

THE SOURCE

ENHANCING PROVIDER PERFORMANCE &
CLINICAL INTEGRATION



REIGNITING THE SPARK

Combating burnout for
the good of physicians &
their patients

A DUTY TO LEAD

How Chris Van Gorder, CEO
of Scripps Health, used his
background in law
enforcement to transform
a health system

THE RULES OF ENGAGEMENT

Best practices for
bringing surgeons into
supply chain decisions

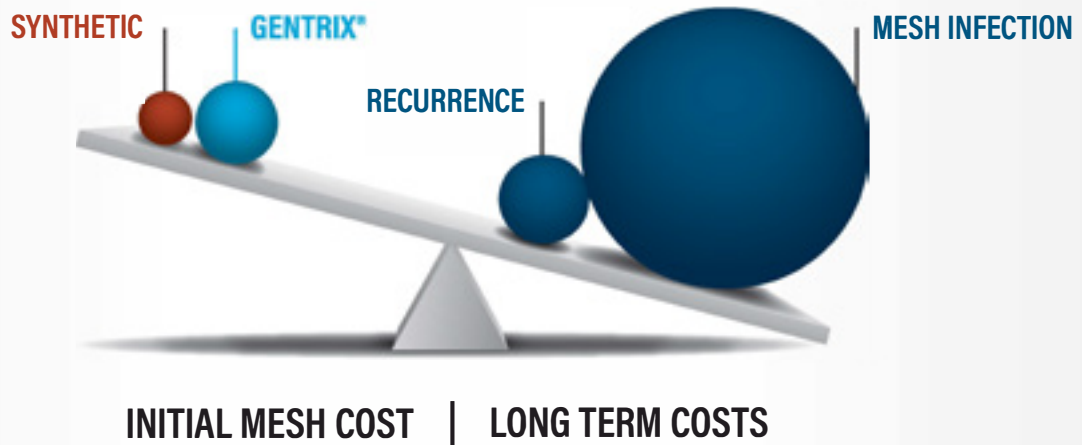


COVID-19 RESOURCES

For information about
HealthTrust's resources
and support, see page 6.



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1. Devila et al. The increased cost of ventral hernia recurrence: a cost analysis. *Hernia*. 2016; 20: 811-817.

2. Augenstein, et al. CeDAR: Carolinas equation for determining associated risks. *J Am Coll Surg* 2015;221:565-6.

3. Sasse, et al. Long-term clinical, radiological, and histological follow-up after complex ventral incisional hernia repair using urinary bladder matrix graft reinforcement: a retrospective cohort study. *Hernia*. 2018;22(6): 899-907.

4. de Vries, et al. Long-term outcomes after contaminated complex abdominal wall reconstruction. *Hernia*. 2020 Feb 20. Epub ahead of print. doi:10.1007/s10029-020-02124-7.

5. Data on file; qa@acell.com

6. Majumder, et al. Comparative analysis of biologic versus synthetic mesh outcomes in contaminated hernia repairs. *Surgery*. 2016;160(4): 828-838.

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EDITORIAL CONTRIBUTIONS:

Clinicians and staff within HealthTrust member facilities are invited to share their expertise as part of upcoming stories. Readers are also invited to suggest other experts for interviews or article ideas for publication consideration. Preference is given to topics that represent:

- * Clinical or supply chain initiatives that exemplify industry best practices
- * Physician Advisor expertise
- * Innovation, new technology, insights from data and analytics
- * Positive impacts to cost, quality, outcomes and/or the patient experience

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CEO perspective

A battle of epic proportion

These are truly unprecedented times. The coronavirus pandemic has had a profound impact on our country, our economy and our lifestyle. Unlike a natural disaster that hits hard and retreats, COVID-19 is universal—impacting every market and industry, with hospitals being the life-and-death safety net for the world's population.

This battle is of epic proportion, made even more difficult by an invisible enemy. I see our GPO as the weaponry in supplying our members' caregivers (the troops) with the protective gear needed to endure and win this fight. The global demand for these products is also unprecedented—it is outstripping supply by a significant margin. Never have we had a situation where the entire world was in a race to secure these critical products, and the raw materials needed to create them, at the same time.

Another of our top priorities has been the health and safety of our colleagues who enable us to deliver on HealthTrust's mission. The HealthTrust team has been working diligently to pursue all leads in securing PPE, ventilators, lab tests and other products critical for the thousands of caregivers battling COVID on the front lines.

The majority of our colleagues are working remotely and temporarily restructured into one or two of 13 work streams aimed at various aspects of the business, including vetting the thousands of supplier leads we have received. There are also teams focused on member support, developing clinical resources and alternative approaches to delivering care and the conservation and utilization of scarce supplies.

I continue to speak with leaders at many of our member organizations in various parts of the country to find out how the numbers of infected citizens are impacting them both from a facility and a health system standpoint. Even prior to government recommendations on social distancing, many had already enacted visitor restrictions; postponed elective surgeries, procedures and outpatient appointments; encouraged an increased use of telemedicine technologies; and were enacting all necessary precautions to triage patients appropriately to prevent the spread of the virus. We look forward to hearing your lessons learned, discussing what will constitute the “new normal” post-COVID-19, and the return to full staffing and schedules at physician offices and surgery centers once elective procedures reenter the market.

I believe this is the biggest test of all of our careers. It will be a defining moment for our country, our company and each of us as individuals. I know from experience that when circumstances are their most trying, our team is always at its best. Please see a list of HealthTrust's resources on page 6, and let us know how we can further assist you. **HT**



A handwritten signature in black ink, appearing to read 'Ed Jones', written in a cursive style.

Ed Jones

President/CEO, HealthTrust
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*To locate Lutonix Global AV Registry data on file call 1-800-321-4254.

HealthTrust COVID-19 Resources

COVID-19 MEMBER RESOURCE CENTER

Found on the secure Member Portal, the site features exclusive members-only clinical, pharmacy and supply chain content related to supplies and suppliers, drug supplies, treatment evidence, caring for COVID-19 patients, condensed FDA Emergency Use Guidelines as well as guidelines from national organizations, edited into a consumable format. There are also COVID-19 updates from suppliers in the Purchased Services, Facility Services & Equipment and the Non-Clinical Product space.



SUPPORTING THOSE ON THE FRONT LINES

HealthTrust's Clinical Services team continues to provide important tools and updated resources on COVID-19 topics such as Disinfection, Personal Protective Equipment (PPE) Conservation & Decontamination, Respiratory Care, Clinical Practice, Lab & Diagnostic Testing, Optimizing Capacity/Resuming Care and Caring for Staff. Visit the Education & Clinical Resources website (<https://education.healthtrustpg.com/clinical-resources/#covid-19>) to access these documents.

VETTING SUPPLIER LEADS ON PPE

Given the shortages in PPE, you may be approached by manufacturers, distributors, brokers or agents offering PPE during these uncertain times. Please exercise caution when evaluating all products and sources. Read our guidance on vetting leads you may be considering (<https://education.healthtrustpg.com/clinical-resources/assessing-supplier-leads-on-ppe>). Or contact us at MemberSpecificCOVIDLeads@healthtrustpg.com or 855-623-0462 if you would like assistance.

HEALTHTRUSTPG.COM

This site is complete with links to currently available and routinely updated resources from the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and more, as well as an interactive dashboard developed by HealthTrust's data scientist. The dashboard is refreshed with data from Johns Hopkins as new, applicable information becomes available.

HEALTHTRUST CLINICAL WARRIORS

Clinicians and staff in our members' facilities are making incredible sacrifices in the fight against COVID-19, and we want to recognize their efforts. If you know of a warrior clinician or team on the front lines with a story to share, please tell us about it at surveygizmo.com/s3/5542956/HealthTrust-Clinical-Warrior-Submissions. We will honor them publicly in a new HealthTrust Clinical Warrior section of our website and on social media outlets.



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CMO perspective

Importance of clinical guidance

This is take-two of my column for this edition.

Who knew when it was initially drafted that our 2020 Innovation Summit would have to be canceled? It's too early to know if any global health or governmental entity could have predicted at the outset that the coronavirus (COVID-19) would reach pandemic status just 2 ½ months after it was initially reported by China to the World Health Organization on Dec. 31, 2019.



There is high anxiety across the U.S. and around the world surrounding COVID-19. Fear can cause rumors and misinformation to spread. With information and updates changing by the moment, none of us yet knows how long the pandemic status will reign or the duration of today's uncertainty.

HealthTrust continues to provide its members with updates through ongoing email communications and conference calls. To further assist members with cutting through the noise and mounds of available information, internal subject matter experts (SMEs) in Clinical Services, Pharmacy Services and Supply Chain have assembled a number of valuable resources (see page 6). Visit them often, as updates are made as new information is available.

My team and I hosted a one-hour COVID-19 clinical update on March 17. Internal SME presenters included **Karen Bush**, MSN, FNP, BC, and **Chris French**, PharmD, MBA. They were joined by HealthTrust Physician Advisor & Infectious Disease Specialist at Duke University Hospital **S. Shaefer Spires**, M.D.,

who offered real-world examples of how facilities are applying CDC guidelines to their treatment plans.

CLINICAL EVIDENCE SUMMARIES

HealthTrust's Clinical Services team is excited to share that it has expanded the Education site to now include Clinical Evidence Summaries (CES).

To make informed decisions around cost, quality and outcomes, supply chain managers and clinicians must arm themselves with the knowledge to understand the safety, efficacy and efficiency of the medical devices and clinically sensitive products they use. Developed with input from HealthTrust Physician Advisors, CES documents are published in an easy-to-read format, which includes an overview of the evidence and a bulleted summary.

CES documents are designed to help members transform internal discussions to clinically integrated purchasing decisions. All members can access CES documents with a simple one-time registration at the HealthTrust Education & Clinical Resources site. (See page 22 for more information.)

Some physician preference product categories have additional resources to benefit members in making clinically integrated purchasing decisions. If available, a New Technology review or a comparative product matrix can be located within a specific contract package in CatScan.

The Clinical Resources section of the Education site is also home to more than 80 COVID-19 resources that address areas such as Clinical Practice, Disinfection, PPE Conservation & Decontamination, Respiratory Care, Lab & Diagnostic Testing, Optimizing Capacity/Resuming Care and Caring for Staff. Contact the Clinical Services Research team at clinical.research@healthtrustpg.com or your HealthTrust Account Director for assistance in accessing these documents. **HT**

We are grateful for the clinicians and staff in our members' facilities who are making incredible sacrifices in the fight against COVID-19, and we want to recognize their efforts. If you know of a warrior clinician or team on the front lines with a story to share, tell us about it at surveygizmo.com/s3/5542956/HealthTrust-Clinical-Warrior-Submissions

John Young, M.D., MBA, CPE, FACHE

Chief Medical Officer, HealthTrust

Executive Publisher & Editor-at-large, *The Source* magazine

The rising tide of new mandates

Concerns about costs & implementation accompany updated rules on radiology, antibiotic stewardship & anti-coagulants



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If it's true that change is the only constant, the adage is particularly relevant for health systems, as a wave of new and updated requirements roll in for radiology use, antibiotic stewardship and anti-coagulant therapy.

The following mandates are coming into play:

- ▶ The Centers for Medicare & Medicaid Services (CMS) is moving forward (after many delays) with regulations around the appropriate use of radiology, which will eventually be linked to reimbursement.
- ▶ CMS is also mandating antibiotic stewardship measures.
- ▶ The Joint Commission has issued new standards surrounding blood thinners.

As beneficial as the mandates could be to patients and providers—potentially improving outcomes and saving money—they still present cost and logistical challenges to facilities, HealthTrust experts explain.

"Hospitals are in a predicament, because they don't have this easy flow of funds to say, 'We can do it all, no problem,'" says **Luann Culbreth**, MEd, MBA, RT, FACHE, HealthTrust Director of Radiology and Cardiovascular Services, Clinical Operations.

At the same time, leadership buy-in is essential, adds **Christopher French**, PharmD, Director, Clinical Pharmacy Operations at HealthTrust. "A pitfall to

consider is not having executive-level leadership to help drive the changes and understand the implications to the hospital."

RADIOLOGY UNDER SCRUTINY

The updated CMS radiology regulations, now in a year-long educational and operations testing period, were a long time coming. Beginning in 2014 with the Protecting Access to Medicare Act, the mandate requires referring providers to consult appropriate use criteria (AUC) through a CMS-approved qualified clinical decision support mechanism (CDSM) before ordering CT, MR, nuclear medicine or PET exams for outpatients covered by Medicare Part B.

Starting in 2021, payment to the facility and interpreting radiologist will be denied without a correctly documented AUC consultation. The law names eight priority clinical areas, including coronary artery disease, headaches and hips.

"CMS wants to make sure there's a process in place in radiology, as is the case with other service lines, that an appropriate exam is being ordered and performed," Culbreth explains. "It's all definitely associated with cost."

Continual delays since 2014 in locking in the mandate are due to a lack of understanding by CMS about the complexities of implementing these extra procedures, Culbreth says. For instance, the additional detail required on billing codes to meet regulations is an extra burden on hospital staff and IT infrastructure.

"Sometimes a government agency is trying to do the right thing. But it doesn't understand all of the nuances of



what it would take to implement a quality decision support mechanism and educate the ordering physicians, who really have no stake in the game—they're just ordering the exam," she says. "There has been a lot of feedback to CMS from the medical community about the hardships of implementing these systems and the cost."

HealthTrust member facilities that stand to be impacted most include those that perform a high volume of outpatient radiology exams on Medicare patients, Culbreth adds. Those who wait to implement the necessary measures will risk not being reimbursed by CMS when the testing period ends. "It's challenging when we have to spend money to make money," she says.

ANTIBIOTIC STEWARDSHIP SPOTLIGHTED

CMS also issued a final rule requiring all acute-care hospitals participating in Medicare or Medicaid to implement antibiotic stewardship programs as part of infection control efforts. Among other measures, hospitals must assign an infection control officer, document evidence-based use of antibiotics in all departments and services, and demonstrate improvements in proper antibiotic use, such as reductions of antibiotic resistance.

"Antibiotic stewardship has been going on in many hospitals for at least four years, if not longer," French explains. "The goal is to reduce hospital-acquired infections and other infectious diseases, and to also reduce inappropriate use of antimicrobials."

In order to optimize the use of antibiotics, The Joint Commission has already been measuring hospitals' efforts to combat antibiotic resistance during triennial accreditation visits, French notes.

ANTICOAGULANT UPDATES

The Joint Commission applied eight new performance metrics in July 2019 to all accredited institutions regarding anticoagulant therapy. With a rise in adverse drug events linked to oral blood thinners, the updated regulations are designed to reverse that trend and improve outcomes, French explains.

Among other requirements, facilities must implement and document evidence-based protocols to manage anticoagulant treatment, including the reversal of such therapy to lower the likelihood of patient harm. Facilities must also educate patients and families about medication and dosing compliance, and potential drug and food interactions linked with severe adverse drug events.

"This is almost like a stewardship of anticoagulant use," French adds. "There will be a lot more monitoring and tracking of safety events—obviously, trying to reduce those events. Some people were starting to do this over the last few years anyway, but now hospitals are going to be required to have standard protocols."

For both the anticoagulant and antibiotic stewardship mandates, French advises hospital leaders to take an active role in the transition process. "It's not only about improved patient care. Downstream costs will be reduced," he says. "If you don't engage executive-level leadership to help drive these changes, you're going to have a hard time effectively implementing the requirements." **HT**



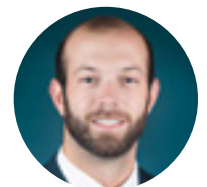
Climbing the ladder to a cure

The potential for gene therapies is rapidly expanding, but not without barriers

The use of gene therapies may turn from a trickle into a torrent over the coming years, prompting the need for hospitals to consider relevant patient populations, policies guiding safe use and payer strategies, among other key issues.

"The first and most important factor driving this focus is how gene therapies may benefit the patient, since these therapies are designed to treat diseases that have been historically incurable,"

says **Kyle Herndon**, PharmD, MBA, BCPS, the PGY-2 Corporate Pharmacy Leadership Resident in Pharmacy Services for HealthTrust.



REALIZING UNMATCHED POTENTIAL

Defined as the transfer of genetic material to a patient to treat disease (by replacing a faulty gene or adding a new one), gene therapy is meant to be a one-time dose, unlike small-molecule drugs or biologics that are taken regularly for chronic diseases. Such therapies are in development to treat rare diseases ranging from spinal muscular atrophy to scleroderma, as well as common conditions such as heart failure and osteoarthritis.



TO LEARN MORE about considerations in gene therapy and access a webinar Herndon delivered recently for HealthTrust members, visit <https://education.healthtrustpg.com/calendar/gene-therapy-considerations-for-pharmacists-today-for-the-future/>

Only two gene therapies are currently available in the market, Herndon says, not including the widely heralded CAR-T cell therapy for certain blood cancers. But by 2025, former Commissioner of the Food and Drug Administration (FDA) **Scott Gottlieb**, M.D., predicts that:

10 to 20 new gene therapy products could be approved each year.

“While gene therapy isn’t heavily utilized now,” Herndon says, “there are many in phase 3 clinical development, so we can expect use to increase as more products become approved and as more standardized policies regarding their use are developed over the next five years or so.”

REMOVING REGULATORY ROADBLOCKS

Gene therapy technology is currently outpacing the regulatory structure surrounding its use. Herndon notes that the FDA hasn’t yet provided guidelines regarding safe handling of gene therapies. And while the National Institutes of Health has stratified viral vectors (which deliver genetic

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material into a part of the body) into risk groups, guidance on minimizing exposure and risk is largely incomplete.

Fortunately, a handful of regional academic medical centers that have emerged as early adopters of gene therapy have created their own policies and procedures guiding operational use, some of which are available online. These include the University of North Carolina and the University of Kentucky.

“If another institution was going to become adept in the gene therapy field and start using these products,” Herndon adds, “a good place to start is to look at what peer hospitals are doing.” Meanwhile, the FDA released a slate of policies in January 2020 related to assessing gene therapies, which arrived as **more than 900** investigational new drug applications were ongoing for gene and cell therapy clinical studies.

“The FDA has acknowledged that we’re now in a pivotal time for gene therapy, and they’re supporting it,” Herndon says.

CONSIDERING COST

As a one-time treatment, gene therapy is expensive, due to high costs for manufacturing and research and development. With a per-patient cost reaching several hundreds of thousands of dollars—or even into the multimillion-dollar range—for just a single dose, Herndon urges hospitals to consider various payer strategies. Among others, Herndon says, these could include annuity-based payment, outcomes-based payment or an outcomes-based rebate.

“There’s no real consensus in practice right now surrounding the best and most applicable payment methodology,” Herndon explains, adding that gene therapy developer Spark Therapeutics has experimented with various mechanisms of payment and has engaged with the Centers for Medicare & Medicaid Services (CMS) to explore the economic impacts of patient installment payments and higher rebates tied to clinical outcomes.

The most viable option in Herndon’s mind is the outcomes-based metric. “I think whatever evolves with payment will probably be based on patients meeting prespecified outcomes,” Herndon says. “Because these treatments are one-time doses intended to last the entirety of the patient’s life, there may be checkpoints: In five years, how is this patient doing? Have they relapsed?”

It’s clear we’re on the brink of discovering what the future holds. “If the FDA is supporting the innovation, it certainly means it’s going to become a reality,” says Herndon. **HT**

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Clinical Advisory Boards are integral to strategic sourcing



CLINICAL ADVISORY BOARD MEMBERS SUPPORT HEALTHTRUST'S STRATEGIC SOURCING PROCESS by staying current on new technology, bringing forth clinical evidence and sharing their clinical knowledge when vetting products for possible addition to the HealthTrust contract portfolio. These members enhance the work of the internal Strategic Sourcing team by validating proposed contracting strategies, supporting final strategies, and driving compliance within their facilities and health systems once products are added to the HealthTrust portfolio.

“HealthTrust has five Clinical Advisory Boards and five Specialty Committees composed of membership representatives with clinical expertise in their respective specialty,” shares AVP of Clinical Operations **Jennel Lengle**, RN, MSN, CCRN, NE-BC. (See page 17 for listing.)

1. A Radiology Advisory Board (RAB) member wears an audio/video headset while a remote service engineer directs her in replacing components in real time. **2.** A member of the Nursing Advisory Board (NAB) tests exam gloves. **3.** An RAB member drives a small lightweight, digital mobile X-ray system on display at RSNA.

“HealthTrust values the clinical expertise of its board members during product vetting and selection. We utilize an aligned decision-making methodology where the Clinical Advisory Boards weigh in on the products and apply principals of clinical efficacy and value to the discussions before voting,” explains Lengle. “And depending upon the products, they are sometimes evaluated by front-line clinicians at the facility level.”

Photos: Carrie Leffingwell/Andres Matalana

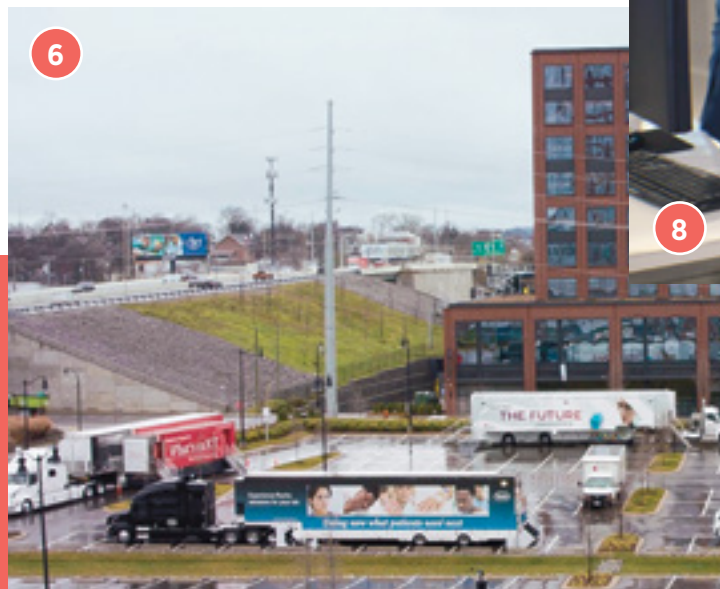
4. NAB members receive demos and test hands-on patient-monitoring equipment. **5.** The Surgery Advisory Board (SAB) meets to discuss new technologies. **6.** Semitrucks line the HealthTrust parking lot as part of the Lab Truck Show. **7.** Matthew Willis, M.D., speaks at the recent SAB meeting. **8.** Members discuss lab products.



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A COLLABORATIVE PROCESS

“Board members are asked to vote for the greater good of the entire membership collective versus just their own facility or health system’s needs,” says Lengle. Recommendations from the Clinical Advisory Boards—along with relevant clinical evidence—are then reviewed and must be approved by the HealthTrust Supply Chain Board prior to awarding a supplier a contract.

The transformation of care delivery relies on clinical evidence and physician engagement to drive value in the contracting process. As a result, HealthTrust’s Clinical Operations and Strategic Sourcing teams collaborate with

research directors on the Clinical Services team who develop Clinical Evidence Summaries (CES) for clinically sensitive product categories that have a significant impact on patient care. Credibility is added to the CES documents with input from practicing physicians who are part of the organization’s Physician Advisor program. (Read more about CES documents, how they’ve evolved and how they help on page 22.)

“Along with feedback from the Clinical Advisory Boards, Physician Advisor insights are essential in facilitating our review of products, suppliers and emerging technologies,” Lengle says.



“As suppliers submit new technology products through the HealthTrust Innovation Center throughout the year, staff clinical board directors are the initial line of review,” says **Angie Mitchell**, RN, AVP, Clinical Services, who manages the process for reviewing new technology. “In years when there is a live Innovation Summit, approved suppliers present their products to the HealthTrust Clinical Advisory Board that most closely relates to their product(s). Input from those board members, along with that from attending Physician Advisors, will determine if a product is recommended for addition to the contract portfolio. In years when there is not an Innovation Summit, products are reviewed by the related Advisory Board in conjunction with the Strategic Sourcing work plan,” explains Mitchell.

“We know that members want to have more voice in the product vetting process,” says Lengle. “I’m excited to announce that we have launched a mobile app and platform where all members can provide feedback on products under review as well as suggest products for contract consideration. This feedback is being incorporated into the sourcing process.



The Clinical Operations team is working to expand the membership within the HealthTrust Advisor platform. The team will attend HealthTrust University Conference in August to demonstrate the app, and it will be featured in the Q3 edition of *The Source*,” Lengle adds.

ADVISORY BOARDS IN ACTION

HealthTrust typically hosts Advisory Board meetings at its corporate office in Nashville, Tennessee. Occasionally, boards will also meet in conjunction with national industry meetings related to those members’ areas of specialty.

- ▶ **Nursing Advisory Board (NAB) – Tara Coleman**, MBA, BSN, RN, Director of Nursing Services, shares that supplier presentations and hands-on product reviews are an integral part of the NAB meetings. The most recent gathering included discussion and supplier presentations on products critical to care delivery—exam gloves. Day two afforded NAB members the opportunity to rotate through a large on-site expo with presentations by nine suppliers in the patient-monitoring product category. Members attending the fall NAB meeting reviewed drills used in neurosurgery, a patient cooling system and enteral feeding pumps. An actual patient bed was delivered from Hill-Rom to show both a contact-free continuous monitoring solution and a call alert system to discreetly notify caregivers of incontinence events.
- ▶ **Cardiovascular Advisory Board (CVAB) – Luann Culbreth**, MEd, MBA, RT, FACHE, Director, Radiology & Cardiovascular Services, indicates the last face-to-face meeting included a “Meet the Press”-style cardiovascular roundtable that featured SMEs from the Clinical Services team: **Robin Cunningham**, MSN, RN, Director, Clinical Research; **Kim Wright**, RN, AVP, Clinical Data Solutions; and HealthTrust’s Chief Medical Officer, **John Young**, M.D., MBA. They were joined by HealthTrust Physician Advisor **Felix Lee**, M.D., Medical Director of Cardiovascular Services and Cardiac Catheter Lab Medical Director at HCA Healthcare’s Good Samaritan Hospital, to discuss the mortality concerns surrounding paclitaxel-coated devices and the current Food and Drug Administration (FDA) guidance. They also reviewed upcoming changes to the proposed rules from the Centers for Medicare & Medicaid Services (CMS) for various procedures, including Watchman and Impella.
- ▶ **Radiology Advisory Board (RAB) – Culbreth** shares that the RAB met in Chicago in conjunction with a national industry meeting—the Radiological Society of North America. Board members participated in hands-on equipment demos with 18 suppliers over the course of

three days in preparation for an RFP on all modalities in medical imaging.

- ▶ **Laboratory Advisory Board (LAB) – Christa Pardue**, MBA, MT(AMT), Director of Laboratory Services, shares that February’s meeting of the LAB was—to the best of her knowledge—an unprecedented event. HealthTrust hosted a “tractor trailer lab truck show” in a parking lot adjacent to its corporate headquarters, featuring five semis that housed state-of-the-art technology in chemistry/ immunoassay platforms and testing. LAB members rotated through 50-minute, hands-on demonstrations from all five major players in the market: Abbott, Beckman, Ortho, Roche and Siemens. One of the attending board members indicates: “The vetting we were able to do at HealthTrust in just one day would have taken two years to try and organize on our own.”
- ▶ **Surgical Advisory Board (SAB) – Jennifer Westendorf**, MSN, RN, CNOR, Director of Surgical Services, shares that a board discussion on the subject of FDA recalls last fall was the impetus for a story in the Q1 2020 edition of *The*

Source on the same topic. A recent meeting of the SAB included two HealthTrust Physician Advisors providing an overview on the cerebral oximetry and arthroscopy categories. Orthopedic Surgeon **Matthew Willis**, M.D., discussed the importance of engaging physicians in the supply chain and new technology review processes. Dr. Willis offered insights on how a surgeon thinks and the importance of understanding both the local market and one’s surgeons when selecting products. He also discussed the realities of publication bias when reviewing research, and the new world of penalties, reimbursements and high-risk patients. “These kinds of insights from practicing physicians are invaluable in helping SAB members better understand the issues weighing on the physicians they work with at home. Hopefully Dr. Willis provided them with suggestions they might discuss at their own health system or facility to make their ORs more efficient and cost-effective while improving patient outcomes,” says Westendorf. (Read more about physician engagement on page 42.) **HT**



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HEALTHTRUST CLINICAL ADVISORY BOARDS & SPECIALTY COMMITTEES

Tara Coleman, MBA, BSN, RN,
Director

- ▶ Nursing Advisory Board
- ▶ Advanced Wound Care Specialty Committee
- ▶ Infection Prevention Specialty Committee
- ▶ Perinatal Specialty Committee



Luann Culbreth, MEd, MBA, RT,
FACHE, Director

- ▶ Cardiovascular Advisory Board
- ▶ Radiology Advisory Board
- ▶ Respiratory Therapy Specialty Committee



Christa Pardue, MBA, MT(AMT),
Director

- ▶ Laboratory Advisory Board



Jennifer Westendorf, MSN, RN, CNOR,
Director

- ▶ Surgical Advisory Board
- ▶ Cardiovascular Operating Room Specialty Committee



Oversight by:

Jennel Lengle, RN, MSN, CCRN, NE-BC,
AVP of Clinical Operations, and
Jocelyn Bradshaw – SVP, Strategic
Sourcing



HealthTrust also has non-clinical Advisory Boards. Learn more about those boards by visiting the Member Portal or by asking your HealthTrust account manager.



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A path to SAVINGS

Expert insights on purchased services

CONTRACTED PURCHASED SERVICES span a wide range of health system functions from landscaping and building maintenance to lab services, pharmacy and more. In many cases, these contracts contain hidden costs that represent significant savings opportunities.

HealthTrust inSight Advisory Solutions AVPs **Andy Motz** and **Drew Preslar** describe some essential steps to realizing opportunities in purchased services:



hospital level. If an Integrated Delivery Network (IDN) with multiple facilities consolidates contracts, the savings can be significant—even with smaller contracts like snow removal.

One of the best ways to lower the cost of purchased services is to have the supply chain department handle all contracts. Supply chain teams have the experience needed to negotiate agreements, drive costs down and obtain the best quality service.

“Leaders, starting with the CFO or COO, must reinforce the message throughout the organization that all contracts need to be centralized,” Motz says. “Communication from the top can prevent individual department directors from signing contract documents.”

There must also be consistent reminders that contracts should not be signed at the local level. In IDNs where each individual hospital has autonomy, that can be a challenge. “When the central organization tries to assert more control over contracts, there may be pushback,” Motz says. “You have to manage that change and keep your eyes on it.”

SOLUTIONS WITH PROVEN RESULTS

Purchased services consulting from inSight Advisory can help members move toward a path of cost savings.

HealthTrust’s inSight Advisory Solutions recently worked with a health system with over 100 hospitals. “The organization had purchased services contracts at the local level that its leaders weren’t aware of,” Preslar says. “The major barriers were getting their arms around the data, understanding what was in scope and determining how to go out to bid.”

Focusing on three contract categories, the inSight Advisory Solutions team helped the system get its data under control. “We added resources to ensure they focused on their initiative and kept to their timelines,” Preslar says. The results have been impressive. Across the three contract categories, the organization has saved \$4 million. **HT**

MAXIMIZE your purchased services savings opportunities by contacting Andy Motz, AVP, inSight Advisory Solutions, at andy.motz@healthtrustpg.com

1 Data access & analysis. When organizations begin identifying potential cost savings, one of the biggest barriers is accessing the data related to purchased services. They must review their accounts payable information to understand what suppliers they are using in different categories, as well as the amount of spend related to each.

Categorization is a major challenge. Even when a health system has adequately captured the data necessary to identify savings in purchased services, it still sometimes struggles to dissect the data in a way that reveals savings.

2 Adequate resources. A lack of human resources can also make it difficult to identify potential cost savings in this space. A contracting department may have staff dedicated to purchased services. However, due to the wide variety of contracts throughout various departments within a health system (e.g., facilities and operations, clinical departments, environmental services), one or two people aren’t enough to cover that scope. Small teams can easily get overwhelmed.

3 Centralized contracting. A hospital operations director may negotiate for environmental services or landscaping while someone in another area of the organization is negotiating for the same services. Each person may keep the contracts in his or her own office, so the larger organization doesn’t have visibility into all of the suppliers being utilized.

Health systems can find quick savings by focusing on services where multiple contracts are in place at the

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Constructing QUALITY

Service line structure can be an essential part of program success

WITH THE TRANSITION TO PAY-FOR-PERFORMANCE AND OUTPATIENT CARE MODELS, hospitals are aiming to stay competitive within their markets while maximizing patient outcomes. Service line structure—a strategic governance model across the continuum of care—is an integral strategy that supports these aims. Service line structure focuses on a hospital's growth strategies, quality initiatives, clinical care delivery and other imperatives identified within the organization.

“Our members need to have a system in place that allows them to identify the opportunity to improve care, grow their footprint in the community and then successfully execute their plan,” says

Kimberly Wright,

RN, AVP, HealthTrust
Clinical Data Solutions.

Unlike historical service line structures that only focused on the acute-care setting, today's service lines need a more holistic approach that includes pre- and post-acute-care strategies.



PLANNING FOR GROWTH

“There are many ways to use a service line structure to tackle program growth,” says **Kyla Stripling,** MMHC, MSN, ACNP, Director of Clinical Data Solutions at HealthTrust. The implementation of a service line governance structure offers regulation across a cohort and within a health system. With the maturation of a service





line governance structure, facilities often experience a return on investment as well as a value of investment—such as improved patient quality and care experience.

“Once a defined governance structure is in place, hospitals are often in a better position to assess what other programmatic offerings

can be added to existing service lines to support patient care,” says Stripling. “This can generate growth, as health systems may be able to provide care to a new cohort of patients previously unmanaged or diverted to other competing entities.”

A service line governance structure within a market or region can help direct resource allocation and avoid competition between hospitals from the same network, says Wright. “This systematic governance structure gives insight into areas of unnecessary resource duplication, identifies service line gaps, and develops a patient-centric strategy across the entire market or region.”

COMMUNITY REFERRALS

“Service line structure aims to reduce gaps in the system and promote a continuum of care across the acute and ambulatory settings for the patients, as well as their clinical providers,” explains Stripling. The reduction in care gaps can improve the community’s view, including the referring provider’s view, of the facility or health system. “This could in return generate community referrals as physicians build confidence in the system,” she adds.

QUALITY CARE

Increasing program growth and referrals go hand-in-hand with providing high-quality care, one of the goals of a service line structure. “By having that foundation, it’s easier to identify potential outliers,” explains Stripling. “If there is suddenly an infection spike, you’re able to go back and say, ‘This is what we implemented for quality. This is the team with oversight. This is the outcome that a patient should be having. Where is the disconnect, and how can we as a team correct it?’ ”

Wright adds, “A dyad leadership structure between physicians and administration; consistent, timely monitoring of clinical and financial metrics; and reduction in the variation of care provided are the keys to success. HealthTrust consultants collaborate with our members to maximize all three areas, resulting in improved service line performance and patient outcomes.” **HT**

FOR GUIDANCE on implementing or optimizing a service line structure within your organization, contact Kimberly Wright, RN, AVP, HealthTrust Clinical Data Solutions at kimberly.wright@healthtrustpg.com



Data-driven decisions

Clinical Evidence Summaries arm decision-makers with the facts about clinically important products

WHETHER THEY'RE ASSESSING a new type of spine implant or a prospective supplier for regenerative tissue, HealthTrust members are perpetually faced with choosing from a wide range of products—determining what's best for their health systems and clinicians and, most important, their patients. To make informed decisions around cost, quality and outcomes, supply chain managers and clinicians must arm themselves with the knowledge to understand the safety, efficacy and efficiency of the medical devices and clinically sensitive products they use.

To help them gain this knowledge, members have long seen the value of the comprehensive, objective and evidence-based Clinical Evidence Reviews developed by HealthTrust's Clinical Services Research team. Now provided in a condensed summary format—called Clinical Evidence Summaries (CES)—these reports are more useful than ever before (see sidebar on page 23).

THE VALUE OF A CES REPORT

A CES document is designed to educate members as well as inform discussions with HealthTrust's Strategic

Sourcing team, to help them determine the safest and most effective products to use for patients. "The creation of these summaries is probably one of the most important responsibilities of the Clinical Services Research team," explains **Angie Mitchell**, RN, AVP, Clinical Services.



"Our goal is to arm purchasing officers, service line leaders, clinicians and other key stakeholders with the clinical information they need to have discussions with the right people in the hospital to make an informed choice," she says.

The Clinical Research team relies on several clinical study formats such as meta-analyses and peer-reviewed and randomized-controlled clinical trials in their research. A key part of that task is ensuring the data provided is comprehensive, thorough and objective. "We want robust clinical studies with larger sample sizes," Mitchell says. The team also incorporates any statements, warnings or recalls from the Food and Drug Administration (FDA) and scours relevant expert consensus guidelines and statements from professional organizations and accrediting bodies.

NEW FORMAT ADDS CONVENIENCE

Clinical Evidence Summaries (CES) are a condensed format of just five to seven pages. Each CES includes an overview and a bulleted summary for a quick read.

“While the summaries get into some level of clinical detail, they are not meant to be a drill down into a scientific, molecular level,” Mitchell says. “That’s because a variety of people use the summaries to make decisions—from the supply chain director who is tapped with the buying decision to key clinicians in the hospital who will actually use the product.”

It’s important that each CES tells a story, Mitchell adds, as well as provides the clinical information needed to help purchasing directors find a champion to drive conversion to a new product. “A CES can provide value to anyone involved in supply chain decisions,” she says.

CES documents may also highlight the features and functionalities of a device compared to devices already on the market—sometimes producing a product matrix to profile the new device along with existing ones.

While cost considerations may ultimately enter into product decisions, it’s not the priority when evaluating products, devices and technologies to be considered for a HealthTrust contract.

A UNIQUE OFFERING

Very few health systems have the internal resources to develop clinical summaries like those provided by HealthTrust. “All of that due diligence and research requires time and a trained eye,” Mitchell explains.

What sets HealthTrust apart is that CES documents are developed with input from its Physician Advisor program.

“HealthTrust Clinical Advisory Boards actively guide the Strategic Sourcing team from a clinical perspective with contracting decisions,” Mitchell says. “Discussing the clinical evidence compiled in a CES helps to ensure Advisory Board feedback is based on objective information, not personal preference.”

Mitchell’s team also watches for ongoing updates from the FDA and new evidence published in journals or presented at industry meetings to keep CES documents up to date. **HT**

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ENVISIONING the POSSIBILITIES of ROBOTICS

Highlights from HealthTrust's 2019 Robotics Summit

THE MARKET FOR ORTHOPEDIC AND SPINE SURGERY ROBOTIC SYSTEMS IS RAPIDLY GROWING, with constant technological advancements. Last November, 42 representatives from HealthTrust member organizations gathered for a Robotics Summit, collaborating to sort through the many complexities associated with building a robotics program and creating action plans for their health systems. Here's a snapshot of some of the components involved in making a robotics program a reality.

CONSIDER THE INVESTMENT

First, health systems must analyze whether the investment in this new technology is going to provide worthwhile benefits. It can be difficult to tease out the value analysis of owning a robotics navigation system.

"No matter their size, every hospital or center must weigh whether the investment in this new technology will pay off in terms of quality of care, surgeon satisfaction and program growth," says **Karen Bush**, MSN, FNP, BC, NCRP, Director of Clinical Research & Education



“Involving physicians from the beginning is a must.”

– Karen Bush, MSN, FNP, BC, NCRP

at HealthTrust. “If the answer is ‘yes,’ then they must decide which robotic system will best fit their collective needs.”

Kade Huntsman, M.D., an orthopedic spine surgeon at the Salt Lake Orthopedic Clinic and the Chief of Surgery at St. Mark’s Hospital in Salt Lake City, Utah, sees the investment as worth considering. An early adopter of robotics (and all things technology), Dr. Huntsman delivered a keynote address on the current state of robotic surgery and served on the physician panel at the Summit. He expresses frustration about the fact that despite how technology has advanced so many facets of our lives, the OR has largely remained old-school and low-tech.



“Today, robots can fly airplanes, vacuum your house and drive your Tesla in traffic,” Dr. Huntsman says. “If we can do all these things, then we should be able to bring that higher technology into the operating room, where the stakes are the highest. It helps us become more efficient and accurate, and make smaller incisions to help patients recover faster.”

Brent Ford, Clinical Director of inSight Advisory – Medical Device Management at HealthTrust, agrees that robotics has tangible benefits for patients and surgeons: “Robotics is exciting because the technology is moving toward improved precision in implant and screw placement, as well as better visualization and preoperative planning.”



CONSTRUCT YOUR TEAM

A successful robotics program requires a team. Find a surgeon champion who is willing to put forth his or her passion, time and energy to develop the program. Enlist other surgeons, the CEO, CFO and the marketing team, who will get the word out.

When choosing a robotic product, Dr. Huntsman says that having a leader is imperative. “The process is going to be

surgeon-driven, so you’ve got to have a surgeon champion who is willing to go through the learning curve.”

EVALUATE THE SUPPLIER

There are many factors to consider when choosing a supplier, which can feel overwhelming. It’s important to lay the groundwork internally first to establish a robust method for evaluating the value of new technology. “Involving physicians from the beginning is a must,” says Bush. Even if physicians know which robotic system they prefer, hospitals should still treat supplier selection as an RFP and bid it out. Before committing, be sure to address maintenance, warranties, upgrades versus updates, the cost of the robotic system and disposables (which can be a major cost), and methods for training.

ESTABLISH TRAINING GUIDELINES

It’s important to attend supplier training. Robotic systems are all different, and each has its own specific set of workflows. Peer-to-peer mentoring can take training to another level. For example, a surgeon who has done 400 surgeries with the robot can help others learn from those experiences.

Some suppliers only make closed systems, meaning you must purchase and use only their screws, increasing the learning curve. There is a concerted effort to change this, so surgeons can work with the screws they’re comfortable using.

WIN OVER LATE ADOPTERS

To convince surgical teams of the value in utilizing robotics systems, emphasize results. With the emergence of robotics, surgeons are now able to perform complicated surgical procedures with minor incisions, and patients can go home the next day versus being in the hospital for a week. With robotics-driven procedures, patients can experience less acute pain, less chronic pain and significantly less tissue damage.

“The goal is that these innovations translate into better quality and safer surgeries for patients and higher job satisfaction for surgeons,” says Ford.

Consider this **EYE ON INNOVATION**

Dr. Huntsman is excited at the thought of advancements moving forward. “I remember my dad’s cell phone that was the size of a shoebox, and we’ve all seen how phones have evolved. In the OR, we’re just now starting to see an evolution. Manufacturers are pushing the envelope and developing this technology quickly, and that’s fun.”

The HealthTrust Custom Contracting team utilizes best-in-class analytics and industry experience to maximize medical device savings in the orthopedic space. **HT**

FOR MORE INFORMATION ON how to maximize savings on orthopedic devices, contact Will Scott (will.scott@healthtrustpg.com) or Jimmy Yancey (james.yancey@healthtrustpg.com), members of the Medical Device Management Custom Contracting team.

ROBOT TEST-DRIVE

Five suppliers demonstrated their robotic navigation technology during the Summit. Participants had the opportunity to “test-drive” the robots to learn about the various features and benefits. Here are the highlights:

- ▶ **Mako total knee robotic-arm-assisted surgery (Stryker)** This system helps surgeons achieve patient-specific joint implant positioning and placement through digital assistance. The system can take CT imaging data and create a 3D model of a patient’s bone anatomy. This allows surgeons to manipulate the implant for a custom fit.
- ▶ **Mazor X spine surgery system (Medtronic)** This guidance platform offers advanced planning software that allows a surgeon to prepare for a

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surgery by designing an individualized plan for each patient's spine procedure. It can be used in both open and minimally invasive or percutaneous procedures. It offers 3D imaging technology that converts 2D fluoroscopic projections from standard C-Arms into a 3D surgical image, so the surgeon can execute the plan with no anatomical surprises.

► **MvIGS (7D)** Machine-vision Image Guided Surgery (MvIGS) is a spine surgery system that offers radiation-free image-guided surgery. There is no intraoperative CT or fluoroscopy used for registration, which reduces radiation exposure for surgeons, staff and patients. The system is embedded in a patented overhead surgical light, and the surgeon can control the technology with a foot pedal, resulting in a better line of sight.

► **NAVIO surgical system (Smith & Nephew)** This system is for robotics-assisted total and partial knee arthroplasties. The hand-held technology is portable and can be used across multiple operating rooms or surgery centers. It uses optical tracking trays affixed to registration pins, rather than preoperative CT scans, to assess the mechanical and rotational axes of the joint and surrounding structures.

► **ROSA knee system (Zimmer-Biomet)** This system is also used for total knee arthroplasty. It has features to assist with bone resection, soft tissue balancing and femoral rotation. It interfaces with another of this manufacturer's products, a mobile app called mymobility. The app allows patients and surgeons to connect through their mobile devices to share data and feedback.

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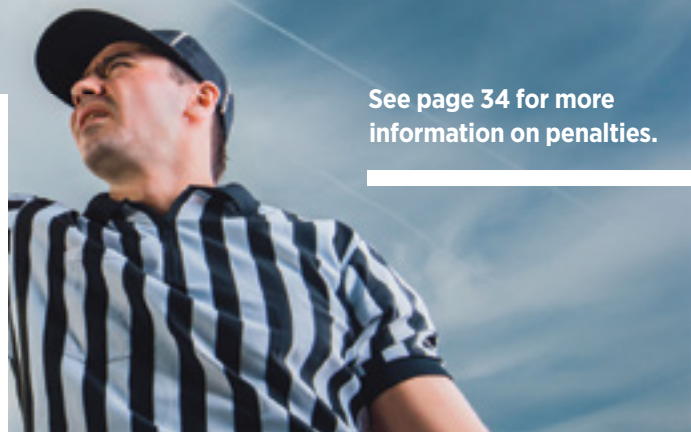


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THE PENALTY BOX

Hospitals face reimbursement penalties from the Centers for Medicare & Medicaid Services (CMS) based on readmissions.* Here's what the numbers tell us.

- ▶ The diagnosis of chronic obstructive pulmonary disease (COPD), heart failure (HF) and pneumonia continue to be the highest overall readmission areas in the penalty program. (Note: The pneumonia diagnosis definition was expanded in the 2017 penalty year.) Also measured are: acute myocardial infarction (AMI), coronary artery bypass graft (CABG), total hip arthroplasty (THA) and total knee arthroplasty (TKA).



See page 34 for more information on penalties.

2019 2020

% Penalized by Population

Condition	2019	2020
AMI	34%	34%
CABG	16%	16%
COPD	45%	45%
HF	45%	45%
Pneumonia	45%	45%
THA/TKA	39%	39%

- ▶ Facilities with fewer than 200 beds are penalized at a higher rate than larger facilities.

2019 2020

% Penalized by Bed Size Strata

# of beds	2019	2020
<100	28%	29%
100-199	28%	28%
200-299	17%	17%
300-399	10%	10%
400-499	6%	6%
500>	10%	10%

- ▶ Urban facilities are seeing a higher rate of penalty than rural hospitals.

2019 2020

% Penalized by Geographic Classification

Classification	2019	2020
Rural	32%	32%
Urban	68%	68%

- ▶ Higher penalties are noted in the Southeast region as opposed to other regions across the map. This may be attributed to a higher-than-average Medicare population in these facilities/regions. (Medicare is the primary insurer for patients over 65 years old.)

2019 2020

% Penalized by Region

Region	2019	2020
Midwest	24%	23%
Northeast	17%	17%
Southeast	31%	32%
Southwest	13%	14%
West	15%	15%

*The penalties applied to each hospital's Medicare payments in 2019 are based on readmissions from July 1, 2014 to June 30, 2017. Penalties applied in 2020 are from July 1, 2015 to June 30, 2018. By law, CMS must grade performance based on a curve.



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VALUE-BASED CARE MODELS CONTINUE TO ENTER THE HEALTHCARE MARKET IN A DRIVE TO REDUCE COSTS AND IMPROVE QUALITY. Back in 2001, the report “Crossing the Quality Chasm” highlighted the quality gap in healthcare and prompted the government to focus on funding quality of care instead of quantity. Though value-based care was originally introduced by the Centers for Medicare & Medicaid Services (CMS) as a way to transition away from a fee-for-service system, many private payers have followed.

“What I like to say to people is, where Medicare goes, others will follow,” says **Karen Bush**, MSN, FNP, BC, NCRP, Director of Clinical Research & Education at HealthTrust. “Generally speaking, every payer source has programming that incorporates value-based care and/or penalty avoidance.”



STEP 1

RECOGNIZE THE BENEFITS & OPPORTUNITIES

Studies have shown that value-based care programs demonstrate a correlation between improved outcomes of care and increased patient experience or satisfaction. They also bring benefits to healthcare providers, as participation in CMS programs is mandatory for Medicare-certified hospitals—with reporting tied to reimbursement. Along with the obvious benefit of avoiding financial penalties, the data that is reported through these programs is publicly available for patients to access, giving hospitals a way to stand out from their competitors.

But value-based programs come with a host of challenges that hospitals need to understand. “These programs and the reporting process are very complex, so I think that’s a barrier,” says **Holly Moore**, MSN, CCRN-K, a Clinical Director within HealthTrust Clinical Services. “They require commitment from the hospital executive suite, physicians, service line leaders and hospital staff. Hospital executives are particularly crucial, as they make strategic and financial decisions that impact the institution’s focus and allocation of resources.”



ABC programs

STEP 2

UNDERSTAND THE METRICS

Each program has its own set of metrics, and it's important for quality departments and hospital leaders to understand what each is measuring because, as Moore points out, "if you don't know what's being measured, you can't improve your metrics."

Understanding that nuance will also draw attention to issues such as the overlap between some of the programs, where hospitals can be penalized twice on similar metrics. For example, the Hospital-Acquired Condition (HAC) Reduction Program focuses on preventing avoidable complications—such as bloodstream infections from IVs and surgical site infections—but hospitals are also being scored on those in the safety domain of the Hospital

Value-based Purchasing (VBP) Program. So hospitals violating both can be doubly penalized.

Differences also exist within each model. HAC and the Hospital Readmission Reduction Program (HRRP), for example, use a penalty model with hospitals judged against a benchmark, while VBP includes both a penalty and an incentive. "CMS is penalizing the poorly performing hospitals and incentivizing the top performers," says Moore, "using a carrot-and-stick approach as a way to get everybody to elevate their care." (See page 34 for more details on these models.)

Performance periods and payment periods also vary between programs. Adding to the complexity is the timing of the penalty or payment: Because penalties

are all done in arrears, hospitals are being penalized or incentivized based on care they delivered up to five years ago, depending upon the program.

For example, the penalty for HRRP is assessed using a three-year average and occurs a year later. This means a hospital receiving a penalty in 2020 is actually being penalized for its readmissions from 2015 to 2018. “That

really affects how soon a hospital is going to see the financial impact of any kind of quality-improvement initiatives they do today,” says Moore.

She explains that foresight is needed. “We want to see the results of our efforts immediately, and it’s easy to lose sight of the long game when you’re focused on the short game.”

STEP 3

TAKE IMMEDIATE ACTION ON DATA

By tracking their own on-site, real-time data, hospitals don’t have to wait out the performance period to take action and see results. “Hospitals have to tackle value-based care by acting on data now, knowing that it is projecting what kind of payment or penalty they’re going to have in the future,” says Moore.

Real-time data also provides ongoing results to share with executive teams, which is helpful in encouraging them to grasp the problem and find meaningful solutions. “You often see hospitals that want to throw 10 darts at a dartboard and hope one of them sticks, rather than targeting their response to the real problem they can find by looking into the data,” says Bush.

Bush recommends using the data to look at individual cases as well as general trends. “With HRRP, for example, part of the assessment should include trending data for the prior discharge location of the readmitted patients,” she explains. “If the trend is showing many of them are returning back from home, a more detailed, patient-level assessment can look at education and resources the patient was provided at discharge, such as follow-up appointments, education using teach-back or medication reconciliation. If they are returning from skilled facilities, a detailed assessment can include evaluation of the transition at discharge, standardized information flow, warm hand-off or other coordinated efforts.”

There are a variety of ways to look at and use this data. HealthTrust members have access to the All Payers Claims Data (APCD). This dataset provides a more complete picture of the population that a member serves because it includes information on all patients discharged in a particular time frame. This is in contrast to the Medicare claims dataset, which only provides information on patients aged 65 or older.

“While no perfect dataset exists, APCD is a rich source of information for our members and provides a way to evaluate performance by trending risk-adjusted outcomes,” says Moore.

As value-based care grows, CMS and other payers continue to introduce programs such as bundled payment arrangements. With the wide array of regulations and policies that go along with this shift to pay-for-performance, hospitals need to stay informed of the complexities in order to minimize penalties and improve patient outcomes and satisfaction. “Understanding what you’re going to be graded on, what the performance periods are in relation to the payment periods, and where you’re going to be penalized or incentivized is key,” says Moore. “And then, keep your finger on the pulse of those metrics in your facility in real-time so that you can impact future payments.”

Continued on page 34

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TO LEARN MORE about maximizing your value-based care program, contact Kimberly Wright, RN, AVP, Clinical Consulting/Clinical Data Solutions at HealthTrust, at kimberly.wright@healthtrustpg.com

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OVERVIEW OF VALUE-BASED CARE PROGRAMS



HOSPITAL-ACQUIRED CONDITION (HAC) REDUCTION PROGRAM

Overview: The HAC Reduction Program aims to **increase patient safety by reducing the number of preventable hospital-acquired conditions**, such as pressure ulcers and central line-associated bloodstream infections. The worst-performing quartile of hospitals receive a 1% deduction in their Medicare payments.

How it works: Hospitals are rated using the CMS Patient Safety Indicator (PSI) 90 and the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) measures. Medicare reimbursements are based on a discharge diagnosis-related group (DRG), with different levels to account for the severity of illness for sicker patients. For example, an otherwise healthy cardiac patient who has a stent inserted will be discharged at a lower DRG than a cardiac patient who also has chronic kidney disease and high blood pressure.

HOSPITAL VALUE-BASED PURCHASING PROGRAM (VBP)

Overview: The Hospital VBP program aims to **improve the quality of care for hospital patients and improve the patient experience**. Hospitals are assessed in four categories:

- ▶ clinical outcomes
- ▶ person and community engagement
- ▶ safety
- ▶ efficiency
- ▶ cost reduction

How it works: The VBP program uses both penalties and incentives to motivate hospitals to provide quality care. Each hospital is graded on the VBP metrics and then compared to each other, with the

poorest-performing hospitals penalized up to 2% of their reimbursements and the top-performing hospitals receiving a bonus.

HOSPITAL READMISSIONS REDUCTION PROGRAM (HRRP)

Overview: The HRRP **reduces payments to hospitals with excess 30-day readmissions** in the areas of:

- ▶ heart failure
- ▶ chronic obstructive pulmonary disease
- ▶ acute myocardial infarction
- ▶ pneumonia
- ▶ coronary artery bypass graft
- ▶ elective total hip replacement and/or total knee replacement

A readmission occurs when a patient is admitted and discharged with one of the targeted diagnoses (index admission) then is readmitted to any hospital for any unplanned readmission in the 30 days following the index admission.

How it works: The HRRP is a unique hospital value-based program in that it includes the 30-day period following discharge. Because of this, hospitals need to work with key players from across the community in order to reduce readmissions, including team members working inside the hospital (e.g., nurses, hospitalists, surgeons), as well as outside (e.g., home health care, EMS, primary care physicians).

“HRRP is bringing to the table a multidisciplinary team from across the care continuum to talk about what is necessary to safely transition patients out of the hospital,” says Bush. “This is a system problem, so the solution has to go across your organization—rather than remain within the walls of your hospital.” **HT**



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REIGNITING the spark

How combating physician burnout is vital for the well-being of physicians, health systems & the patients they serve

NEARLY HALF OF DOCTORS IN THE U.S. REPORT FEELING BURNED OUT, according to a 2020 survey conducted by Medscape. There are many causes of physician burnout, but the effects are undeniable—and can even be a matter of life and death. So it's crucial for healthcare facilities to prioritize the psychological well-being of their doctors.

“An energized, engaged and resilient physician workforce is essential to achieving national health goals,” says **Patrice A. Harris**, M.D., MA, President of the American Medical Association (AMA). “Given the link between physician dissatisfaction and quality problems, an ounce of prevention is worth a pound of cure.”





EXTINGUISHING FACTORS

Burnout can be defined as “the long-term stress reaction of emotional exhaustion and depersonalization,” explains **John Young**, M.D., MBA, Chief Medical Officer of HealthTrust. Burnout rates differ across specialties—they’re highest in urology, neurology and nephrology, while they’re lowest in public health and preventative medicine, ophthalmology and orthopedics.



Despite these variations, burnout is a factor across the board, and while there have been improvements in recent years, it remains a significant issue. It’s of particular concern today for physicians in those areas of the country hit hardest by the COVID-19 pandemic.

Physician burnout doesn’t have a single cause. Dr. Harris says major drivers of physician burnout include burdensome governmental regulations, environmental barriers to providing high-quality care, unsupportive leadership teams and the fact that insurers do not always cover medically necessary services.

Dr. Young adds that primary contributing factors also may encompass the loss of physician autonomy, an ever-demanding work pace and multiple oversight entities that demand quality measures—although these measures don’t always prove valuable when it comes to patient outcomes. He also cites the burden of electronic health records (EHR)—a factor that **Christopher Ott**, M.D., FACEP, Chief Medical Officer with HCA Healthcare’s Physician Services Group, agrees is significant.



“When a physician spends five minutes with the patient and 30 minutes on a computer, that’s not a good use of the physician’s time,” Dr. Ott says.

A culture of negativity has an impact as well. Dr. Ott says that the feedback physicians receive is often negative—

doctors who are successfully managing their patients don’t typically hear about that from leadership. Instead, they hear about their infection rates or failure rates for certain surgeries. The data is mostly quantitative, and the physicians have a limited voice.

Amy Frieman, M.D., MBA, FAAHPM, Chief Wellness Officer at Hackensack Meridian Health in New Jersey,



explains that this problem is compounded by the fact that doctors often don’t feel comfortable pursuing mental healthcare. For example, every time physicians complete a credentialing or relicensure form, they’re asked questions about whether they have any mental health diagnoses and are seeking treatment.

“Those are things that really discourage clinicians from coming forward to seek help,” Dr. Frieman says. “But there is a push to start making some regulatory changes around those issues.”

SCORCHING CONSEQUENCES

The effects of physician burnout are significant and far-reaching. Dr. Ott notes that doctors who are burned out are at higher risk of making clinical errors. Indeed, research shows overburdened physicians reduce the amount of time they devote to their clinical work, and some even leave medicine altogether. A 2019 study conducted by the Association of American Medical Colleges (AAMC) predicts that the U.S. will face a shortage of between 46,900 and 121,900 physicians by 2032.

“In addition to the emotional and physical toll of burnout, it’s driving physicians to retire earlier. This is contributing to the increasing shortage of physicians in this country,” says Dr. Young.

Physician burnout can have a ripple effect on their entire team—the nursing and operational staff are likely to suffer as well. “As a result, patients have longer wait periods to see their doctor, or, worse yet, lose their trusted physician altogether,” adds Dr. Harris.

The problem can be more devastating, leading to alcohol and drug abuse—or worse. Dr. Young explains that doctors in the U.S. have twice the rate of suicide as the general population.

Research from the American Foundation for Suicide Prevention (AFSP) found that 28% of medical residents experience a major depressive episode during their training, while 23% of interns report having suicidal thoughts.

“As we go through medical training and into practice, many physicians are unfortunately touched by the suicide of a colleague or a fellow trainee,” Dr. Frieman adds.

Although the numbers from the AFSP are alarming, research has shown mental health interventions can make a difference—suicidal ideas decreased by 50% in interns who completed just four online sessions of cognitive behavioral therapy (CBT).

“There are resources out there, and it’s critically important that we recognize these kinds of issues before they escalate to losing physicians from suicide,” Dr. Frieman says. “It’s a very real issue and something we shouldn’t ignore.”

SPARKING SOLUTIONS

In addition to offering mental health services, medical institutions can protect the well-being of physicians, fellows, residents and interns in many ways.



► **Monitor the burden.** Dr. Young suggests one crucial strategy is monitoring high-volume operators—physicians who manage a significant number of procedures or patient encounters.

“Early in their careers, this may be driven by a desire to grow their practice and maximize earning potential,” Dr. Young explains. “But over time, this can lead to exhaustion and unpredictable mistakes that aren’t readily apparent to the physician.”

Dr. Young says to be on the lookout for sudden and uncharacteristic behavioral changes. Also, make sure physicians understand their system’s leadership structure and know the appropriate communication channels for discussing any issues.

It’s important to foster collegial empathy and provide positive feedback, too. “Outside of their practice, you never know what is going on in their personal life that may also be contributing to changes in behavior and signs of burnout,” Dr. Young adds. “Start with open-ended questions first, then gently lead into the physician practice concerns that are evident. The conversation should always be about what’s best for the physician and not seen as punitive.”

TECH TROUBLE

Several research studies conducted over the past five years have found that poor usability of electronic health records (EHR) can lead to job dissatisfaction, burnout and compromised patient safety.

“One of the primary causes of burnout is electronic health records,” Dr. Ott says. “Interactions with EHR and IT platforms that require physicians’ time have grown exponentially over the past 20 years.”

In an attempt to fix this problem, the Office of the National Coordinator for Health Information Technology (ONC) at the U.S. Department of Health and Human Services (HHS) instituted EHR design requirements in 2015 to encourage usability.

A 2019 study published in JAMA Network Open found that despite these new requirements, physician satisfaction with EHR usability has not improved for the most widely used products. The study authors recommend involving clinicians in the product design process to improve usability.

Continued on page 40



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Dr. Frieman believes it's also important for the leadership within an organization to closely track burnout. "We need to have measures of clinician well-being on our dashboards alongside our operational and quality metrics," she says. "We really should be measuring this and have leadership accountability for it at the highest levels."

▶ **Reduce the red tape.** Institutional changes are an instrumental solution. Leadership should optimize physicians' overall workflow, progress toward an efficient EHR system, and reduce physicians' responsibility for the operational, bureaucratic side of medicine—things like excessive paperwork, billing and coding.

"The physician should be able to show up, practice care, document, move on and not worry about whether the lights are on," Dr. Ott says. "That is not why doctors go into medicine."

▶ **Invest in wellness.** Instituting a wellness advocacy group or similar program can be an effective strategy. And wellness should be a consideration in all aspects of hospital operations. "All hospital committees should be cognizant of the negative impacts their decisions could have on physician and advanced-practice provider wellness," Dr. Ott says.

Health systems can also consider adjusting physicians' schedules. Several studies have shown limiting the number of working hours, modifying work schedules or promoting time-banking (through activities such as teaching and mentorship) can have a positive impact on physician well-being.

FANNING THE FLAME

While the U.S. still has substantial room for improvement when it comes to remedying physician burnout, some significant strides have been made in the past few years.

A recent study conducted by the AMA, the Mayo Clinic and the Stanford University School of Medicine looked at how many doctors exhibited at least one symptom of burnout.

After steadily increasing to 54.4% in 2014, the burnout rate decreased to 43.9% in 2017. Medscape's recent survey found that burnout rates in the U.S. decreased from 46% in 2015 to 42% in 2020.

"The progress we've seen in reducing burnout in the U.S. physician workforce suggests that growing national efforts are on the right track," Dr. Harris says. "But more work is needed to achieve meaningful change." **HT**

BY THE NUMBERS

Medscape's National Physician Burnout & Suicide Report 2020 surveyed more than 15,000 physicians across dozens of specialties to assess the overall well-being of doctors in the U.S. It found:

- ▶ **42%** of doctors report feeling burned out
- ▶ At **54%**, urologists have the highest levels of burnout
- ▶ At **29%**, public health and preventative medicine practitioners have the lowest rates of burnout
- ▶ **48% vs. 37%**: The burnout rate in female vs. male doctors
- ▶ **38% vs. 48%**: The burnout rate among millennial vs. Generation X physicians
- ▶ **55%** of physicians say too many bureaucratic tasks (like charting and paperwork) contribute to burnout
- ▶ **33%** of physicians say too many hours spent at work contribute to burnout
- ▶ Half of physicians said they would take a **\$20,000** salary reduction in exchange for fewer hours and better work-life balance
- ▶ **77%** of millennial doctors say their relationships have been affected by burnout

HELPFUL RESOURCES

The American Medical Association (AMA) offers several resources to help healthcare facilities fight burnout.

- ▶ **STEPS Forward:** This online tool offers modules focused on preventing burnout, enhancing joy and creating a wellness culture at medical facilities.
- ▶ **American Conference on Physician Health:** This conference hosted by the AMA, the Mayo Clinic and Stanford Medicine, explores physician health and well-being. At the time of this writing, it is set to be held in September 2020 in Charlotte, North Carolina.
- ▶ **Joy in Medicine Recognition:** The AMA recently established this program to recognize healthcare organizations that prioritize physician well-being.

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The rules of ENGAGEMENT

Best practices for involving surgeons in the supply chain decision-making process

FROM KNEE REPLACEMENTS TO ANGIOPLASTIES, the work of surgeons requires a high level of skill, expertise and poise under pressure. And although their contributions to healthcare can be a matter of life or death in the OR, surgeons can also be integral to other facets of medicine—including the supply chain.

Because surgeons are the end-users of countless products procured by the supply chain, their involvement in the decision-making process only makes sense, says **John Young, M.D., MBA**, Chief Medical Officer at HealthTrust.

“Beyond reimbursement, surgeons are best positioned to weigh in on the balance between cost, quality and outcomes—and ultimately the potential for standardization,” Dr. Young says.

When healthcare systems can engage surgeons in choosing and committing to certain suppliers and products, the supply chain process is more clinically integrated, leading to quality control, efficiency and cost savings—benefitting surgeons, health systems and, most important, patients.

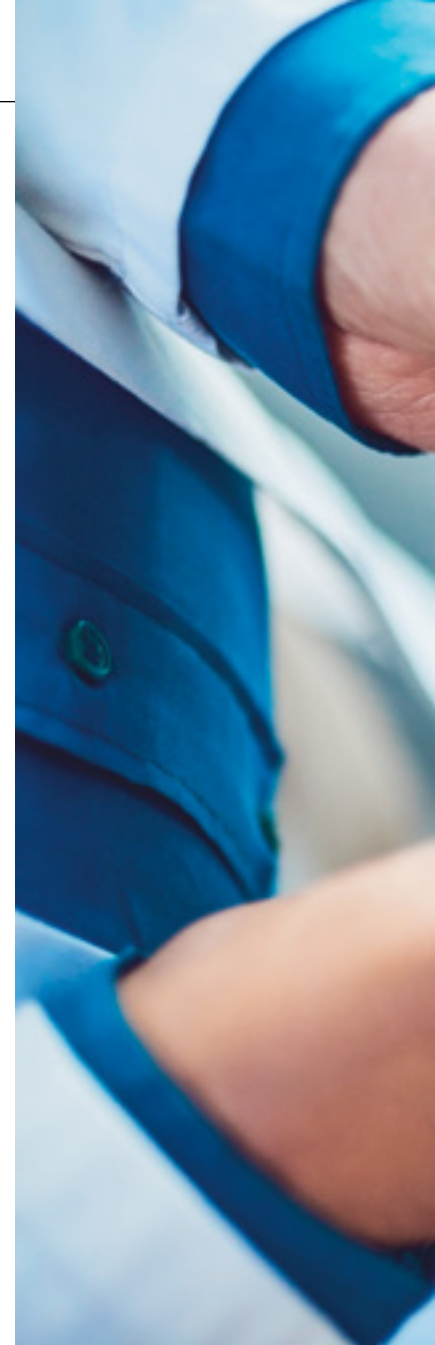
For facilities looking for tips on bringing surgeons into this conversation, here are the rules of engagement.

DEMONSTRATE THE SYSTEM-WIDE BENEFITS

Engaging surgeons in supply chain decisions has myriad benefits, from cutting unnecessary costs to improving patient outcomes through new technology, says **Matthew P. Willis, M.D.**, an orthopedic surgeon with Tennessee Orthopaedic Alliance.

Dr. Willis says a benefit of surgeon engagement is that when clinicians are involved in the decision-making process for products, they feel as though they’re providing their patients with the best care possible. It also helps ensure that hospitals are properly using emerging technology instead of remaining stagnant and relying on less-advanced devices.

Surgeons understand the goal of hospitals and administrators when it comes to cost containment, Dr. Willis says.





When surgeons are integrated into the process, they are able to voice their opinion on the quality aspect of all products.

“When we’re engaged, we feel like we’re part of the system,” he says. “It boosts overall satisfaction when we feel like we’re involved—that leads to happier and more productive physicians.”

In addition, surgeons can see that cost savings from product changes can allow for more optimized spending in other areas within the hospital—such as more modern operating rooms—which supports patients, surgeons and administrators alike.

“Reduction in variability and elimination of waste that is often not readily recognized can lead to significant savings that can be invested elsewhere within the system—or service line—to improve performance,” Dr. Young says.

IDENTIFY POTENTIAL ROADBLOCKS

Although there are notable advantages to engaging surgeons in the supply chain, it’s not always a simple process. It’s no secret that most people are opposed to change. Surgeons are no different. “If a surgeon is comfortable with a certain implant and they’ve used the same one for years, it might make them nervous to think about switching,” Dr. Willis explains. He notes that although the learning curve is typically small when it comes to using a new implant, anchor, joint replacement, plate or screw, it’s still there, and it might affect surgeons’ openness to trying new products.

ENCOURAGE BUY-IN

Surgeons often take several factors into consideration when deciding whether to switch products. Ensuring the following

priorities are in place can help surgeons get on board with clinically integrating supply chain decisions:

Choice. Dr. Willis says the No. 1 driver of surgeon buy-in when it comes to new implants and devices is the idea of having options. “If doctors feel like they have a choice between implants A, B and C, that gives them more satisfaction,” he says.

Transparency. As a surgeon, Dr. Willis values administrators being open about goals when they approach surgeons about supply chain decisions. “Physicians want to see transparency with the cost-containment process,” he says, “sitting down and saying, ‘Here’s what we’d like to save, can you help us out?’”

Dr. Young agrees that transparency is of the utmost importance. Because some surgeons are resistant to changing their preferred tools and supplies for specific procedures, communicating openly and honestly about the goals and potential benefits of making certain changes can make a world of difference, he explains.

“Sharing data around unwanted variability and waste can open the dialogue and demonstrate the improved efficiencies and outcomes associated with standardization and evidence-driven care,” Dr. Young adds.

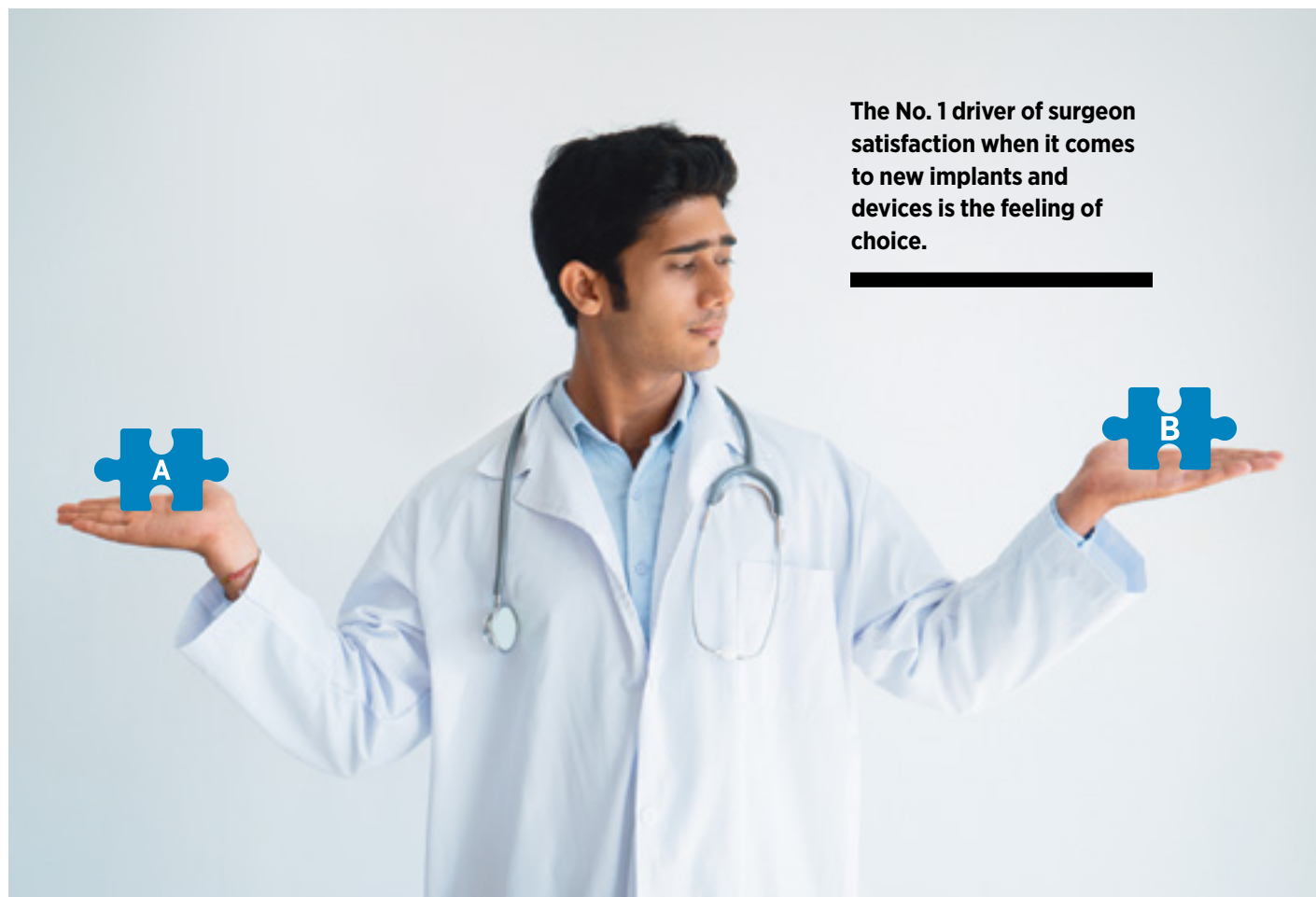
Quality. “There’s one constant that virtually none of us would sacrifice: quality,” Dr. Willis says. During the supply chain decision-making process, it’s crucial to provide data supporting a product’s efficacy.

Dr. Young says that when quality is at the forefront of the conversation, the discussion about cost will inevitably follow.

“The most important point is to come at this from a quality perspective—driving efficiencies in care delivery and elimination of waste,” Dr. Young says. “A data-driven approach to those two elements will naturally lead to a conversation around cost as an important component of the overall value equation.”

It’s particularly important to involve surgeons at the beginning of the decision-making process.

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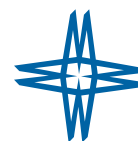
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“Engaging surgeons in the value analysis discussion early on is critical,” Dr. Young says, adding that establishing a committee that reviews new products and technology could be a natural way to start this conversation. “The structure of that committee can lead to the identification of opportunities to improve quality while simultaneously driving out costs.” **HT**

“Sharing data around unwanted variability and waste can open the dialogue and demonstrate the improved efficiencies and outcomes associated with standardization and evidence-driven care.”

– John Young, M.D., MBA



TO LEARN HOW
HealthTrust can help you align physicians around initiatives that improve value for your supply chain and service line, contact Kelsey Duggan, AVP, Medical Device Management at kelsey.duggan@healthtrustpg.com

ENGAGING PHYSICIANS IN REDUCING OPERATING ROOM WASTE

HealthTrust’s inSight Advisory Solutions can help healthcare systems engage surgeons to reduce waste. **Drew Preslar**, AVP inSight Advisory Solutions, suggests the following:



- ▶ To build consensus with surgeons and improve supply efficiency in the OR, base the conversation on data. Gather metrics, such as how many items are opened in the OR but not used, or how often products are used but not identified on the surgeon’s preference cards.
- ▶ Meet with surgeons one-on-one to review preference cards. Discuss whether any products can be eliminated, as well as whether it’s necessary to open every product prior to a procedure. In some cases, it’s

possible to use a secondary “hold table” in the OR for unopened products that may or may not be used for a patient.

- ▶ During the onboarding process, facilitate conversations between supply chain leaders and newly employed physicians. Surgeons who are accustomed to using particular products at their former employer may request off-contract products.
- ▶ Consider appointing a “physician operations executive” or POE. POEs have financial responsibility for the operation of their hospitals and can encourage physicians to eliminate wasteful practices.

To discuss how inSight Advisory can assist you in reducing OR waste, contact AVP Drew Preslar at drew.preslar@healthtrustpg.com

ADVANCING CONNECTED CARE™

What if a patient bed could serve as an extension of the caregiver, so that caregivers could focus on what matters most – helping patients get better sooner?

With features that can optimize patient safety, detect incontinence events and continuously monitor for potential patient deterioration, the Centrella® Smart+ Bed enables caregivers to focus on patients and intervene earlier – before the fall, the skin breakdown, the respiratory episode, or the code blue – to improve patient outcomes.



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INCONTINENCE DETECTION

The WatchCare Incontinence detection system is designed to:

- Protect patient's skin by reducing the onset of Incontinence Acquired Dermatitis (IAD) and initiate earlier intervention

CONTINUOUS MONITORING

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- Monitor heart and respiratory rates to alert caregivers of patient deterioration and initiate earlier intervention

PATIENT FALLS
REDUCED BY

23%¹

PATIENT FALLS WITH
INJURY REDUCED BY

58%¹

DECREASED
EXPOSURE TIME

54 min → 9 min²

CODE BLUE EVENTS
REDUCED BY

86%³

MED-SURG LOS
REDUCED BY

9%³

¹ Cuttler, et al. Beyond the Falling Star: Sustained Decrease in Falls and Injuries with Targeted Bed Exit Alarm, Staff Education Icons, and Patient Education Video. Collaborative Alliance for Nursing Outcomes. 2015.

² Kennedy, R, Slaughter C, Raygoza, H, Brooks, P. Evaluation of an incontinence management system in the critical care environment: A case series. Presented at NPUAP Annual Conference 2019.

³ Brown HV, et al. The American Journal of Medicine. 2014; 127:226-232.

A DUTY TO LEAD



Chris Van Gorder reflects on his experience as a police officer and how it has prepared him for the role of hospital CEO.

Scripps Health CEO Chris Van Gorder relies on his background in law enforcement to lead community-centered change

WHEN **CHRIS VAN GORDER** WAS APPOINTED INTERIM CEO OF SCRIPPS HEALTH IN MAY OF 2000, it was a “code blue” situation. He inherited a large, San Diego-based healthcare system that was losing money and desperately needed to invest heavily in capital equipment. While a strong legacy endured, the health system was broken and needed to be rebuilt. Amid all the change, employees were anxious about their futures—and the news media was watching. “It was a difficult time,” remembers Van Gorder. “Everything needed to be fixed at once.”

It’s 20 years later, and Scripps has consistently met its goals every year

Photo: Steve Anderson

since. Under Van Gorder's leadership, the health system has grown exponentially. It has received national recognition as an employer of choice as well as for having high-performing, high-quality hospitals. How did the new-to-the-job CEO get it done? With a special approach ... and unique training.

PREPARING FOR THE NEXT LINE OF DUTY

Van Gorder didn't take the typical career path to hospital CEO. After having served eight years on the police force, he was attacked while responding to a domestic situation. He was badly injured and spent time in a hospital recovering. No longer able to serve on active duty, the police department retired him.

Then, in a twist of fate, the hospital where Van Gorder received care hired him as the security director. He went back to graduate school and ultimately became a hospital administrator. With the training in law enforcement behind him, he was uniquely positioned to transform a health system.

NEGOTIATING BASED ON TRUST

Like any effective police officer and CEO, Van Gorder had to draw on his negotiating skills to get Scripps on the right path.

The physician group wanted a hefty raise to take emergency room calls. Because the emergency department is essentially the front door of the hospital, Scripps administrators would have had to shut down without physicians on call. Van Gorder explained that he could do it, but he'd have to tell the staff that they weren't getting raises that year. He invited the physicians to help him manage scarce resources.

Van Gorder knew he had to start with rebuilding the relationship with physicians in order to negotiate. He began meeting with division chiefs and medical staff-elected representatives, and suggested the formation of an advisory group of physician leadership captains. "If we could find a way to fill the gap with information and transparently share our challenges with each other, then smart people would reach the same conclusion," says Van Gorder.

The doctors studied the problem and acknowledged that they had no idea things were so dire. They negotiated and successfully came to an agreement. "When physicians owned the issue, in the end we got a better decision," explains Van Gorder.

CUSTOMIZING A COMMUNICATION STYLE

The ability to read facial expressions and body language is crucial for police officers, because it helps them to mitigate potentially violent situations and other conflicts. Van Gorder

uses body language as information and adjusts his communication style based on the visual cues he gets from people. "My training as a police officer enables me to defuse situations and make decisions quickly," he says.

At Scripps, he established leadership academies as a communication strategy. There are academies for middle managers, physicians and front-line employees. He meets with the groups monthly and holds question-and-answer sessions for hours. "Middle managers are the most influential people we have. If they are on board, then we can swiftly make changes."

Making sure that people understand the "why" behind decisions is a key to change management. "When people feel insecure about their jobs, they tend to resist change to protect themselves," says Van Gorder.

To this day, Van Gorder lets his guard down and shares a lot with employees, so they view him as a human being who is not so different from them. His only rules are: no HIPAA violations, no nondisclosure agreements and no personal information about other colleagues. This approach makes people feel comfortable sharing both their concerns and aspirations with him.

As CEO, Van Gorder invests his time in talking with people at all levels of the organization—from board members and front-line employees to patients and their families. He sends a daily email to leadership that provides market news and trends, so they're aware of what's going on outside of their organization. He also answers every single one of the hundreds of emails he receives each day.

Van Gorder saves time by delegating and trusting the people he works with. "I surround myself with good people and respect them enough to let them do their jobs," he says.

CREATING A CULTURE OF COMMUNITY

Any police officer can vouch for the fact that serving the community reaps huge rewards for all involved. That holds true in the corporate world as well. "Community work builds culture," says Van Gorder.

As a result of what happened on 9/11, Scripps created a medical response team that would allow volunteer staff to go into communities in subsequent disaster situations. "After Katrina, the surgeon general asked us to respond to the Gulf," says Van Gorder. Scripps sent three teams. Van Gorder went along with them in the role of chief storyteller. As the George Bush Convention Center in Houston filled with hundreds of survivors, the teams ran the medical center there for a period of time. There were countless inspiring stories. Van Gorder used his Blackberry to collect the stories and photos, and then emailed them each night to the thousands of employees and doctors back in California. "It was



amazing how the culture shifted almost overnight,” he says. The power of storytelling filled everyone with pride. It reminded them of their collective purpose: to help people in their times of greatest need.

Van Gorder also believes that the heart of building a culture is celebrating the people within the community at home. He never gives a presentation without first telling a patient story. He believes that in light of all of the challenges the healthcare industry faces, it’s important to remind each other and the community of a hospital’s core mission—caring for people.

The focus on people and community is a part of what has allowed Van Gorder to lead Scripps to success. He’s never had to terminate anyone for missing their targets. Scripps also has a no-layoff philosophy. “It’s a philosophy, not a policy,” says Van Gorder. But he would consider a layoff his personal failure because “it would mean we didn’t anticipate the change in advance and made bad decisions or weren’t able to adjust.”

FORGING AHEAD

Van Gorder still contends with the injuries he endured that night long ago while on watch. He has ongoing spinal cord problems and chronic migraines. “Luckily, I’m surrounded by excellent doctors,” he laughs. Whenever he gets frustrated, he walks around and sees patients. He also sometimes joins his wife, Rosemary, in her work at the hospital—visiting patients with their therapy dog, Amber. “I always come away knowing the work we do is important and there are patients having a much worse day than me,” he says. “Then I come back with a whole different attitude.”

As for Scripps Health, it has become one of the most successful health systems in the country. The health system

has been ranked five times as one of the nation’s best healthcare systems by Truven Health Analytics. Its hospitals are consistently ranked among the best in the nation by *U.S. News & World Report*. Scripps also is recognized by Advisory Board, *FORTUNE* and *Working Mother* magazine as one of the best places in the nation to work. The organization has grown to acquire existing hospitals and open new ones, as well as new research institutes, outpatient centers and innovative community programs.

Scripps is working to update all of its hospitals by 2030 in order to meet California’s seismic safety codes, which, as Van Gorder puts it, “is like asking hospitals to change their wings while still flying in the air.” While it is challenging and expensive, he welcomes change and thrives under pressure.

After 25 years, Van Gorder is still a police officer. He is a reserve assistant sheriff for the San Diego Sheriff’s Department. “I’m very proud of my background,” he says. After all, it’s where he learned to trust in his training and experience in order to give a major hospital system a clean bill of health. **HT**

Photo: Steve Anderson

7 TIPS FOR LEADING THROUGH CHANGE

Chris Van Gorder, author of *The Front-Line Leader — Building a High-Performance Organization from the Ground Up*, gives advice for leading effectively:

1. To earn trust, invite your people to be part of the decision-making process. In the end, smart people will come to the same conclusion.
2. Create opportunities to regularly interact with all levels of the organization. Make time to talk with board members, executives, middle managers, doctors, patients, families and volunteers.
3. Let your guard down with employees so that they view you as a human being. It makes it easier for them to trust you.
4. Communicate regularly and in different formats to ensure people understand the “why” behind decisions.
5. Surround yourself with good people. Respect them enough to let them do their jobs.
6. Community work builds culture. Participate as a company in community service work to remind everyone who you’re serving and how you make a difference.
7. Don’t underestimate the power of storytelling.



To all of the
healthcare
professionals:

**Our heartfelt
thanks.**

The power of a NURSE'S VOICE

At HCA Healthcare, nurses are the cornerstone of patient care and considered the lifeblood of the organization



Jane Englebright, Ph.D., RN, CENP, FAAN (left), believes that when healthcare leaders listen to nurses' insights, it can lead to advancements in patient care.

Photo: hcatodayblog.com

HCA HEALTHCARE'S SENIOR VICE PRESIDENT & CHIEF NURSE EXECUTIVE, **JANE ENGLEBRIGHT**, Ph.D., RN, CENP, FAAN, says that because nurses are with patients and their families during some of the most important and vulnerable moments in life, it means they have a unique opportunity to make a difference. And they can positively impact both outcomes and the care experience for every patient.

Englebright recently provided her thoughts through an executive Q&A.

Why is it important for nurses to have a voice in their profession?

ENGLEBRIGHT: In the United States, nursing is the largest healthcare profession, with more than 3.8 million registered nurses nationwide. I'm also a nurse. Many of us pursue this profession because we care deeply about improving peoples' lives. Nurses are insightful, creative and passionate about patient care, and their perspective is invaluable because they spend more time with patients than anyone else in a hospital. As we advocate for patients, our voices influence positive changes for the practice of nursing and, ultimately, that improves patient care. So it's important for healthcare leaders to create open environments where nurses' voices are heard and acted upon because it can lead to exciting advancements in patient care.

Listening to nurses through surveys and focus groups helps leadership understand what nurses need to advance their careers as well as to build and maintain a realistic work-life balance to care for their families. Giving a voice to nurses has significant benefits to the organization and its mission to care for and improve human life, but also to the amazing people who deliver that care with compassion and expertise.

How do healthcare organizations benefit when nurses are heard and supported?

ENGLEBRIGHT: Historically, the voices of nurses have led to better patient care. From Florence Nightingale to Clara Barton, we've

seen that some of the greatest success stories in healthcare occur when nurses are given latitude in guiding decisions that affect patients. That's the approach we've taken at HCA Healthcare for many years now, and it has unlocked possibilities that we and others in care delivery hadn't yet realized.

Continued on page 54



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75
Years

Continued from page 53

For example, 10 years ago, through our CNO Council, nurses asked for a tool to electronically document patients' vital signs. Documentation was done at that time mostly room-to-room with pen and paper. Automation would create significant time savings for nurses, and would lead to better and safer care for our patients. Companies were asked to present their vital sign solutions to a group of nurses from HCA Healthcare who tested the tools and chose the right technology for them. The tool they selected didn't exist until these nurses told us what they needed, and that probably wouldn't have happened if we weren't actively seeking their perspective.

More recently, we surveyed more than 800 of our nurses for their feedback on advancing nursing practice at our hospitals. Through the survey, we found that a large portion of documentation was neither efficient nor effective. Thanks to our nurses, Evidence-based Clinical Documentation (EBCD) was born.

The EBCD tool helps nurses spend more time with their patients and less time documenting the encounters. The patient-centered focus of EBCD minimizes the time spent inputting data, and at the same time, allows the information that has been entered into the medical record to be extracted in a more meaningful way. As a result, we've seen our nurses save at least 30 minutes on documentation, per shift.

Besides the surveys you mentioned previously, what are some additional ways HCA Healthcare ensures nurses' voices are heard?

ENGLEBRIGHT: We have a number of ongoing vehicles and venues to give voice to our nurses:

- ▶ **Professional Practice Councils.** Every hospital within HCA Healthcare has these councils, which exist to proactively identify issues and opportunities to improve care. They are venues for bringing forth new ideas and for testing innovations in care delivery. The councils systematically raise the bar on nursing performance.
- ▶ **Advisory Councils.** These specialty councils govern how best practices are shared across the health system and include nursing representatives from each division and various clinical roles, including direct care nursing staff and nurse leaders.

“As we advocate for patients, our voices influence positive changes for the practice of nursing and, ultimately, that improves patient care.”

- Jane Englebright, Ph.D., RN, CENP, FAAN



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- ▶ **Nurses at every level of our organization.** While nurses are best known for being on the front lines of care, they are stepping beyond nurse director and CNO titles and into positions such as CEO and COO. Nurses in C-suite roles are helping to shape business and operational decisions across the enterprise.
- ▶ **Vital Voices.** Through this program, which utilizes a continuous listening approach, colleagues actively seek conversations to solve problems and generate ideas. This allows nurses to provide real-time feedback and see real-time improvement.
- ▶ **Inspire App.** The app is an easy way for nurses to recognize excellence, chart professional growth, and connect with mentors and peers. **HT**



Thank You.

To the devoted caregivers on the front lines, and all those who sustain them, we send our heartfelt gratitude.

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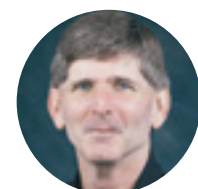


HEALTHTRUST®

HARNESSING ENERGY challenges

Facing increasing regulations, facilities must get creative at controlling energy costs

HOSPITALS HAVE BEEN HIT WITH MYRIAD CHALLENGES AS THE COUNTRY MOVES TOWARD RENEWABLE ENERGY SOURCES, says **Bill Miller**, Director of Strategic Account Integration, HealthTrust inSight Advisory –Energy. There are bailouts of nuclear plants in New York, New Jersey and Illinois, and potentially Ohio and Pennsylvania soon, he says.



Continued on page 58



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For more info go to pdihc.com/tracking-2019-novel-coronavirus-2019-ncov/

¹ <https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2>

BE THE DIFFERENCE[®]



Continued from page 56

“We’re always looking forward as far as the market’s concerned. ... We’re trying to be more proactive with our facilities, so they continue to become more energy efficient as time goes on.”

– Bill Miller

HealthTrust’s energy team helps healthcare facilities look at energy-efficient ways to cut back on usage.



“The bottom line is that right now, all of these bailouts for nuclear plants are probably costing our customers between \$2.5 and \$3 million a year,” Miller explains.

These bailouts have far-reaching effects, as more of the energy supply has to come from renewables, which means there’s another add-on surcharge to consider. In total, facilities could face a total of \$4.5 to \$5 million in increased costs, Miller explains, which HealthTrust strives to help them manage.

DIGGING INTO THE DETAILS

The key to success in handling this change is optimizing energy usage without jeopardizing the facility’s reliability. “We want to know how the facility operates and if there’s anything that can be done more efficiently,” Miller adds.

The energy team helps member facilities from a variety of angles. One strategy is looking at energy-efficient ways to cut back on usage. “We analyze what a facility’s hourly use is on the electricity side,” Miller says. “We’ll delve into it and actually analyze what’s happening on an hour-by-hour basis.”

If they see anything that doesn’t make sense—say a spike in usage during a certain period of time—they will attempt to figure out what’s causing that increase in order to remedy it.

HealthTrust’s energy team also helps healthcare facilities aggressively contract for reduced rates on energy pricing. They look for trends in the market and recommend that their customers buy (gas or electric) during dips. “We’re always looking forward as far as the market’s concerned,” Miller says.

In addition, inSight Advisory – Energy also helps member facilities by recommending state-sponsored initiatives. They

try to push their customers to take full advantage of any state incentives that exist for energy-efficient work. “We’re trying to be more proactive with our facilities, so they continue to become more energy efficient as time goes on,” Miller adds.

BIG-PICTURE VIEW

HealthTrust recently implemented a program in Maryland to bypass changes in Renewable Portfolio Standards (RPS). The program will save one facility about **\$1 million over six years**. Because facilities don’t generate revenue from energy, it’s often overlooked, even though it could be an important part of a facility’s savings, Miller says.

“This is the way we look at it: You’re going to pay the energy costs no matter what, and you don’t generate any revenue off of them,” Miller explains. “But if I can knock off \$500,000 or \$1 million, maybe that’s money that could go toward something that will start generating revenue for the facility.”

Zoë Beck, Manager of Sustainability for HealthTrust, is attempting to bridge this gap, so those at the corporate level understand the far-reaching benefits of energy-efficient initiatives.



“I’m working with HealthTrust’s energy team to make sure that hospitals realize not only the financial value of the project that they’re working on, but also what it can bring in terms of sustainability,” she explains. “My goal is to marry those priorities to help hospitals tell their whole story.” **HT**

FIND OUT if there are untapped energy savings opportunities within your facility. Email Bill Miller, inSight Advisory – Energy, at bill.miller@healthtrustpg.com

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projected potential savings from interventions that reduce waste.*
(*Excluding savings from administrative complexity.)

Source: "Waste in the U.S. Health Care System—Estimated Costs and Potential for Savings," JAMA. doi:10.1001/jama.2019.13978. Published online Oct. 7, 2019.

1/3
of a hospital's non-labor spend is in purchased services (i.e., food services, blood products & facilities management).

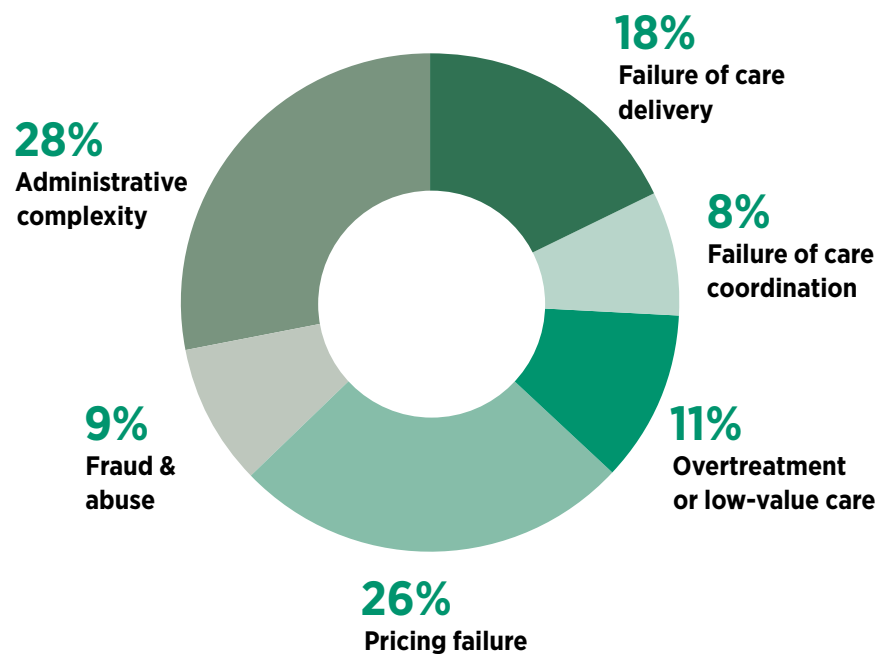
INSIGHT ADVISORY CAN HELP

HealthTrust's consulting solutions help members reduce wasted spend in a number of areas, including purchased services. Some of those strategies include:

- ▶ Centralize all purchased services contracting under the supply chain.
- ▶ Implement a formalized bidding process.
- ▶ Include standard terms and conditions and quality-control measures in contracts.
- ▶ Negotiate volume-based contracts with one or two suppliers for the same purchased service throughout the system.
- ▶ Implement an analytics tool to identify, benchmark and track savings.
- ▶ Conduct supplier performance reviews throughout the life of each contract.

See page 18 for more details.

WASTE IN THE U.S. HEALTHCARE SYSTEM



CONTACT Andy Motz, AVP Consulting,
at andy.motz@healthtrustpg.com



SEE PAGE 46 for information on how HealthTrust's inSight Advisory Solutions can help your facility reduce OR waste.

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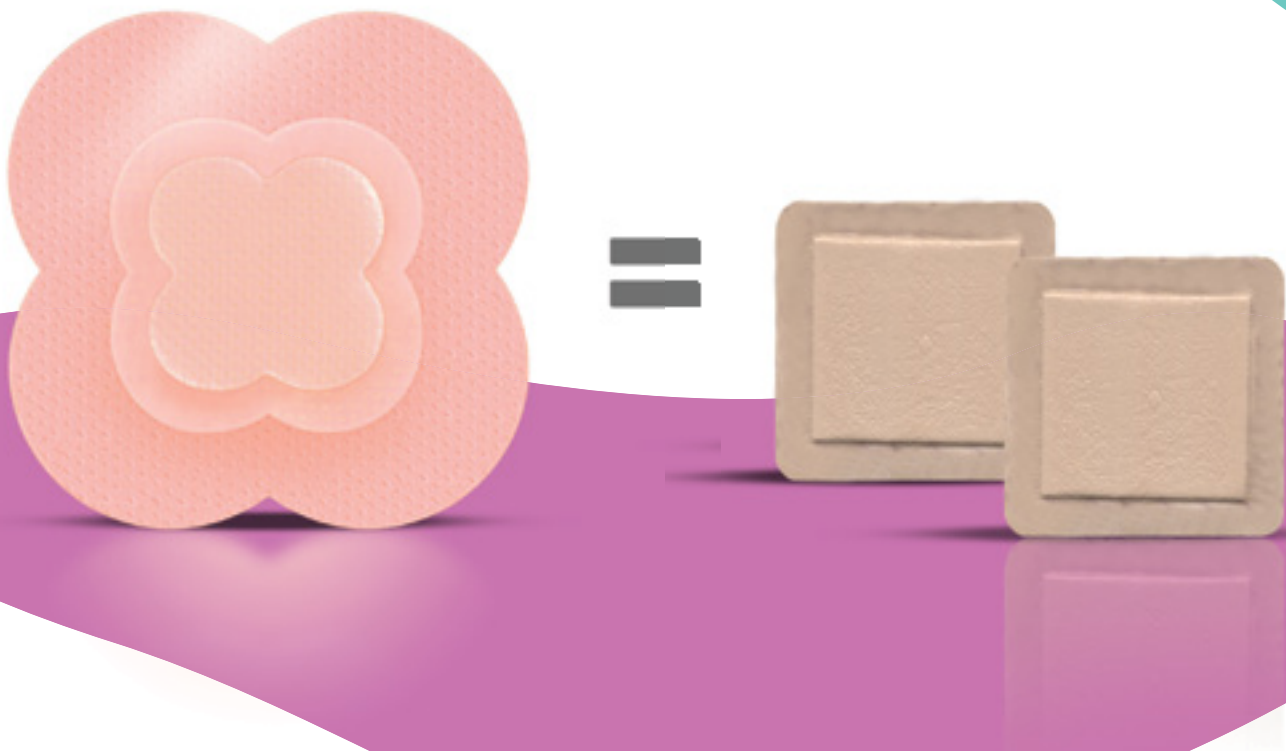
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