

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1. Rosen M, Bauer JJ, Harmaty M, *et al*. Multicenter, prospective, longitudinal study of the recurrence, surgical site infection, and quality of life after contaminated ventral hernia repair using biosynthetic absorbable mesh: the COBRA Study. *Annals of Surgery*. 2017;265(1):205-211.
2. W. L. Gore & Associates, Inc. *Clinical Performance with Staple Line Reinforcement. Scientific Literature Analysis (n = 4689 patients).* Flagstaff, AZ: W. L. Gore & Associates, Inc; 2013. AP6010-EN3.

Products listed may not be available in all markets.

Continued from page 28

For a healthcare organization starting its sustainability journey, how do you recommend finding executives and colleagues to champion the cause?

Beyer: Find someone in the organization, from leadership or in the trenches, who is passionate about sustainability and willing to be a servant leader to introduce and then support the program on an ongoing basis.

Garrett: It starts with the CEO showing team members they will be supported in their endeavors.

How do you make your surrounding community aware of the sustainable characteristics, initiatives and results within your operations and/or facilities?

Beyer: Whenever possible, we get the community involved through our PR and communications. For example, one of our hospitals has a Christmas tree recycling event every year that provides an opportunity to showcase all of our other sustainability efforts.

Garrett: We routinely share the good news of Hackensack University Medical Center's recognition as one of the greenest hospitals in America with patients and the community. We want them to know we are committed to providing a healing environment that's as free of chemicals as possible, and continuously improving our programs to reduce waste and provide healthy food options. We also let it be known that Hackensack's John Theurer Cancer Center supports cooking with antibiotic-free meat. In 2016, the hospital announced that 85 percent of total meat served is antibiotic-free, and today we are close to our goal of 100 percent. The hospital also installed rooftop beehives to raise awareness about the importance of honeybees to the local food supply.

What impact do your sustainability initiatives have on your organization's mission, legacy and/or accountability to the communities you serve?

Beyer: HSHS is committed to being good stewards of limited natural resources. Sustainability is part of our commitment to the community, and our legacy and mission.

Garrett: A healthy community begins with a healthy environment, and that's what the network of Hackensack Meridian Health is creating. Hospitals of the future will treat the sickest of the sick patients, but we want people to think "health" when they think of us.

From your perspective, what's next in your organization's environmental journey going forward?

Beyer: Getting better and more efficient at educating all of our colleagues, visitors and patients about sustainability. It's something we want engrained in the culture and maintained as an expectation.

Garrett: We'll continue to incorporate best practices from each hospital within our system. Although the work done at Hackensack is being modeled systemwide, all of our sustainability programs have unique features that we want to keep intact. Our goal is for our overall health system to be known as a national leader in healthcare sustainability.

How can HealthTrust best partner with you in EPP (Environmentally Preferable Purchasing) and sustainable efforts in the future?

Beyer: By ensuring that we are holding suppliers to terms and conditions regarding sustainability and environmental stewardship, such as assistance with green disposal of packaging and chemical waste.

Garrett: HealthTrust can leverage its purchasing power so that suppliers are more forthcoming about the raw materials in their products and the manufacturing process, and willing to eliminate any cost gaps when members switch to more sustainable products. It also has an important educational role to play with members. For our communities to get healthier, we need healthcare facilities around the country to incorporate sustainability into every aspect of their operations.

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Going Green at Boston Medical Center

Earlier this year, Boston Medical Center (BMC) was recognized for the first time as a Top 25 hospital for its environmental stewardship initiatives by Practice Greenhealth. At BMC, going green equates to "being good stewards to the environment, our people and our resources," says **Robert Biggio**, senior vice president of facilities and support services. "It is a holistic approach to our work and how we operate, and is incorporated into the fabric of our culture."

Robert Biggio

Green initiatives have had implications in three key areas at BMC:

Energy conservation. BMC seeks to maximize its efficiency efforts around energy consumption. It has partnered with a North Carolina solar energy farm to reach a goal of being carbon neutral by 2020. Most recently, BMC installed a natural gas-fired, 2 megawatt cogeneration (combined heat and power) plant to save $1.5 million annually on energy costs.

Food sourcing. The beef BMC serves is local and grass-fed. Seafood comes from a partnership with the Gloucester Fishermen's Wives Association and is delivered fresh daily. Produce hails from local New England farms and BMC's 7,000-square-foot rooftop garden. (*See story on page 44.*)

Integrated waste program. Each month, a biodigester diverts 4 tons of food waste and 40 solar-powered trash receptacles divert 1 ton of single-stream waste.

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What does the recognition of your organization's efforts by Practice Greenhealth and related entities mean to leadership, staff and the surrounding community?

Beyer: This year's recognition by Practice Greenhealth as a System for Change, and with individual awards going to 12 HSHS facilities, provides affirmation of our hard work that is frequently cited by our community and board leaders. It sets us apart from competitors in the communities we serve.

Garrett: Hackensack University Medical Center was recently named one of the top 25 most sustainable hospitals in the country for the fourth time, which is a great honor. It acknowledges the efforts of that team, and highlights its leadership role in our endeavors as a network to create a healthier environment for team members, patients and the communities we serve.

In 2016, Hackensack was the only New Jersey medical center named to the "50 of the Greenest Hospitals in America" list of *Becker's Hospital Review* and, earlier this year, it received the New Jersey Business & Industry Association's 2017 Award for Excellence in the environmental quality category. ●

Bob Beyer is vice president of supply chain services for Hospital Sisters Health System. He also serves on the board of directors of Hospital Sisters Mission Outreach and as a member of a HealthTrust board. HSHS has been in continuous operation since 1875 and today cares for patients in 14 communities in Illinois and Wisconsin. With 15 hospitals, many community-based health centers and clinics, and nearly 2,300 physician partners, HSHS has more than 14,600 colleagues.

Robert Garrett is co-CEO of Hackensack Meridian Health. He is currently leading the development of New Jersey's only private medical school (opening in 2018) with Seton Hall University as well as overseeing the network's partnership with Memorial Sloan Kettering Cancer Center. Previously CEO of the Hackensack University Health Network, Garrett claimed the top spot on this year's NJBIZ Power 50 Health Care list. The Hackensack Meridian Health network includes 13 hospitals, more than 6,000 physicians and another 120+ care sites.

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JUMPSTARTING INNOVATION

HealthTrust member hospitals and other industry leaders are embracing and investing in innovation as a strategy for improving patient care, increasing patient satisfaction and easing common healthcare headaches.

GETTY IMAGES/JOHN FEDELE

"We recognize that to achieve our vision and put our people-centered strategy into action, innovative models of care need to be implemented as we move from volume to value."

Anna Marie Butrie, vice president, innovation program and services, Trinity Health

GETTY IMAGES/ PORTRA

Virtual reality headsets aren't just for video gamers. At Alder Hey Children's Hospital in Liverpool, England, surgeons have begun using virtual reality (VR) headsets to prepare for complicated heart surgeries on very small hearts. Traditionally, they were unable to fully understand a child's heart problem until they started operating because images rendered on CT and MRI scans are so small. But VR technology uses those scans to produce a virtual heart they can study prior to surgery.

"Standing inside a virtual heart 8 feet high while operating a virtual torch to examine for defects has been one of the highlights of my innovation career so far," says **Iain Hennessey**, M.D., head of innovations at Alder Hey. "The ability to accurately assess the miniature detail of a sick child's heart, using advanced 3-D visuals, has the potential to reduce the number of exploratory surgeries and operation times."

Technological improvements of this caliber hold great promise for healthcare innovation, with opportunities to develop or improve medical devices, diagnostics and mobile health platforms, as well as clinical workflows and processes. And ongoing innovation is vital to the provision of better, more reliable care at affordable prices.

"In Liverpool, 120 years ago, 50 percent of children did not survive to see their 10th birthday," says Hennessey, the featured speaker at the 2017 HealthTrust Innovation Summit, held in October in Ponte Vedra Beach, Florida. "Today, that number is almost nothing, thanks to 120 years of continuous innovation. We cannot stand still until that number is zero."

At all hospitals, today's healthcare challenges demand new ways of approaching patient care—and those that are focused on innovation are seeing positive results. "Our goal is to become the national leader in improving the health of our communities and each person we serve, and to be the most trusted health partner for life," says **Anna Marie Butrie**, vice president of the innovation program at Livonia, Michigan-based Trinity Health. "We recognize that to achieve our vision and put our people-centered strategy into action, innovative models of care need to be implemented as we move from volume to value."

CONSIDER ALL OPTIONS

Healthcare innovation is a hot topic, with numerous technology companies and entrepreneurs developing new tools and techniques to address clinical and workforce issues. Many hospital teams also have their own ideas for solving specific challenges.

When it comes to innovation at Alder Hey, "we use any and all means," Hennessey says. "Sometimes it begins with a startup company offering a new product; sometimes the clinical need drives the innovation. We often craft innovation around one patient or experience. The best relationships can come from the most unlikely places."

At Nashville, Tennessee-based HCA Healthcare, the innovation team works closely with physician and nursing teams, and information technology staff, to identify potential problems and develop

solutions. “There’s so much innovation going on in healthcare that we also bring in outside solutions to see how they might fit here,” says **Chip Blaufuss**, assistant vice president of strategic innovation at HCA Healthcare.

The Mayo Clinic’s Center for Innovation works directly with senior Mayo Clinic leaders to create solutions that will help achieve strategic priorities. Individual projects may originate with staff at the dedicated center or with anyone else in Mayo’s system who seeks the center’s help in solving a problem or developing a new idea.

Many successful healthcare innovations involve a good deal of collaboration. For instance, Trinity Health recently challenged colleagues and external organizations to submit proposals for reducing the readmission rate for dual-eligible beneficiaries of Medicare and Medicaid. The health system is now conducting pilot projects at Trinity Health facilities around some of the submitted suggestions.

Innovators designed the ***OB Nest*** to provide prenatal care for women with low-risk pregnancies that would save doctors’ time for sicker patients and still provide value and ***patient satisfaction***.

MEETING COMPLEX NEEDS

Hospitals and healthcare partnerships continue to unveil innovations that help meet needs on multiple fronts, most notably the way care gets delivered to patients. Among the positive effects:

Increased patient satisfaction

At the Mayo Clinic, the department of obstetrics and gynecology collaborated with the Center for Innovation to develop the “OB Nest,” a new way for pregnant women and their families to experience prenatal care. Traditionally, prenatal care consists of 12–14 doctor visits, most of which are brief check-ins. While research shows that fewer visits are fine for healthy patients, previous attempts to reduce the number of visits resulted in lower patient satisfaction scores.

OB Nest, designed specifically for women with low-risk pregnancies, overcame this hurdle, freeing up doctors’ time for sicker patients while leading to higher patient satisfaction scores and perceived value. In a pilot study, participants were assigned a nurse as their lead contact, scheduled for eight office visits—with an option to add more—and provided with home monitoring equipment so they could check their baby’s fetal heart rate and their own maternal blood pressure whenever they wanted. The mothers-to-be could also opt to participate in an online community with other participants and nurses.

AmSurg, which owns and operates more than 250 ambulatory surgery centers throughout the United States, implemented “Patient Connect,” an engagement program focused on communicating promptly with patients. The program consists of a web platform (and will eventually include a mobile app), through which patients can obtain procedure results, better understand risks associated with pathological findings and schedule follow-up procedures, if needed. The platform directly links the patient to available procedure times for appointment scheduling, says **Eric Thrailkill**, vice president and chief information officer for AmSurg.

At HCA, leaders understand that patients and their family members often have difficulty getting around a hospital campus. Since most people are familiar with Google Maps’ blue dot navigation, HCA incorporated it into a new wayfinding mobile app. Developed with the help of an outside provider, the app shows users their current location on the hospital campus. Users can also input their destination, such as the nursery, for step-by-step directions to get there.

“Blue dot wayfinding was our answer to how we could bring technology from outside healthcare into our organization and help people get around better, improving the patient and family experience,” Blaufuss adds. The system has been deployed at one hospital with plans to expand in the near future.

Improved patient care and safety

Pediatric orthopedic surgeons at Alder Hey use a 3-D print hub to provide printed models of patients’ spines for preoperative planning and as a reference to guide them through complex spinal procedures. An outside partner converts CT scan images of a patient’s spine into a 3-D printable format, which then allows a sterilized, life-size model of that spine to be printed and used as a model in the operating room.

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ISTOCK

Community Aging in Place, Advancing Better Living for Elders (CAPABLE) deploys a three-person team to participants' homes to ***improve their functional abilities*** and reduce avoidable readmissions.

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At Trinity Health, a hospital is piloting a program originally created by John Hopkins to help aging patients safely stay in their own homes longer. Community Aging in Place, Advancing Better Living for Elders (aka CAPABLE) deploys a three-person team to participants' homes to improve their functional abilities and reduce avoidable readmissions, Butrie says. The team includes an RN, an occupational therapist and a licensed handyman who work with the clients to implement small adjustments that will keep them living in their homes independently, such as installing bathtub rails or shelving.

Gregory Brown, M.D., Ph.D., an orthopedic surgeon at St. Joseph Medical Center in Tacoma, Washington, and orthopedic service line medical director for HealthTrust, developed a predictive analytics tool for patients considering total knee replacement surgery. It's a simple red-yellow-green matrix that quickly shows patients if they're likely to have a poor, good or excellent surgical outcome and their potential risk of infection.

Enhanced nursing workflows

HCA has begun providing nurses with mobile devices and innovative apps that make it easier to access information and communicate with physicians and other nurses. Now, HCA is also working with nurses to identify opportunities to increase the functionality of the phones in the course of their daily work. For instance, nurses might use mobile apps to administer medications, manage phlebotomy, or capture images of wounds to get input and insight from other care providers.

"Our goal is to improve their access to timely and actionable information as well as to their ability to connect with their colleagues, while putting them in a position to spend more time at the bedside, doing what they've been trained to do," Blaufuss says.

COMPETITIVE NECESSITY

A continuing focus on innovation is, for many hospitals, translating into promising new ways to provide better healthcare, more efficiently serve patients and, ultimately, drive more positive outcomes. The critical factor, notes Butrie, is aligning the activity with the organization's strategic objectives. Hospitals are also likely to succeed with innovation when they foster a creative culture that is open to risk, and encourage staff to think about new ways to approach routine tasks.

"The process of identifying new solutions to problems that patients and clinicians face every day allows us to stay competitive and provide high quality, cost-effective care," Blaufuss agrees. "If we're not figuring out how to improve the care we provide, we're going to fall behind others who are doing that." **S**

Members can download HealthTrust's latest executive briefing, *"Innovation in Healthcare: Current State & Future Needs,"* from the Clinical Evidence section of the HealthTrust member portal.

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Supplier Diversity Helps Hospitals Fulfill Their Mission

In most communities, healthcare facilities are an equalizer: Local residents of various social, racial and ethnic backgrounds may live in separate neighborhoods and attend different schools, churches and synagogues, but they can all find care at the same hospital. And increasingly, healthcare facilities seek to reflect their focus on serving people from all walks of life by doing business with diverse suppliers.

Michael Berryhill

HealthTrust works with many members to help increase supplier diversity, and it is proactive about seeking contracts with minority-, woman- and service-disabled veteran-owned enterprises (MWSDVEs).

"A diverse supplier program promotes competition, builds stronger communities, creates jobs, drives creativity and fuels economic development," says **Michael Berryhill**, HealthTrust's executive vice president and chief operating officer. "HealthTrust's commitment to supplier diversity not only supports HealthTrust's core values, but also supports our members in achieving their diversity goals."

Driving Economic Development

HealthTrust member Catholic Health Initiatives (CHI), based in Englewood, Colorado, is devoted to supplier diversity for both economic and moral reasons.

"Supplier diversity is important to CHI because it aligns with our mission, which urges us to promote social justice as we create healthier communities," says **Rosalyn Carpenter**, chief diversity officer and vice president for diversity and inclusion at CHI. "We energize the communities we serve when we intentionally utilize the innovation, quality and savings opportunities of diverse suppliers for needed business solutions."

One of the most important ways that CHI achieves diversity among suppliers is by actively seeking occasions to partner with

Continued on page 42

"Supplier diversity is important to CHI because it aligns with our mission, which urges us to promote social justice as we create healthier communities." **Rosalyn Carpenter,** chief diversity officer and vice president for diversity and inclusion at CHI

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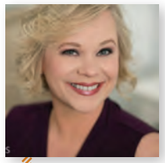


In 2016 and 2017, Catholic Health Initiatives (CHI) moved the contracting of several products—certain types of needles, scalpels and lancets—to MYCO Medical, a HealthTrust MWSDVE supplier. CHI's **Karen Morehead**, RN, BSN, CNOR, director preference surgical category, integrated supply chain, estimates initial savings from the successful conversion to be $200k+.

minorities, women, veterans and other small-business owners, Carpenter says. Typically, supply chain operations within a health system identifies prospects, notably suppliers of medical, surgical and commodity products. When possible, CHI also opens doors for diverse suppliers in the areas of construction, facilities investment, human resources and other purchased services.

It's simply the right thing to do from the standpoint of fairness, Carpenter says. But it also makes good economic sense, allowing CHI to cut costs as well as contribute to a vibrant economy.

Today, MWSDVEs are the driving force behind the growth of the U.S. economy, Carpenter says, creating jobs that support individuals, the well-being of families, and entire communities.

For other hospital systems interested in building a strong supplier diversity program, Carpenter recommends working with a consultant to establish the framework, identify their current diversity spend and define future MWSDVE spend goals. In addition, Carpenter endorses the sharing of best practices among the "brain trust" of hospital systems, group purchasing organizations, insurance companies, manufacturers, distributors and retail providers that are members of the National Minority Supplier Development Council (NMSDC) and the Women's Business Enterprise National Council (WBENC).

New Leader, Renewed Vision

Recognized as a model in the industry, HealthTrust's supplier diversity program provides a sizable roster of contracts with diverse suppliers and expertise on building relationships with them. Currently, 89 MWSDVEs hold 165 contracts with HealthTrust.

Agreements with these nationally certified diverse suppliers represented more than $267 million of annual contract volume in 2016, according to **Janet McCain**, director of business diversity.

Janet McCain

"Our continued success is a result of contracting with, and then fully supporting, diverse suppliers that can provide excellent service, quality products and increased value to our membership."

HealthTrust verifies certification of companies before considering them for a contract award. Certification is accepted from NMSDC, WBENC, the Small Business Administration or the Association for Service Disabled Veterans.

The program acquired new leadership in August 2017, when **Joey Dickson** took on the role of assistant vice president for supplier diversity. He also continues to serve as HealthTrust's assistant vice president of strategic sourcing for purchased services. Dickson, who joined HealthTrust in 2007 as corporate counsel, is a member of the Federation of American Hospitals, Nashville Health Care Council and the Tennessee Bar Association.

"We believe the relationships Joey has built in the purchased services space will be an asset to growing diversity spend, since many of the opportunities reside with local or regionally based service providers," Berryhill says.

In his new position, Dickson wants to maximize the participation of minority-, woman-, veteran-owned and other small businesses in HealthTrust's contracting process.

"I look forward to working with diverse suppliers ready to compete for a spot in our contract portfolio," he says.

An expanding vision for HealthTrust's supplier diversity program reflects the goals of the most progressive health systems within our membership, Berryhill adds. "We plan to promote inclusion in such a way that our contracted suppliers mirror the diversity found in the communities served by our member hospitals." ●

Joey Dickson

For more on the HealthTrust supplier diversity program, contact Janet McCain at janet.mccain@healthtrustpg.com or Joey Dickson at joseph.dickson@healthtrustpg.com.

AN OPPORTUNITY OR A RESPONSIBILITY?

HEALTHTRUST MEMBERS OFFER A NEW DEFINITION OF HEALTHY FOOD

Hospital food often gets a bad rap—most people think of bland mashed potatoes, jello and mystery meat when they picture a patient's food tray. While that reputation may have been grounded in reality at one time, today's hospitals and healthcare systems are making a conscious effort to implement guidelines, programs and initiatives to ensure the food they serve patients, visitors and employees is much more nutritious than past offerings.

"Healthy food," according to Health Care Without Harm (HCWH), "cannot be defined by nutritional quality alone. It is the end result of a food system that conserves and renews natural resources, advances social justice and animal welfare, builds community wealth, and fulfills the food and nutrition needs of all eaters now and into the future." As such, it promotes "environmental nutrition." Hospitals have a unique opportunity and what many see as a responsibility to lead the charge by using food to prevent disease and improve the general well-being of people in the communities they serve.

However, many agricultural practices can negate food's nutritional value. To determine if food is truly healthy, it is necessary to consider how it was produced, processed and distributed. For example:

- More than 20 million pounds of antibiotics are used in agriculture every year, according to the Food and Drug Administration. The majority of these antibiotics serve to promote growth rather than treat disease. Routinely giving them to healthy animals raised for human consumption increases the prevalence of infection-causing, antibiotic-resistant bacteria.
- Animals in concentrated animal feeding operations (aka CAFOs) live in cramped conditions with no access to pasture, fresh air or light, thereby impacting their overall health.
- The widespread use of pesticides on the farms where animals live and breed also contributes to air pollution, putting livestock producers at risk of chronic health problems.
- Agricultural pesticides, plastics with chemicals (i.e., bisphenol A and persistent bioaccumulative and toxic substances, including methylmercury) are some of the many chemicals of concern touching today's food supply.

"HealthTrust food contracts offer cage-free eggs, antibiotic-free poultry, beef and pork products, as well as wild-caught fish products," says **Sam Potter**, senior director of food and nutrition procurement services at HealthTrust. Companies such as Dannon are even moving product lines toward clean-label, non-GMO and nonsynthetic selections.

Access healthier food resources within the sustainability page of the HealthTrust member portal.

FOSTERING A SUSTAINABLE FOOD SYSTEM

Local foods have been linked to several government priorities—including enhancing the rural economy, the environment, food access and nutrition, and supporting agricultural producers. In response to rising consumer demand for locally sourced products, many states have mandated a certain percentage of food be purchased locally as part of the 2014 Farm Bill.

In 2011, the Michigan Health & Hospital Association (MHA) asked nearly 150 hospitals across the state to sign and adopt the tenets of the Healthy Food in Healthcare Pledge, part of HCWH's initiative to help Michigan citizens combat the obesity epidemic. The MHA suggested hospitals commit at least 20 percent of their purchasing to Michigan-grown and sustainably produced food products. Hospitals in the Livonia, Michigan-based Trinity Health system complied, says **Joyce Hagen-Flint**, system director of food and nutrition services.

According to Hagen-Flint, the requirement for those signing the MHA pledge is to "buy local"—meaning products grown, manufactured or distributed by a local supplier. Trinity Health turned to Gordon Food Services, a HealthTrust-contracted supplier.

"Not only is Gordon a Michigan-based distributor, but it has a 'Near Here' program that promotes locally sourced products, many of which are contracted through HealthTrust agreements," Hagen-Flint explains. "This partnership is helping Trinity Health achieve the 20 percent goal that was established for Michigan hospitals."

Hospital Sisters Health System (HSHS) is committed to offering locally produced foods and beverages at its 15 hospitals across the Midwest, says **Rick Beckler**, director of environment at HSHS. "Our food department contracts specify that a minimum of 15 percent of our total spend has to be local. We're able to buy meat, bread, dairy and community favorites, such as coffee, from local farms. In the last six years, approximately 20 percent of our food spending has been locally sourced."

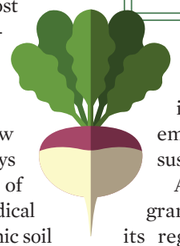
Each of those suppliers are within 150 miles of any HSHS hospital, in stark contrast to the average 1,500 miles that food is typically transported to reach its destination. Buying local not only supports the nearby economy and ecologies, but also helps reduce air pollution caused by carbon monoxide emissions from food trucks, which can lead to asthma and other chronic respiratory illnesses.

"We feel a responsibility to provide healthy, sustainable foods," Beckler says. "We want to ensure the food we're offering patients or selling to staff and visitors is following the highest standards for health, wellness and the treatment of animals. There are no hormones in our chicken, and our meats are Grade A."

HSHS is also dedicated to working with food suppliers adhering to guidelines of the 5-Step Animal Welfare Rating Program,

developed by the Global Animal Partnership to promote continuous improvement in animal agriculture and farming practices that are friendly to animal welfare, and the Monterey Bay Aquarium's Seafood Watch program, which facilitates the purchase of ocean-friendly seafood.

In the Northeast, Boston Medical Center is taking "local food" to a new level. Earlier this year, the hospital's first rooftop farm opened at the facility's power plant building. The farm is expected to produce almost 15,000 pounds of produce in 2017, most of which will go directly to hospital patients and their families, while reducing greenhouse gas emissions.



"From farm to fork, we know what's touching these crops," says **David Maffeo**, senior director of support services at Boston Medical Center. "We're planting in organic soil and washing the produce ourselves. We know there are no pesticides touching these products. Plus, we're growing food literally 1,000 feet from where we're serving it, so we're reducing greenhouse gas emissions. That's both healthy and sustainable."

According to Potter, "Our food program through Entegra—along with its regional partners throughout the country—offers our member facilities a variety of healthy and sustainable choices." Programs include a farmers market, where customers can purchase fresh and organic produce right at their hospitals. Facility or health system food service directors can set up the program according to their volume needs. Contact Sam Potter (**sam.potter@healthtrustpg.com**) for more information on these and other healthier food options available through HealthTrust contracted suppliers.

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OFFERING HEALTHY OPTIONS ON-SITE

Promote healthy choices by making these changes in the cafeteria at your hospital or corporate office:

> Place signage or labels near better-for-you choices. Use a "traffic light" system and put green labels near healthy choices, yellow near "in moderation" options, and red near non-healthy options.

> Ensure healthy choices are not more expensive than unhealthy choices.

> Don't offer free refills on sodas or carbonated beverages, a practice which helps cut back on the overconsumption of sugar.

> Provide a salad bar with fresh ingredients and healthy vinaigrette dressings and toppings.

> Skip fried foods and instead offer steamed, baked or grilled options.

> Offer alternatives to cream-based soups and fried vegetables.

> Provide a "healthy meal" discount (such as 10 percent off) to customers who choose more nutritious options. ●

HEALTHY SNACKS & BEVERAGES INITIATIVE

Research shows that sugar-sweetened beverages—including sodas, energy and sports drinks, and some fruit drinks and teas—are related to obesity as well as chronic diseases associated with weight gain. In addition, the production and waste associated with sugar-sweetened and bottled beverages have negative consequences for the environment. That's why Health Care Without Harm is challenging hospitals and health systems to participate in the Healthy Beverages Initiative, which aims to reduce the amount of unhealthy drinks on hospital grounds and encourages visitors, patients and staff to choose non-sugar sweetened drinks, with an emphasis on consuming water.

HealthTrust is helping member hospitals achieve these goals. "Our clients are seeking a balanced approach to wellness with simple ingredients that are lower in calories and sugar," explains **Sam Potter,** senior director of food and nutrition procurement services at HealthTrust.

One option is the Evive Wellness Station (**HealthTrust Contract No. 18085**), a beverage kiosk that cleans, sanitizes and refills a reusable bottle with purified or flavored water. Facilities can choose an employee payment plan or subsidize all or a portion of the cost for their employees. Facility employees receive an Evive reusable bottle that is embedded with an RFID tag that unlocks their member profile, which tracks personal hydration goals, monitors results via wearable technology, and encourages competition with colleagues.

In addition to the Evive Wellness Station, HealthTrust offers Entegra's Pepsi Right Fit program (**HealthTrust Contract No. 683**) to hospitals wanting to supply healthier beverages and snacks within their facilities, Potter adds. The program offers water, Naked juices, Gatorade, SoBe LifeWater and Muscle Milk at prices comparable to that of the sodas and other sugar-added beverages they are replacing. Frito-Lay (a subsidiary of PepsiCo) pairs its healthier snack varieties—such as oven-baked chips and Smartfood Popcorn—with the Right Fit beverages. These, when retailed in hospital cafeterias, both offer customers healthier alternatives and generate additional revenues. ●

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PROMOTING HEALTHIER CHOICES

Healthcare professionals are consistently ranked as some of the most trusted authorities on health and wellness—and that means they have a responsibility to educate and motivate consumers to make food choices that are healthy for themselves and the environment. At Boston Medical Center, individuals with specific nutritional needs are referred to the hospital's Preventive Food Pantry by primary care providers who write "prescriptions" for supplemental foods. There, patients and their families can stock up on perishable goods, such as fresh fruits and vegetables, which are grown on the rooftop farm.

"A large portion of our patient population is underserved," Maffeo says. "About 7,000 patients and their family members visit the pantry each month."

In addition to the Preventive Food Pantry, Boston Medical Center has a demonstration kitchen where it teaches pantry visitors how to cook the items they pick up and accommodate any dietary restrictions. The kitchen is open to anyone, including hospital employees, who want to learn the ins and outs of cooking healthy.

"Many people come to the hospital and learn they need to change their nutritional habits, but they don't know where to start," Maffeo says. "We're able to teach people how to change their lifestyle by changing their diet."

Hospitals don't have to offer a food prescription program to promote healthy eating. Here are six ways they can encourage people to make smart food choices that benefit both their health and the environment:

1. **Make over the hospital menu.** Replace canned and prepackaged foods, which are often riddled with sodium and sugar, with organic fruits and vegetables that are free of additives. Canned fruits and vegetables are banned from HSHS, where only fresh produce gets served, Beckler notes.

2. **Decrease the amount of meat purchased.** On average, Americans eat about 56 pounds of red meat per year, according to the U.S. Department of Agriculture. High consumption of meat fats and processed meats is linked to an increased risk of obesity, diabetes and cardiovascular disease. Seek out companies that raise grass-fed beef and don't routinely pump animals with antibiotics.

3. **Rethink your seafood options.** The ocean's fish population is declining,

Continued on page 50

FOOD LABELS AND CERTIFICATIONS

Meat and poultry that have been produced without the routine or non-therapeutic use of antibiotics carry one or more of the following labels or claims:

- USDA Organic
- American Grassfed Association
- Animal Welfare Approved
- Certified Humane Raised & Handled
- Food Alliance Certified
- Global Animal Partnership
- USDA Processed Verified Program shield along with labels such as "Raised Without Antibiotics," "No Antibiotics Added" or "Never Ever 3"

Check to make sure the certification has:

- Clearly stated principles and criteria
- Measurable and transparent (publicly available) standards
- Third-party verification
- Improvements to standards as science, technology and markets allow

Seafood that has been raised or caught sustainably will carry one or more of the following labels:

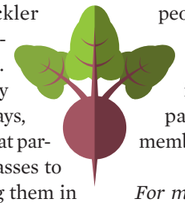
- Farmed Responsibly Certified (Aquaculture Stewardship Council)
- Best Aquaculture Practices Certified
- Friend of the Sea
- Certified Sustainable Seafood (Marine Stewardship Council)

Continued from page 48

but the demand for seafood is growing rapidly. Today, over half the fish we eat comes from aquaculture, or fish farms, which are not without their faults. Fish farms are overpopulated, meaning fish—and their waste—are crowded together. Antibiotics, hormones and pesticides are required to avoid diseases caused by overcrowded conditions. Purchase seafood from environmentally responsible providers or farms. Boston Medical Center, for example, partners with the Gloucester Fishermen's Wives Association to help preserve the Atlantic Ocean and bring fresh seafood into the hospital, Maffeo says.

4. **Banish fried foods.** "We just opened a new hospital in Southern Illinois, and we didn't include a deep fryer in the cafeteria," Beckler says. "While people still want deep-fried food, we're slowly moving them to healthier options. The food industry now offers many appetizing products that can be baked, grilled or steamed."

5. **Offer communitywide cooking and nutrition classes.** "We do a lot of cooking classes both in the community and in our kitchens," Beckler says. "Typically patients are educated on their prescribed diets. We share recipes featuring quality ingredients and, during the holidays, healthy options they can choose at parties and events." If you offer classes to employees, consider advertising them in the hospital's internal newsletter. Classes that are open to the larger community can be promoted by placing flyers around the hospital's public areas, an ad in the local newspaper or posts on social media. Encourage attendees to share photos or post to social media on event day.



6. **Work with community-supported agriculture (CSA) groups and farmers markets.** Help make fresh, healthy food more accessible by hosting farmers markets and CSAs on hospital grounds. Giving people the option to buy healthy foods on-site is a win-win—it helps support community farmers and also impacts the eating habits of patients, hospital employees and members of the community. **S**

For more information on healthier and sustainable food options available through HealthTrust contracted suppliers, contact Sam Potter, senior director of food and nutrition procurement services, at **sam.potter@healthtrustpg.com**.

Your Patients
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TEAMWORK TOOLS

YOUR **Q4 GUIDE** TO BALANCING WORKFORCE NEEDS AND INSPIRING OTHERS THROUGH SERVICE-MINDED LEADERSHIP

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MANAGEMENT MATTERS: HealthTrust Workforce Solutions partnered with St. Luke's University Health Network in Pennsylvania to implement an automated productivity system, making it easier for leaders to match staffing to patients and ensure optimal care.

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LEADERSHIP LINK: Raymond Rodriguez, M.D., serves as a role model for his cardiac patients, empowering them to make fitness a part of their lifestyle. He also inspires his healthcare colleagues by devoting time each year to medical mission work.

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The Art and Science of Workforce Management

HealthTrust Workforce Solutions Balances Facilities' Needs in a Complex Healthcare Labor Market

In today's complex healthcare environment, including one of the largest nurse shortages in history, labor often presents the greatest challenges. An aging population, coupled with higher overall usage of healthcare services, will continue to escalate the need for qualified medical professionals.

According to the U.S. Bureau of Labor Statistics, the demand for registered nurses is expected to expand 14 to 16 percent between 2015 and 2021. Yet about 55 percent of today's nursing workforce is 50 or older and approaching retirement age. While there are 2.7 million RNs working in the United States, another 500,000 unfilled nursing positions are being advertised at any given time—making nursing one of the hardest to fill and most frequently posted job openings in the nation.

"Labor is often the single largest expense for healthcare organizations," says **Tony Pentangelo**, executive vice president of managed clinical services, HealthTrust Workforce Solutions. Hospital operators are already stretched thin with responsibilities to enhance patient care, boost workforce satisfaction and lower overall costs. Add to that list: grappling with the nursing shortage and limited visibility into scheduling, as well as staffing and productivity levels, and managing contingent labor overall.

COMBATING WORKFORCE CHALLENGES

Healthcare leaders need proven strategies to help them manage and overcome their workforce-related challenges. The HealthTrust Workforce Solutions team offers a data-rich approach to improving employee and patient satisfaction, and workforce efficiencies, including:

> inSight Advisory Services. Management and nursing professionals serving with Workforce Solutions' inSight Advisory Services team are knowledgeable about staffing ratios and how to best utilize staff based on the level of care a unit requires.

"Our professionals consult with hospital leaders about their patient volume, scheduling processes and overall workforce planning," says **Rich Lopez**, vice president and business unit leader, inSight Advisory Services, HealthTrust Workforce Solutions.

The team starts by analyzing a hospital's current scheduling practices, staffing levels and labor productivity metrics. "We measure that information against departmental benchmarking data from high-performing hospitals around the country of all types and sizes," Lopez explains.

After analyzing the data, the inSight Advisory Services team makes recommendations designed to improve productivity, beginning with workforce planning and scheduling processes, including:

- Labor productivity and optimization programs
- Scheduling and productivity technology
- Best practices for scheduling effectiveness
- Design and management of a more efficient float pool to fill staffing shortages
- A management engineering department to provide on-site monitoring, education and assistance with workflow improvement
- Potential adjustments to recruitment practices

Many solutions are enhanced by HealthTrust's web-based labor management technology, which builds schedules around forecasted patient volumes and aligns with approved staffing grids to meet labor budgets and productivity targets. The final piece of the puzzle is a daily productivity monitoring system that allows managers to make timely adjustments if staffing levels are not in line with goals.

> Managed Services Programs and Contingent Labor Management. Sourcing and managing today's healthcare workforce is also challenging because of the scarcity of nurses with specialty skill experience. These external market forces all heighten hospitals' need to engage contract labor. Critical clinical vacancies can lead to an increase in the utilization of premium labor, nurse dissatisfaction and turnover. Productivity challenges can also easily trickle down into decreased patient satisfaction scores.

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Some facilities have a hard time even determining how many contract labor employees are on-site at any one time and how these employees were sourced, hired and onboarded. As the industry's largest healthcare managed services program (MSP) provider, HealthTrust can help hospitals and other healthcare organizations improve visibility to contingent workforce utilization and optimization so they can improve their labor processes.

More strategically managing contract labor can help address clinician shortages, says **Jim Davis**, senior vice president of MSP and strategic accounts, HealthTrust Workforce Solutions.

"Using this and other best practices that have been refined within the walls of leading hospitals, we assist healthcare organizations in first understanding and then implementing solutions to address their workforce issues—whether it be clinician shortages, scheduling problems or productivity lags."

When it comes to filling short-term positions, HealthTrust's MSP serves as an extension of existing supply chain management and talent acquisition teams, featuring a web-based platform that helps engage contingent labor. Because the MSP is funded by suppliers, hospitals can fulfill staffing needs without incurring additional costs.

PARTNERING FOR A BETTER POSITIONED WORKFORCE

HealthTrust Workforce Solutions recently partnered with St. Luke's University Health Network, a 972-bed nonprofit health system in Pennsylvania, to meet its staffing goals while elevating some of the economic pressures caused by rising costs and diminishing payments and reimbursements.

St. Luke's managers spent a considerable amount of time on a daily basis addressing the staffing needs of their units for the next 12 to 36 hours. A positive attitude and teamwork spirit existed within the system, with departments routinely sharing staff across the six-hospital network. But there was little process or discipline applied across the staffing and scheduling continuum, resulting in overstaffing one day and understaffing the next. This policy had the potential to damage morale and loyalty, create inefficiencies and threaten the health system's commitment to effective operations and excellent patient care.

Workforce Solutions identified a need to produce a smoother and more predictable work life for St. Luke's staff that was less wasteful and better supported the organization's goals. HealthTrust's inSight Advisory Services team started by conducting a labor productivity assessment that included interviews with more than 100 managers across the six hospitals, an analysis of scheduling processes and systems, and a study of productivity benchmarks at the department level.

Among inSight Advisory Services' recommendations was for St. Luke's to develop a volume forecasting process, and to determine core, average and peak staffing requirements for each department that would become the basis for hiring plans.

> "With good systems and tools in place to educate our managers, HealthTrust made us a better organization. The process helped us understand that staffing management is both an art and a science." **Ed Nawrocki**, president, St. Luke's Hospital, Anderson Campus

The team also suggested the development of a central staffing center and nursing PRN pool. Finally, to increase labor productivity performance, HealthTrust proposed that daily productivity monitoring systems and tools be employed in all departments to support improvement initiatives.

After implementing inSight Advisory Services' recommendations, St. Luke's was able to reduce its staff productivity challenges across the network by 20 percent. It accomplished this without cutting any positions; instead, St. Luke's adjusted the way it managed staffing levels in every department to better target the workforce to the workload.

Ultimately, St. Luke's was able to strengthen a daily productivity infrastructure and implement an automated productivity system, leveraging technology and improving manager knowledge on best practices for scheduling. St. Luke's department managers now have a timely, accurate snapshot of their real-time daily needs, allowing them to match staffing to patients to ensure optimal care.

"With good systems and tools in place to educate our managers, HealthTrust made us a better organization," says **Ed Nawrocki**, president, St. Luke's Hospital, Anderson Campus. "The process helped us understand that staffing management is both an art and a science.

"Our managers now have the labor productivity strategies and knowledge to manage staffing in a disciplined, unified way," he adds. "We no longer spend time debating our data; we simply take action. HealthTrust rates 5 out of 5 for staffing management and approach." ●

HealthTrust Workforce Solutions also offers contract staffing and recruiting services such as travel and per diem staffing, local contracts, interim leadership, permanent placement, locum tenens, physician search and international nursing. For more information on any of these solutions, contact Cheryl Rhody at cheryl.rhody@healthtrustws.com or visit healthtrustpg.com/workforce.

Q&A With Raymond Rodriguez, M.D.

Fitness, Missions & the HealthTrust Physician Advisor Program

An ultra-marathoner and eight-time marathon runner, **Raymond Rodriguez**, M.D., serves as a role model for his cardiac patients, inspiring and empowering them to make fitness a part of their lifestyle. In an interview with *The Source*, Rodriguez talks about his practical ideas for improving population health, his passion for medical missions work in the Dominican Republic and his plans to assist members as a HealthTrust physician advisor.

In what ways are you improving healthcare on a micro level?

I operate a very patient-centered practice. When sick patients walk in unexpectedly, it doesn't throw us a curveball. I've trained my staff to ask specific questions to help determine if we need to accommodate them immediately, or if they can wait.

Through this simple process we're able to identify some very ill patients who need to be hospitalized. Recently, a 50-year-old man showed up at the office on a Friday morning and told my receptionist he wasn't feeling well. After asking our preliminary screening questions, she realized he needed to be seen right away. I examined him and saw that he was having a heart attack. We rushed him to the hospital, where he underwent a heart catheterization and coronary stenting for two major blockages. Thankfully, he's OK.

Whenever an incident like this happens, we convene a flash huddle to review what we did well and what, if anything, we could have done better.

How about improving healthcare on a macroscale? What would you like your role to be?

Fitness is a huge focus of mine, and I believe it can play a major role in improving a population's health. However, I became acutely aware a few years ago that many people know they need to get into shape but they don't know how to do it. If they have arthritis or other chronic conditions, it complicates the process further.

When I worked at the University of Pennsylvania, an exercise physiologist and I ran a popular "Walk in the Park With Your Cardiologist" beginner fitness program. We helped patients make walking one of their healthy habits. Each group was composed of 10 people, many in their 50s, 60s and 70s with heart problems.

The program included 30–40 minutes of education on cardiovascular fitness. I

Raymond Rodriguez, M.D. is a board-certified, non-invasive cardiologist and serves as medical director of Mount Sinai Cardiology of the Florida Keys in Marathon, Florida. He also serves as an assistant professor of medicine at the Columbia University Division of Cardiology at Miami Beach, Florida-based Mount Sinai Medical Center.

Previously, Rodriguez held a similar appointment with the University of Pennsylvania, where he practiced for more than 20 years. He was affiliated with multiple hospitals in the Philadelphia area, including Abington Hospital-Jefferson Health, Chestnut Hill Hospital and Penn Presbyterian Medical Center.

Rodriguez earned his medical degree at Georgetown University in Washington D.C., and completed his internship and residency in internal medicine and a cardiology fellowship at Thomas Jefferson University Hospital in Philadelphia. He is a fellow of the American College of Physicians and the American College of Cardiology, and a member of the American Medical Association, American College of Sports Medicine and Chest Pain Society.

answered questions the average non-athletic person tends to ask, such as: What is aerobic exercise? Should I stretch before and after I exercise and, if so, how? What's the best way to cool down? How long and intense should the workout be? We also talked about practical matters, such as what kind of shoes to buy and clothes to wear.

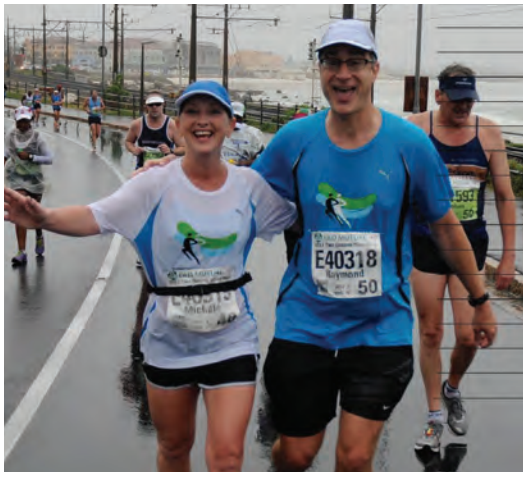
Each session ended with a two-mile walk in a beautiful park. Even though it was only a four-week course, individuals within the groups formed friendships and continued to meet after the formal program was over.

What does it mean to be a fitness role model for your patients?

I wasn't very athletic until 12 years ago, when a patient inspired me to run a marathon. The training journey taught me a lot about fitness and exercise physiology, and the mechanics and psychology of running. The first marathon really was a life-changing event for me.

I've done eight marathons since. Four years ago, my wife, Michele, and I did the Two Oceans Ultra Marathon in Cape Town, South Africa. It's a 36-mile route across the Cape of Good Hope from the Indian to the Atlantic oceans. It was extremely challenging, but I'm so proud to have done it.

Even after all the races, I still don't like to run when my alarm goes off at 6 a.m., but I like how I feel when I'm done. My days always start off better. I often share this anecdote with my patients so they know it's normal not to always love exercise.



Rodriguez with his wife, Michele, after running the Two Oceans Ultra Marathon in Cape Town, South Africa

How do you motivate your patients on their fitness journeys?

Instead of telling my patients to exercise, I tell them to focus on being FIT, an acronym for frequency, intensity and time devoted to an activity. I ask for 20 minutes of cardiovascular activity five days a week. Then I tell them they can organize the rest of their lives into the other 23 hours and 40 minutes of the day.

Another important part of the FIT equation is regularity. Even a trained Olympian athlete starts to decondition after four days of not participating in aerobic activity. Naturally, when we non-Olympians go on vacation for a week or stop exercising because we have a cold, it hurts to go back to working out. I tell my patients bluntly that they should avoid missing more than a week of

their fitness program—that's often when people fail.

The final piece of the puzzle is accountability. I encourage my patients to find an accountability partner to help give them the jumpstart they need and provide motivation when challenges come up.

Rodriguez with his Somos Amigos Medical Missions colleagues in the Dominican Republic

What does medical mission work mean to you?

I've been on five trips with Somos Amigos Medical Missions, which serves a remote, mountainous village of 300–400 people in the Dominican Republic that lacks access to medical care.

The program is unique because it's focused on medical volunteers going into the same community with the goal of long-term healthcare management. For a week, from sunup to sundown, our team sees all types of patients—from young children and pregnant women to 80-year-old men. We live with the community, eat local food and sleep in mountain houses, most of which don't have indoor plumbing. It's a powerful experience because we really get to know the patients by living among them.

We come back home exhausted, but it's such a rewarding experience professionally and personally. In almost every trip, I diagnose some kind of congenital heart disease, even with basic cardiology tools. It definitely grounds me, as well as reminds me of how fortunate we are in this country.

Why were you interested in becoming a HealthTrust physician advisor? What are your initial impressions after a few months "on the job"?

A colleague of mine at the University of Pennsylvania was a member of HealthTrust, and he talked about the mission of the organization. I thought it was intriguing because of my interest in healthcare projects that change the paradigm and physician leadership education.

I have been incredibly impressed with HealthTrust's clinical evidence reviews. They're well researched, concise and practical, referencing documents and abstracts presented at the American College of Cardiology and American Heart Association meetings. I can complete my analysis in an hour, rather than spending 10 hours on my own to reach the same conclusions.

How have you contributed to HealthTrust's work in the cardiovascular specialty area?

Most recently, I provided input on atherectomy catheters and devices used in the treatment of chronic total occlusion. For many of these devices, I was able to tap the opinions of my colleagues across the country. Even if I'm not familiar with a device being evaluated, I'm able to glean a variety of opinions within the field to gain a broader, more balanced perspective that helps me formulate my response to a HealthTrust inquiry. The process certainly keeps me on the cutting edge, which helps make me a better physician.

What's your view on HealthTrust's product review process?

I admire HealthTrust for recruiting a wide spectrum of physician advisors and promoting deep dives into products. I've been amazed by the almost universal response to questions about particular products or devices, even across different institutions and geographic locations. Having a consistent voice from physicians who are actually using the devices becomes very powerful. If other physicians want to ignore the consensus reached by these physician advisors, they must have a really good reason.

What do you see as one of the biggest healthcare challenges facing physicians today?

The push for electronic medical records has negatively impacted physicians, particularly senior physicians. I see so much physician burnout and discontent, and less clinical activity. But, they're not alone—I recently polled 20 medical residents and asked, "In a 10-hour day, how much time are you spending on your computer versus spending with patients?" The near-universal response was "I spend eight hours a day on computer work and two hours a day interacting with patients." That's just wrong. For physicians to understand the nuances of their patients' health, they need to maximize face-to-face interactions with patients. The move away from that is frightening. ●

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THE OPIOID EPIDEMIC

As healthcare providers wrestle with the opioid epidemic, initiatives within HealthTrust **member hospitals are pointing the way toward a future where patients don't have to choose between pain relief and possible dependency on or addiction to opioids.**

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CONFRONTING A CRISIS

2017 HealthTrust Innovation Grant winner battles drug epidemic with perioperative opioid stewardship program

In 2014, providers wrote nearly a quarter of a billion opioid prescriptions. The intention may have been noble—to alleviate patient pain—but the fallout has been devastating. Since 1999, sales of opioid prescriptions have quadrupled, and so have overdose deaths involving prescription opioids.

As the government and other public health agencies sound the alarm on this nationwide crisis, healthcare providers around the country are looking at the role they can play in curbing the opioid epidemic. At San Diego-based Scripps Health, a multidisciplinary team of clinicians has developed an opioid stewardship program (OSP) that aims to fundamentally change the attitudes and expectations prescribers, nurses, patients and their at-home caregivers have about pain and how it should be managed.

As the winner of the 2017 HealthTrust Innovation Grant, the Scripps Health team—**M. Jonathan Worsey**, M.D., and **David Dockweiler**, M.D., co-chairs of the surgery care line; **Valerie Norton**, M.D., chair of the systemwide pharmacy and therapeutics council; **Melissa Flaherty**, PharmD, clinical pharmacy director and co-chair of the systemwide pharmacy and therapeutics council; and **Emily Hernandez**, RN, MSN, clinical resource specialist in supply chain—received a $25,000 cash award and $25,000 in HealthTrust service line expertise to help launch this important program and support sharing it across the HealthTrust membership.

The overarching goal of the OSP is "to decrease the amount and duration of opioid usage in an organized way across the spectrum of care, in response to the ongoing opioid epidemic," Worsey says. And his health system is clearly on board: After a formal presentation by Flaherty and Norton, Chief Medical Officer **Jim LaBelle** and the rest of the Scripps Health leadership team quickly endorsed the opioid stewardship approach. Dockweiler took on the task of educating fellow physicians during grand rounds, and Norton, Worsey, Flaherty and the OSP's Executive Sponsor **Lisa Thakur** (corporate vice president of OR, pharmacy and supply chain) worked to achieve buy-in for the program across the enterprise.

"Our medical staff has been overwhelmingly supportive and passionate about this initiative, raising the awareness and our call to action among their peers," Flaherty says.

IAN CUMMINGS

"This is as much about changing patients' expectations of pain as it is about changing prescribing habits that are decades in the making."

M. Jonathan Worsey, M.D., co-chair of the surgery care line, Scripps Health

THE CATALYST FOR CHANGE

The idea for the initiative emerged last spring after the team participated in the HealthTrust Perioperative Pain Management Collaboration Summit, which brought clinical leaders from five health systems together to create provider-specific action plans for building programs to manage surgical pain using fewer opioids. (*See story on page 70 for an update on what other participating health systems have accomplished since the summit.*) During the two-day event, the role of healthcare professionals in the opioid crisis was a key component of the discussion.

"Before the summit, we knew there was an opioid epidemic, but saw it more as something that affected chronic pain patients," Norton says. "We hadn't wrapped our heads around the fact that providers might actually be creating some of these dependency situations in opioid-naive populations. The summit really opened our eyes to this and let us see that we can play a pivotal role in prevention."

Scripps Health leaders developed the OSP with five key factors in mind:

1 Opioid overuse and misuse is often a healthcare-acquired condition, one that Scripps Health has no formal program to address.

2 Six percent of opioid-naive patients become chronic opioid users after routine surgery.

3 Orthopedic spinal surgeons are challenged with patients who have chronic pain syndrome prior to spinal surgery; these patients are among the most complex in terms of perioperative pain management, and remain difficult to manage after surgery. Scripps does not have the specialty resources to support these patients perioperatively and thereafter.

4 Lawmakers and payers are setting refill limits on opioids and requiring prior authorization to renew prescriptions for ongoing pain.

5 The Joint Commission recently announced new and revised pain assessment and management standards, including requirements for safe opioid prescribing, effective Jan. 1, 2018.

CHANGING PATIENT EXPECTATIONS

The first wave of OSP implementation is focused on preventing surgery patients from becoming chronic opioid users. At the heart of the initiative is a series of education-oriented interventions delivered across

IAN CUMMINGS

"Before the summit, we knew there was an opioid epidemic, but saw it more as something that affected chronic pain patients. We hadn't wrapped our heads around the fact that providers might actually be creating some of these dependency situations."

Valerie Norton, M.D., chair of the systemwide pharmacy and therapeutics council, Scripps Health

episodes of care—starting with a patient's initial visit to the hospital or physician's office—and continuing for three months after surgery.

These interventions will help set realistic expectations of postoperative pain and ensure a clear understanding of the side effects of opioids, including the potential for addiction, abuse and diversion. Patients will be contacted at 30, 60 and 90 days; asked about continued opioid use and potential side effects; and counseled on the safe disposal of unused opioids.

"Many patients think they should have no pain after surgery, and that if they do, we're not doing our jobs," Norton says. "Through these educational materials, we want to show them that some pain after surgery is normal, the risks associated with opioid use are real, and there are other ways to manage pain that don't involve opioids."

The team plans to use the grant funding from HealthTrust to partially offset the cost of producing the patient education materials, which will include print brochures and videos tailored to different types of patients. A former newscaster working in the Scripps Health education department is even preparing a short informational video for posting on YouTube.

Initially, the focus will be on general and gynecological surgeries that are part of the enhanced recovery after surgery (ERAS) pathway. "ERAS is a good starting point because rapid recovery protocols already promote the use of multimodal pain management over opioids," Worsey says. "Research shows that opioid overuse or prolonged use slows recovery time, lengthens hospital stays and increases the risk of complications."

David Dockweiler, M.D., co-chair of the surgery care line, Scripps Health

REFORMING PRESCRIBER HABITS

In addition to developing educational materials targeted to patients, the team will also work to change the mindsets and prescribing habits of clinicians.

"This is as much about changing patients' expectations of pain as it is about changing prescribing habits that are decades in the making," Worsey adds. Some of the overprescribing of opioids can be traced to 1996, when the American Pain Society declared that pain was the fifth vital sign—and that it was being undertreated. As a result, in 2001 The Joint Commission established its first standards for pain assessment and treatment.

"After the standards were published, physicians responded appropriately by prescribing more pain medication, predominantly opioids," Worsey says. "This has clearly contributed to the problem we have now. It's time to change the way physicians think about pain."

Nurses need a fresh perspective, too, Hernandez says, since they are often the ones assessing pain and dispensing medications.

"As nurses, we've always been grateful to receive an opioid prescription for our patients in pain," Hernandez says. "Now, we're asking patients to tolerate a bit more pain and be open to other treatment options. That's a huge shift; the challenge will definitely be in how best to communicate this for understanding and acceptance."

Scripps Health is assembling an opioid stewardship committee, composed of physician champions like Norton, Worsey and Dockweiler; pharmacists and nurses; and other clinicians from across the enterprise, including those in primary care, emergency medicine, anesthesiology, surgery and hospice care. The committee will be tasked with developing and disseminating patient and clinician education, as well as creating enterprisewide policies to identify patients at high risk of opioid abuse. It will also be responsible for tracking outcomes related to the initiative. Pharmacists will drive appropriate tapering schedules for postoperative opioid use and encourage the use of non-opioid pain relief options, among other interventions for acute, post-acute and ambulatory patients.

Norton has developed a newsletter for physicians and nurses that talks about goals of the opioid stewardship program, the role of clinicians in preventing addiction and effective non-opioid pharmaceutical cocktails. The newsletter includes program mantras such as "Opioids are not benign," and "Complete pain relief is not a reasonable or healthy goal: We need to reset patient expectations."

MEASURING SUCCESS

Moving forward, post-discharge phone calls with surgical patients will track if and when prescribed opioids were discontinued, Worsey says. Opioid use and adverse events related to opioid consumption in the hospital will be tracked and compared to historical data on matched patient populations. Readmissions or ED visits for opioid-related issues in these patients will also be measured. And, to provide feedback from the perspective of patients, a survey will be developed to evaluate satisfaction with postoperative pain management and perceptions of multimodal pain management.

Melissa Flaherty, PharmD, clinical pharmacy manager and co-chair of the systemwide pharmacy and therapeutics council, Scripps Health

Scripps Health will also provide instructions on how patients should dispose of excess pills to eliminate the risk of their diversion to someone else, including teenagers or anyone with access to leftover medicines. Meanwhile, prescribing physicians will monitor California's Controlled Substance Utilization Review and Evaluation System (CURES) for one of the early telltale signs of addiction—doctor-shopping for more opioids.

While Norton acknowledges that opioid stewardship will require a shift in patient expectations, she doesn't expect it to have a negative impact on patient satisfaction.

"Studies have shown that when we take the time to explain our decisions, patients get the message that we are concerned about them," she says. "This is not us being punitive. We care, which is why we want to limit their exposure to opioids."

The challenge will be getting this message across clearly and consistently, which Worsey says is aided by more and more patients realizing the gravity of the opioid epidemic.

"The response of our colleagues has been amazing," he says. "Without exception, they want to know how they can help."

LONG-TERM GOALS

By next summer, Norton expects all ERAS patients to have access to the patient education materials. Eventually, the program will expand to spine surgery and orthopedics. The team wants to develop similar prevention content for nonsurgical patients, including those in inpatient, ambulatory and emergency settings, as well as a standardized approach to managing patients who are already opioid-dependent.

"We'll look to create better connections with pain specialists and addiction medicine specialists around the county," Worsey says, "and educate our colleagues about resources to help patients experiencing withdrawal symptoms." ●

IAN CUMMINGS

"We must help everyone see that addiction is not a character flaw—it is a chronic illness that we must approach with the same skill and compassion with which we approach heart disease, diabetes and cancer."

Vivek H. Murphy, M.D., MBA, Surgeon General, U.S. Department of Health and Human Services, November 2016

IAN CUMMINGS

"As nurses, we've always been grateful to receive an opioid prescription for our patients in pain. Now, we're asking patients to tolerate a bit more pain and be open to other treatment options. That's a huge shift; the challenge will definitely be how to properly communicate this for understanding and acceptance."

Emily Hernandez, RN, MSN, clinical resource specialist in supply chain, Scripps Health

HealthTrust Members Take On the Opioid Epidemic

AWARENESS AND EDUCATION INITIATIVES UNDERWAY

Health systems participating in the inaugural HealthTrust Perioperative Pain Management Collaboration Summit in April 2017 have made significant progress in raising awareness of the risks posed by prescription opioid drugs—notably, unpleasant side effects that include chronic use and dependency. Understanding current prescribing patterns and opportunities to use non-narcotic alternatives are among the investigative tasks currently underway.

As originally envisioned, the objective of the summit was for participants to use clinical evidence and best practices to develop organization-specific strategies for implementing multimodal approaches to managing surgical pain. But, as described by **Michael Schlosser**, M.D., MBA, FAANS, chief medical officer (CMO), HCA National Group and vice president, Clinical Excellence and Surgical Services at HCA, the conversation quickly shifted to "ways to change the pervasive and damaging culture of reflexive prescribing for pain management that exists among many providers across the country." (*Read more of Schlosser's thoughts in "The Case for Confronting Long-term Opioid Use as a Hospital-acquired Condition," a Sept. 8, 2017, post he coauthored for healthaffairs.org/blog.*)

HCA Healthcare is one of two health systems at the event that have launched a major education initiative to help address the disturbing national trend of opioid addiction that often begins with a surgery. The other is San Diego-based Scripps Health, whose opioid stewardship initiative was awarded the 2017 HealthTrust Innovation Grant. *(See article on page 66.)*

First steps taken by Brentwood, Tennessee-based LifePoint Health included presenting enterprisewide data on prescriptions per 100 patient ED encounters—looking at all controlled substances, not just opioids—at its biennial Executive Patient Safety Conference in June, which also featured a breakout session on the opioid crisis, says National Medical Director **John Young**, M.D., MBA, FACHE. The conference had approximately 600 attendees, including CEOs, COOs, CMOs and CNOs from most of its 70+ facilities.

FOCUS ON JOINT REPLACEMENTS

Leaders at HCA's TriStar Centennial Medical Center, including President and CEO **Scott Cihak** and CMO **Divya Shroff**, M.D., have enthusiastically embraced the idea of wholesale culture change around the way pain is viewed, assessed and treated, according to summit attendee **Jeffrey Hodrick**, M.D., an orthopedic surgeon with Nashville, Tennessee-based Southern Joint Replacement Institute (SJRI).

The hospital is working to identify the most effective pain management regimen for its patient population, which is expected to involve fewer narcotics. SJRI surgeons have created a database that allows them to make changes to prescriptions on the fly based on how well patients' pain is being managed, he explains. Currently under investigation is a perioperative phamaceutical cocktail of certain pain medicines, which gets injected around the knee or hip being replaced and

ISTOCK

appears to decrease the need for narcotics in the postoperative period. The doctors are also researching the benefit of using the older intravenous anesthetic ketamine, especially for patients known to be chronic narcotic users.

Aromatherapy has already been embraced as a pain-reducing strategy by surgeons at SJRI, Hodrick says. Other alternative pain management practices commonplace in obstetrics and oncology, including massage and acupuncture, are also being explored for use in the surgery setting.

According to data pulled from Tennessee's Controlled Substance Monitoring Database, orthopedic surgeons at SJRI aren't currently overprescribing narcotic pain medicines at discharge, Hodrick says. But that's the baseline for measuring the impact of ongoing initiatives. The biggest opportunity overall will be in preventing diversion of opioids from the individual for whom they were prescribed to another person—often a loved one at home—for illicit use. That highlights the need for patient education about how to securely store and safely dispose of unused narcotics, as covered during the U.S. Drug Enforcement Administration's annual Prescription Drug Take Back Day.

In the near future, Hodrick says he hopes to see greater adoption of a functional pain scale for joint replacement patients that would limit the prescribing of pain medicines to instances where they're truly needed—e.g., those who have trouble getting out of bed or engaging in physical therapy. "There's a big difference between being uncomfortable and being totally incapacitated by pain, which I don't think describes a lot of our patients."

A large in-service event was recently held to educate nurses on how to identify, diagnose and treat opioid withdrawal symptoms, Hodrick says. Eventually, much of what is being piloted with joint replacement patients may be rolled out more broadly across TriStar Centennial Medical Center. Some of the key principles—e.g., use of medicines that are non-narcotic, non-systemic and have no addictive properties—would apply, irrespective of the surgical population.

On the patient education front, TriStar Centennial and Dr. Hodrick hosted a communitywide event in late October as part of National Prescription Drug Take Back Day. A brochure designed to raise awareness of the opioid epidemic and the potential for misuse and addiction of narcotic pain relievers is expected to be ready for distribution across the hospital and its associated clinics by the end of this year.

Hodrick notes that he is keeping TriStar Centennial's Joint Replacement Council apprised of progress. It's a large, diverse group that includes hospital administrators, surgeons, nurse managers, operating room managers, case managers and environmental services, each of whom provides support as needed for the various pain management initiatives. Hodrick is also serving as a subject matter expert at some of the upcoming regional pain summits HCA Healthcare has planned around the country. The objective is for HCA

hospitals and divisions to develop specific action plans for balancing patient comfort and safety, and a process for continued collaboration well into the future.

STARTING IN THE EMERGENCY DEPARTMENT

The aggregated data presented at LifePoint's recent patient safety conference revealed what has been reported in related literature—notably high variability across prescribers and states, Young says. This includes a proportionately higher level of opioid prescribing in rural, less socioeconomically advantaged states where LifePoint has a market presence.

Facility-specific data on the same metric (controlled substances prescribed per 100 patient ED encounters) was shared by one LifePoint hospital, pointing to a quantitative reduction in its opioid prescribing rate after issuing a guidance document on how to do so responsibly. LifePoint's newly authored national guidance statement for EDs was revealed at the conference and disseminated across the enterprise in July. Tracking of its implementation and adoption is now underway, says **Carly Feldott**, PharmD, MS, CPPS, director of medication management informatics.

"We realize there's much more to do beyond the ED space," Feldott says. "It was just a really good starting point because we had the interest and buy-in from our ED Physician Guidance Council." The group, national in scope and representation, had already begun working on a number of quality improvement initiatives that include standardizing the approach to managing painkillers and opioids.

At the corporate level, a new multidisciplinary Opioid Stewardship Committee is meeting monthly to guide efforts moving forward, Young explains. In addition to himself, it includes Feldott and other representatives from the IT clinical team, as well as subject matters experts from the quality department, pharmacy operations, surgical services and the ED. Upcoming initiatives include developing a multimodal pain management order set, reviewing the latest Joint Commission guidelines for pain management and assessment, and identifying appropriate milestones and metrics around opioids for the ED and surgical service lines.

The director of surgical services, Young adds, is also very interested in developing enterprisewide guidelines or strategy for enhanced recovery after surgery (aka ERAS) programs. Currently, just a few LifePoint hospitals have a program of this type.

Efforts will "slowly but surely extend into the realm of primary care," Young notes. "We'll need to take inventory of who within that space is licensed to treat opioid withdrawal. Right now, there is a national shortage of physicians who have this additional training and licensure."

The national guidance statement offers some suggestions for speaking with patients about pain, limitations on the dispensing of opioids and non-narcotic alternatives. LifePoint has many local-level community coalitions involving both hospitals leaders and regional resources, such as public health departments, which could be used as a forum for more broadly disseminating educational materials to patients, Young says. ●

Medicare-related Expenses, Patient Profiles & Discharge Disposition

HealthTrust's Clinical Data Solutions (CDS) turns data into information that can guide actions to improve patient outcomes. As the graphics below illustrate, the number of hip fracture patients is increasing, and these cases are complex and require rapid treatment in order to mitigate adverse events.

Medicare Beneficiary Profile

The 2016 profile of Medicare beneficiaries with hospital admissions for hip fractures

Admissions With Hip Fractures
276,429

Mean Cost During Stay With Hip Fractures
$17,034

Actual Medicare Reimbursement
$9,876

Mortality Rate(s)

During Index Admission: **2%**

Within 30 Days of Discharge: **6%**

Within 90 Days of Discharge: **14%**

These Patients Are Sick

55% HAVE MAJOR COMPLICATING OR CO-MORBID CONDITIONS (MCC)

25% HAVE COMPLICATING OR CO-MORBID CONDITIONS (CC)

20% WILL NEED A BLOOD TRANSFUSION WHILE IN THE HOSPITAL

6% WILL HAVE RENAL FAILURE WHILE IN THE HOSPITAL

5% WILL HAVE PNEUMONIA WHILE IN THE HOSPITAL

2% WILL HAVE A CARDIAC EVENT WHILE IN THE HOSPITAL

Admission by Fiscal Year

The number of hip fracture procedure admissions performed from 2010 to 2016 has risen 12 percent.

ENHANCING THE PLACES
WHERE HEALTHCARE HAPPENS

Steelcase Health offers innovative solutions for clinical spaces where patients and clinicians come together to support healing, as well as administrative spaces where leaders and supporters work to manage the organization.

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Measure Up

Enhancing Clinical, Supply Chain & Workforce Performance

As a leading healthcare performance improvement company, HealthTrust is constantly looking for ways to help members raise their results in areas beyond purchasing. To that end, HealthTrust's inSight Advisory Services recently launched a set of Performance Capability Scorecards to help members enhance their performance in supply chain management, clinical performance, and labor management and productivity.

The tools will help health systems understand their current practices and capabilities in these three areas, as well as compare them to the practices of industry-leading health systems. Ultimately, the scorecards should help members accelerate their efforts to improve operational performance and financial health.

"The development of the scorecards came in response to requests from some members for a means of quickly understanding how they're performing in terms of their supply chain, clinical and workforce productivity areas," says **David Osborn**, senior vice president of inSight Advisory Services, HealthTrust.

The scorecards go beyond a grade, or a rating of good, average or bad, Osborn explains, and don't benchmark a particular hospital against a lot of others. "They provide helpful information on a facility's achievements compared to what it potentially could achieve," he says.

"And, because the inSight Advisory Services team has worked in operations for low-, medium- and high-performing hospitals, members also want to know how they can take advantage of HealthTrust operator knowledge," Osborn adds.

For HealthTrust members interested in the free scorecard service, just two things are needed:

1. A summary of high-level data.

The data required is generally the type that's already readily available in a member's reporting systems, such as high-level summary data on readmissions and patient volumes. "It's data that should be available and accessible without too much difficulty," Osborn says.

2. An interview with key stakeholders.

An in-person or phone meeting with a few leaders who can answer questions about the facility's current environment and processes is necessary to start the process.

"Conversations with multiple people might be helpful since no one person generally has all the understanding of how a facility is running," Osborn says. "These interviews—usually no longer than an hour—help us complete the assessment on members' behalf."

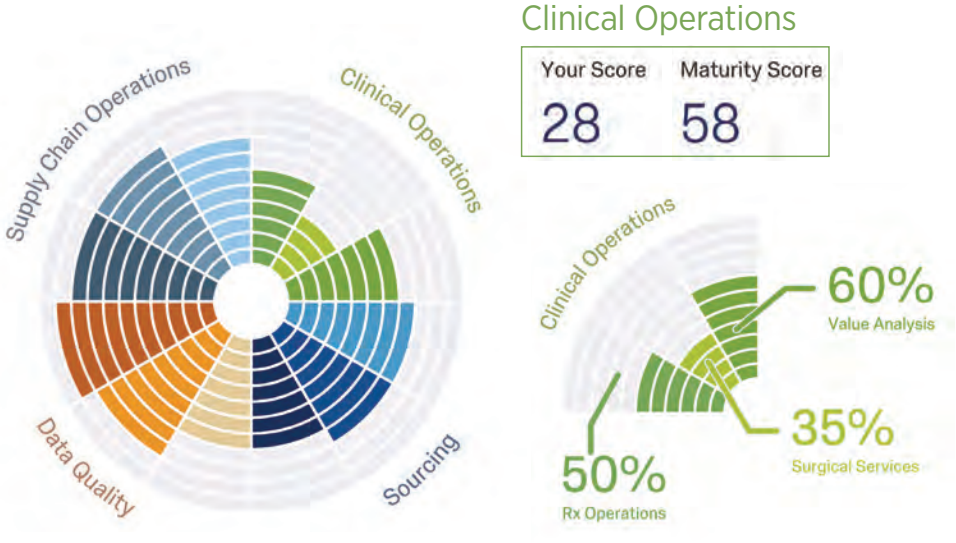
Within a short time, the customized scorecard will be complete. The inSight Advisory Services staff then discusses the results with key stakeholders and answers questions.

"We want people to understand the data and our recommendations for improving performance and developing deeper capabilities in certain areas where there appear to be some gaps and opportunities," Osborn says. "We also go beyond what's on the printed page and give members our perspective on how to accomplish certain recommendations."

HealthTrust has devoted significant time to developing the questions asked, data analyzed and the algorithms used to calculate the scorecard. "We've done testing not only on the model, but also on how we communicate the results," Osborn says. "We don't want to give members a bunch of jargon. We want to present our recommendations in ways that are understandable and actionable so they can actually start to make positive changes." ●

INTERESTED IN LEARNING MORE? Members can contact their HealthTrust account director for more information on initiating the process.

Snapshot of a Scorecard | A sample of the clinical operations portion of the Supply Chain Performance Capability Scorecard shows how a facility's performance in this area (a score of 28) measures up to its potential (a maturity score of 58).



Latest on Abbott Bioresorbable Stent, Maquet IAB Pump

HealthTrust's physician services team regularly reviews all U.S. Food and Drug Administration (FDA) 510(k) approvals and premarket approvals related to physician preference products and those used in a diagnostic setting.

Abbott Will Stop Selling Bioresorbable Stent

Abbott Vascular has stopped selling the Absorb GT1 Bioresorbable Vascular Scaffold (BVS). The announcement was made Sept. 8, 2017 and went into effect six days later. The company says providers with inventory can continue using the absorbable stent if they so choose.

Earlier this year, the FDA issued a safety alert after an initial review of two-year data from the ABSORB III trial showed an 11 percent rate of major adverse cardiac events in patients treated with the BVS at two years, compared with 7.9 percent in patients treated with the previously approved Abbott Vascular's metallic XIENCE drug-eluting stent. (*For more information, see the Q2 2017 issue of* The Source.)

Maquet Recalls Intra-aortic Balloon Pumps

Maquet has recalled its CS100i, CSO100 and CS300 Intra-aortic Balloon Pumps, manufactured and distributed between 2003 and June 16, 2017, due to a faulty false blood detection alarm and ingress of fluid into the balloon pump. The FDA warns that device failure could cause immediate and serious adverse health consequences, including death.

In all, this Class I recall affects 5,049 devices in the United States. Maquet will contact affected healthcare providers to schedule on-site service that will correct these issues. Until the service is done, healthcare providers are advised to take the following precautions:

> Do not leave a patient unattended during intra-aortic balloon pump therapy

> Review the water condensation procedure to reduce the potential for condensation accumulation

> Review operating instructions regarding cautions on placement of fluids and hanging bags of fluid over the device

> Validate and clear false blood detection alarms; if alarm fails to clear, remove the device from service

Additionally, healthcare professionals are urged to report any problems with this device to the FDA MedWatch program. ●

Visit the Physician Services page on the HealthTrust member portal for more FDA approvals and clinical evidence reviews.

Tangled Up in Blue?

A Blue Wrap Recycling Program Is the Place to Start

Polypropylene is a plastic used to make surgical blue wrap. Blue wrap plays a critical role in maintaining the sterility of surgical instruments prior to use in the operating room. The U.S. Environmental Protection Agency estimates it accounts for 19 percent of all operating room waste. For hospitals without a sustainability program or formal greening the OR initiative in place, "what to do with all that wrap" is a common dilemma. For those intent on reducing their environmental footprint, it's an important consideration, as Practice Greenhealth estimates some 255 million pounds of blue wrap is thrown away each year.

According to **Faye Porter**, director of sustainability and member education for HealthTrust, this represents a significant opportunity for hospitals to reduce waste and, through recycling, give life to tons of old blue wrap.

Blue Renew, a recycling program from HealthTrust surgical blue wrap supplier Halyard Health (**Contract No. 456**), assists hospital customers in recycling both clean and used Halyard surgical wrap from their ORs. Through this program, more than 400 U.S. hospitals are diverting over 4 million pounds of blue wrap from landfills each year. The program is expected to extend the life cycle of single-use wraps, allowing healthcare facilities to recycle more than 30 million pounds of blue wrap waste annually.

> Blue Renew is expected to extend the life cycle of single-use wraps, allowing healthcare facilities to recycle 30M+ lbs. of blue wrap waste each year

"Blue Renew is customized to a facility's needs, so each can actively achieve its sustainability goals," says **Joseph Hannibal**, Halyard's associate marketing director. Halyard offers the program at no charge and that includes on-site consulting services

to educate and train facility staff. As part of the program, Halyard will also connect hospital staff with the appropriate recycling partners, and monitor and report on performance.

Hospitals should not experience any internal operational costs to run Blue Renew. Hannibal suggests the facility's supply chain manager or green team member check with the hospital's contracted supplier for waste collection to inquire if there is a charge for each pickup or to amend an existing contract to include the collection of blue wrap.

For more information on the Blue Renew program, contact your Halyard Health account manager or visit the sustainability section of the HealthTrust member portal.

Turning Blue Wrap Into New Products

Healthcare sustainability advocates are concerned about a product's life cycle—essentially, what happens from manufacturing through disposal or end of life.

"It was important to Halyard when developing the Blue Renew program that the wrap benefit the local community in its reuse," Hannibal notes. "Halyard works with recyclers to keep the wrap free from harsh chemicals as the material melts into resin used to manufacture a variety of products that can be used both inside and outside of the hospital setting."

Consider the work of Medford, Massachusetts-based Circular Blu, formerly Blu2Green. Through its recycling and repurposing of blue wrap, Circular Blu is dedicated to helping people with disabilities find gainful employment and become part of the community. Its wallets, totes and neckties are hand sewn by employees, who are often challenged to find employment.

At the core of Circular Blu's vision is the idea of a "circular economy"—a model that turns what was otherwise waste into a reusable commodity—providing benefits for all stakeholders in the process.

Do blue wrap bags sound familiar? Attendees at HealthTrust's 2014 University Conference were greeted at the registration desk with a conference tote handcrafted by the team at Circular Blu. ●

Halyard's Blue Renew Process

- ✓ Facility collects clean blue wrap
- ✓ Approved collector picks up wrap and stores for recycler pickup
- ✓ Recycler collects and processes
- ✓ Processor creates resin pellets
- ✓ Resin pellets are used to create new products

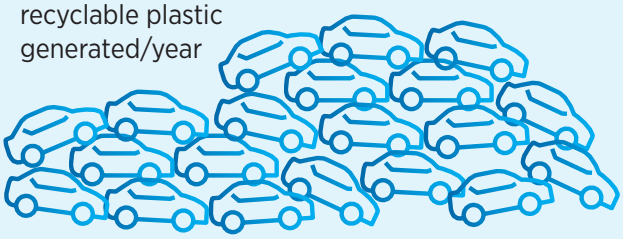
Hospital Plastic Waste

It's hard to conceptualize what so much waste looks like. If you think in terms of a car, the team at Circular Blu suggests 1 million pounds of blue wrap is equivalent to 250 cars. Considering 15 percent of hospital waste is recyclable plastic ...

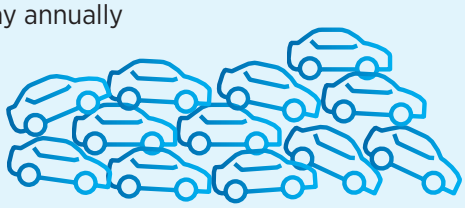
Equivalent to (in cars)*

2.1M lbs. → **525**
recyclable plastic generated/day

766.5M lbs. → **191,625**
recyclable plastic generated/year



255M lbs. → **63,750**
of blue wrap thrown away annually



Sources: Practice Greenhealth.
**Circular Blu, formerly Blu2Green (http://circularblu.com)*

Sharing a Patients-first Mission

Continued from page 4

contracted products (software and/or hardware) potentially vulnerable to cyber-attack. We thank our supplier community for their commitment to this important patient safety issue.

Welcome New Member

We're pleased to welcome CHRISTUS Health to the membership in November. CHRISTUS Health is an international, faith-based, not-for-profit health system, which includes more than 60 hospitals and long-term care facilities, 350 clinics and outpatient centers, and dozens of other health ministries and ventures.

Listed among the top 10 largest Catholic health systems in the United States, CHRISTUS Health employs approximately 45,000 associates and 15,000-plus physicians. We are excited about this new relationship. In addition to CHRISTUS Health utilizing our contract portfolio, we look forward to collaborating with its team on innovative supply chain management solutions.

Clinical Update

HealthTrust Workforce Solutions recently announced the hiring of **Shaun McCamant**, MSN, RN, as chief nursing officer. Along with her team of clinical operations directors, Shaun will focus on promoting clinical excellence and ensuring clinical governance. Her clinical leadership will amplify the collective work of the organization to execute on clinician attraction, engagement and retention.

Innovation Summit

The physician services team recently hosted HealthTrust's third innovation summit. Fifty suppliers showcased their latest product developments designed to further enhance the delivery of patient care. HealthTrust physician advisors and members from advisory boards related to the exhibited products gave feedback on their possible addition to our contract portfolio in the areas of clinical IT, lab, OR, imaging, physician preference and pharmacy. A special supplement to the Q1 issue of *The Source* will feature much more about this annual event.

Ed Jones
President/CEO, HealthTrust

Free Hercules Rental for HealthTrust Members

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Caregiver Injuries	HAPIs	Employee Satisfaction
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Why Healthcare Needs a Course Correction

Continued from page 6

Priorities for 2018

HealthTrust recently finished another collaboration summit around ways to improve the management of acute myocardial infarction patients. (*See story on page 14.*) Participating HealthTrust members sent teams of leaders and practitioners to learn, design and create plans for enhancing care using an accelerated design and planning process. We plan to convene additional summits of this nature in 2018 to address other common challenges faced by our membership.

Another area of priority in 2018 is to better leverage clinical evidence and big data to lower healthcare costs while improving patient outcomes. Healthcare as a whole trails multiple other industries—including retail, hospitality and financial services sectors—when it comes to treating data as a strategic asset.

To begin assessing the data and analytics sophistication of the HealthTrust membership, our resident data scientist **Ed Hickey** is compiling results of an initial survey completed by a subset of attendees at this year's HealthTrust University Conference. A comprehensive survey will be distributed more broadly in early 2018 to get a better read on current perceptions, business objectives, investment intentions, the design and implementation of a data and analytics operating model, and where data is currently creating value. With one-quarter of the nation's hospitals now partnered with HealthTrust, the findings should be revelatory, particularly if the opt-in rate is high. I urge you to participate when the survey hits your desk, keeping in mind that you'll be rewarded with a scorecard of how you're doing relative to your peers as well as companies in more data-driven industries.

We'll be issuing a brief state-of-the-industry report with key findings from the initial survey before the end of 2017. It will be posted to the member portal. (Watch for the alert in your weekly HealthTrust *Response*.) We already know healthcare has a lot of catching up to do. Findings of our research are intended to quantify gaps in attitudes and capabilities, and point organizations toward recognized practices that define data and analytics maturity.

David Osborn
Senior Vice President,
InSight Advisory Services, HealthTrust

Announcing the 2018 HealthTrust University Conference

CALL FOR PRESENTATIONS

- *Positive outcomes from a clinical initiative?...*
- *Improved operations from an innovative supply chain solution?...*
- *Success story using a HealthTrust service line?...*

Share your story with other HealthTrust members during our annual conference event

SUBMISSIONS DUE DEC. 12

Sessions to be considered for presentation at the 2018 HealthTrust University Conference are being accepted now through **Dec. 12, 2017**. Using Google Chrome as your browser, visit **www.conferenceabstracts.com/healthtrust2018.htm** for more details and to submit your program idea for review by the **Dec. 12 deadline**.

Questions? Email **university@healthtrustpg.com**.

2018 HTU CONFERENCE: JULY 23 – 25
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HEALTHTRUST℠

HealthTrust Clinical Watch

A Systematic Overview of Current Products & Emerging Technologies

HealthTrust's physician services team conducts clinical evidence reviews in product categories that have a significant impact on patient care and physician preference items. Input for these reviews comes from practicing physicians at HealthTrust member facilities, as well as members of HealthTrust clinical advisory boards, which are made up of facility-level representatives with expertise in their respective specialties.

Check out the HealthTrust member portal for the latest clinical evidence and technology reviews and FDA updates. Here are the most recent additions:

Clinical Evidence Reviews:

- Bone cement
- Dura repair
- Endometrial ablation
- PVA (percutaneous vertebral augmentation)

Technology Reviews:

- Bard's AV Lutonix 035 drug-coated angioplasty balloon (DCB) catheter
- Boston Scientific's Trapper Exchange Device
- BSN Medical's Cutimed Sorbact Dressing Pad
- Cardinal Health's Tryton Side Branch (bifurcation) Stent
- Kerecis' Omega3 Wound Graft
- NuVasive's Bendini spinal rod
- St. Jude Medical's Amplatzer PFO Occluder
- Spectranetics' Stellarex DCB platform

Coming soon: **Product reviews for cardiovascular and electrophysiology categories**

The Source

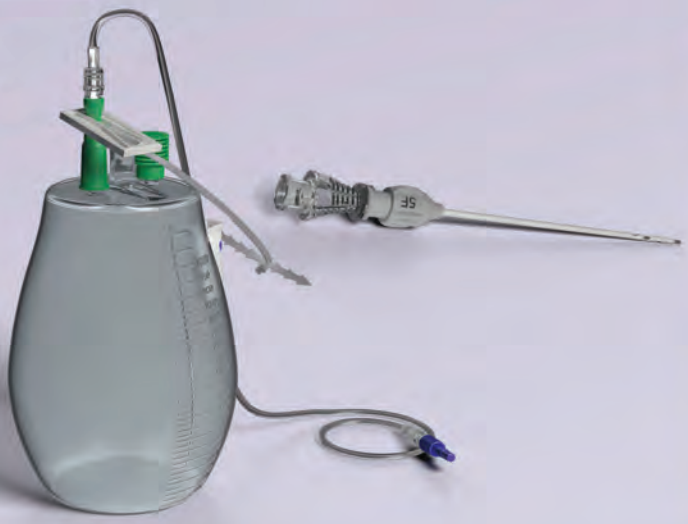
Find an archive of past issues of HealthTrust's award-winning member magazine at healthtrustsource.com, or bookmark Trending Topics (healthtrustpg.com/trending-topics) for fast access to magazine stories as well as thought leadership related to industry topics, clinical best practices and healthcare supply chain.

Symphony™ Centesis Kit

Symphony is a rapid deployment, high volume, high flow-rate 5 French centesis kit that includes the most commonly used components for these procedures. Included in each kit is:

- 1,000 ml evacuated suction bottle with sterile drain line
- Sterile packaged 5F x 10 cm centesis catheter with echogenic needle and porous plug
- Sterile packaged fenestrated drape, 60cc syringe, patient label, 22G needle, scalpel and syringe cap

Symphony MAX 6 French centesis kit is also available.



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- Available in 1,000 ml with or without sterile drain line.
- Consistently draws 1,000 ml or more every time.
- Does not contain natural rubber latex.

Evolution, Symphony and Symphony MAX are now available to all HealthTrust members.

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Map the Most Complex Cases[1,2]

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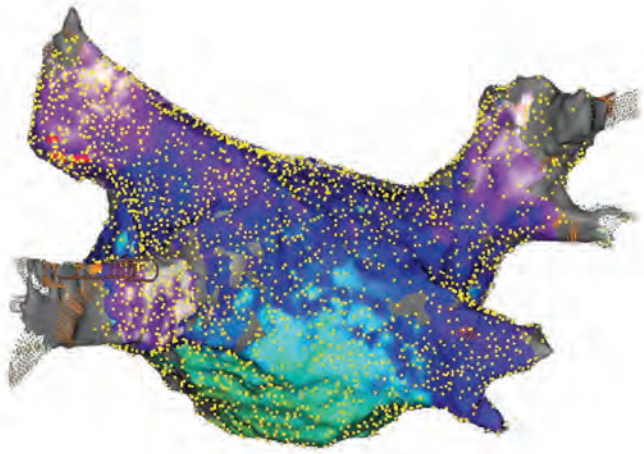
- Transform Procedures with **Intuitive Automation**[1,2]
- Expand Procedural Options Using **Superior Flexibility**[1,2*]
- Effectively Manage Patients through **Greater Precision**[3**]



Impedance-Field Flexibility[1,2*]

Magnetic-Field Precision[3**]

- Green points are impedance data points.
- Orange points are magnetic data points.

HealthTrust Contract #4456

*The open-platform feature of the EnSite Precision™ cardiac mapping system allows for use of almost any catheter, thus offering superior flexibility as compared to the CARTO‡ system by Biosense Webster, which limits use to Biosense Webster‡ catheters only.

**Greater precision based on improvement in accuracy of impedance model with magnetic field scaling applied via robot testing vs. EnSite™ Velocity™ software v4.0.2.

1. Ptaszek, L., Moon, B., Sacher, F., Jais, P., Mahapatra, S., & Mansour, M. (2015). A novel tool for mapping multiple rhythms from a single mapping procedure. Poster abstract P849. *Europace,17*(Suppl 3), iii115.
2. Ptaszek, L., Moon, B., Mahapatra, S., & Mansour, M. (2015, Nov). *Rapid high density automated electroanatomical mapping using multiple catheter types*. Poster presentation P097. APHRS Scientific Sessions, November 21, 2015, Melbourne.
3. Abbott. Data on File. Report 90237452.

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St. Jude Medical is now Abbott.

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Brief Summary: The EnSite Precision™ Cardiac Mapping System is a suggested diagnostic tool in patients for whom electrophysiology studies have been indicated. The EnSite™ Precision System interfaces to either the MediGuide™ Guided Medical Positioning System or the EnSite Precision Module to combine and display magnetic processed patient positioning and orientation mapping information. When used with the EnSite™ Array™ Catheter, the EnSite Precision™ Cardiac Mapping System is intended to be used in the right atrium of patients with complex arrhythmias that may be difficult to identify using conventional mapping systems alone.

Prior to using these devices, please review the Instructions for Use for a complete listing of indications, contraindications, warnings, precautions, potential adverse events and directions for use.