The Source
A HEALTHTRUST PUBLICATION
FIRST QUARTER 2017 VOLUME 12 | NUMBER 1
9-1-1 EMERGENCY
HealthTrust Members Defend Against Disasters With Well-executed Emergency Operations Plans
PATIENT SAFETY STRIDES
Smarter Disinfection and Tracking of Surgical Instruments
MEMBER IN ACTION
Mitul Patel, MD
Dr. Mitul Patel Makes Infection Prevention a Priority
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Reference: 1. Nasso G, Piancone F, Bonifazi R, et al. Prospective, randomized clinical trial of the FloSeal matrix sealant in cardiac surgery. *Ann Thorac Surg*. 2009;88:1520-1526.

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Patient Safety Strides

As healthcare providers work to improve the safety of patients in the OR and throughout treatment, they are finding better processes for disinfecting and tracking surgical instruments. HealthTrust member Community Health Systems is one IDN devoting significant resources to this crucial area.

ON THE COVER: Dr. Mitul Patel

Photography by Sheri O'Neal

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Code Silver

From 2002 to 2014, incidents of serious workplace violence were on average four times more common in healthcare than in private industry, prompting healthcare facilities to think much more seriously about improved security.

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CONTACT US

Email: theSource@healthtrustpg.com
Mail: THE SOURCE, c/o HealthTrust, 1100 Charlotte Ave., Suite 1100, Nashville, TN 37203

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Made For life

Impact of the Political Shift in Power on the ACA & U.S. Healthcare Providers

Driving cost-effective, higher value healthcare is more important than ever

The Affordable Care Act (ACA) and its resulting marketplace exchanges have played a significant role in healthcare over the last six years. As the United States prepares for the reality of a new Republican-led administration and congressional majority, the evolution and longer-term viability of the ACA will take center stage as lawmakers continue the debate on the best way to provide healthcare coverage for all Americans.

The jury is still out on how former President Barack Obama's legacy will ultimately be defined in terms of healthcare. Proponents point out that he enabled an additional 20 million Americans to have healthcare coverage through the ACA. Opponents, on the other hand, indicate they are still attempting to tally implications from the resulting financial and regulatory burdens.

Driving Performance Improvement

During the often less-than-civil 2016 presidential election campaign cycle, there were candidates, pundits and proponents on both sides of the debate who expertly argued why Obamacare should be repealed or replaced. And yet there were others who, just as persuasively, spoke to the advantages of expanding the existing program.

As a candidate, Donald Trump campaigned on seven key components of healthcare reform that involved a repeal and replace scenario (*see sidebar*), which, if brought forward, may find the Republican congressional majority facing a potential filibuster by its Democratic colleagues. A subsequent next step would likely be an attempted repeal through reconciliation that not all Republican lawmakers would support. Senator John McCain's opposition has already been reported because such an act would replace Arizona's Obamacare-sponsored Medicaid expansion.

Many hospital systems are hoping guidance from major providers and their representative membership organizations—i.e., the American Hospital Association (AHA) and the Federation of American Hospitals (FAH)—will be sought by lawmakers in crafting an ACA replacement bill. In fact, on Dec. 6, both organizations sent letters to then President-elect Trump and congressional leaders highlighting details from a new report* that outlines the severe impact a repeal would have on community hospitals—with total net losses for hospitals estimated at nearly 100 percent more than the hospital reductions in 1997's Balanced Budget Act.

If a "repeal only" scenario comes first, Congress needs to understand the importance of repealing cuts to the hospital market basket, Medicare and Medicaid Disproportionate Share Hospital. Such cuts were enacted for the very purpose of funding the coverage expansion that would now be repealed.

Fulfilling this campaign promise will not be cut and dry. It remains to be seen what the viability of any of these initiatives will be. However, you can anticipate some levels of change if lawmakers are able to find common ground.

The new administration campaigned on seven key components, which, if passed, will change the enduring legacy (or short-term tenure) of President Obama's Affordable Care Act.

1. Repeal the ACA.
2. Modify the existing law to allow the purchase of health insurance across state lines.
3. Allow individuals to fully deduct health insurance premium payments from tax returns.
4. Allow individuals to use health savings accounts (HSAs) in a more robust way than regulation currently allows.
5. Require price transparency from all healthcare providers.
6. Block-grant Medicaid to the states. This would remove federal provisions on how Medicaid dollars can and should be spent by the states.
7. Remove barriers to entry into free markets for drug providers that offer safe, reliable and cheaper products.

Source: www.donaldjtrump.com/positions/healthcare-reform

What Does This Mean for Healthcare Providers?

In an industry where change traditionally moves glacially, what does the political shift in power mean for the countless providers who deliver healthcare services in the United States? As regulations and policies change there's a definite impact on operations, a new cause for staff re-education, and revised methods of compliance, tracking and reporting to master—all impacting reimbursements and the ever-present bottom line.

Regardless of the future of the ACA, the need to drive cost-effective, higher value healthcare is more important than ever. And, stable and trusted partnerships are increasingly valuable in helping you meet your integrated clinical and supply chain goals. HealthTrust is proud to be such a partner

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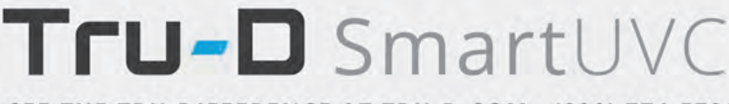

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Creating New Leadership Roles for Practicing Physicians

For practicing physicians, the term "managed care" has long conjured up an image of bean counters denying care for vital services. What it should be about, as I recently shared in a Viewpoint published by *Managed Care* magazine, is finding answers on how to best take care of patients and drive utilization patterns toward the highest value options.

To that end, I made the case for building an infrastructure for rigorous value analysis that resides closer to points of care—one that would open up medical director positions to those actually delivering healthcare. Physicians at the bedside are the only ones who should be making clinical judgment calls, especially when they have a medical problem to solve that doesn't fit neatly into treatment guidelines. It's why growing numbers of hospitals are seeking to close the divide between clinicians and executives, and the ongoing disconnect between physicians and supply chain professionals, by employing practicing physicians as medical directors.

Putting doctors back in the driver's seat was the rationale behind the creation of HealthTrust's pioneering Physician Advisors Program, as well as the recent hiring of two highly pedigreed physicians to serve as part-time medical directors for our cardiovascular and orthopedic service lines. In their new role, they will be working collaboratively with our clinical teams and advisory boards, contracting teams, physician advisors and the larger physician community to vet clinically sensitive products and emerging technologies. They will also work closely with HealthTrust's clinical data analytics team to explore how product utilization factors into the cost, quality and outcomes (CQO) equation, and identify research opportunities around treatment trends that can positively influence clinical outcomes.

Felix Lee, M.D.

Assuming the medical director position for our cardiovascular service line is **Felix Lee**, M.D. He is medical director of cardiovascular services at HCA's Good Samaritan Hospital in San Jose, California, as well as a partner in cardiovascular medicine, nuclear cardiology and interventional cardiology at Heart Associates of Northern California. He earned his medical degree, with multiple awards and honors, from the University of Pennsylvania School of Medicine in Philadelphia.

Greg Brown, M.D.

Greg Brown, M.D., will be overseeing our orthopedic service line. He is a board-certified orthopedic surgeon specializing in knee joint reconstruction and sports medicine at St. Joseph Medical Center in Tacoma, Washington (part of CHI Franciscan Health), and associate chief of surgical outcomes with the Franciscan Medical Group. He is an active member of the American Orthopaedic Society for Sports Medicine, the American Association of Hip and Knee Surgeons, and the Orthopaedic Trauma Association. A Harvard graduate, Dr. Brown has conducted award-winning research on hip and knee replacements, and lectures nationally on fracture management.

Drs. Lee and Brown will be actively assisting HealthTrust in designing the clinical strategy, developing the clinical content and leading physician engagement efforts for their respective service line. They'll also be collaborating with our recently hired data scientist **Ed Hickey** to identify the necessary data requirements, clinically relevant product categorizations, and appropriate methodology for analyzing clinical and financial outcomes. Additionally, as occasions arise, they will represent HealthTrust in speaking and publishing capacities. Speaking of which ...

Ed Hickey

In the last issue of *The Source*, we shared plans by the University of Miami Hospital to build a Life Skills Gym with the help of a \$25,000 grant and another \$25,000 in service line support from HealthTrust.

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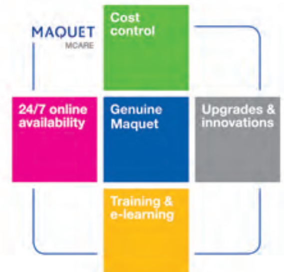

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SOURCEBOOK

YOUR **Q1 GUIDE** TO BUNDLED PAYMENT MODELS, ANTIMICROBIAL STEWARDSHIP, UV LIGHT DISINFECTION AND JOINT COMMISSION PREPARATION

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UNDER THE MICROSCOPE: Healthcare organizations have prioritized antimicrobial stewardship for a number of reasons—to combat resistance, control costs and improve outcomes. A looming federal mandate is another reason to get on board.

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PRODUCT LAB: Ultraviolet light disinfection is a promising, yet unproven, strategy in the fight against hospital-acquired infections. As the evidence mounts, clinicians and facility leaders will need to weigh the pros and cons of this evolving technology.

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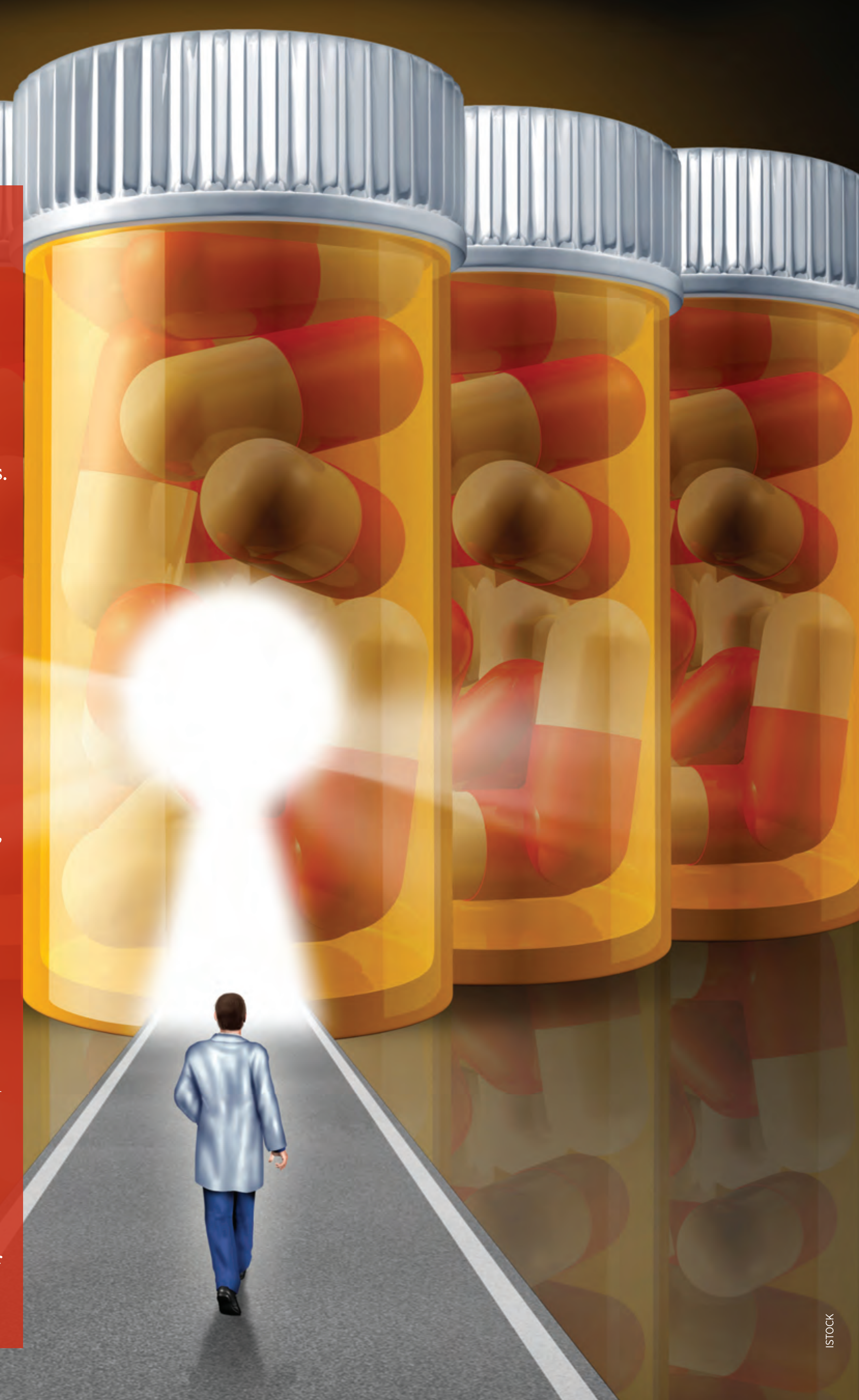
CLINICAL CHECK-IN: Accreditation by the Joint Commission means always being ready to meet the commission's rigorous standards for performance and service. Here's an insider's look at what it takes to earn the prestigious seal of approval.



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Update on Value-based Care

More Bundled Payment Models on the Way

HealthTrust's inSight Advisory Services—Clinical Integration

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- > Care Redesign
- > Clinical Data & Benchmarking
- > Medical Device Management
- > Patient Engagement & Patient-reported Outcomes
- > Cost Optimization

See page 64 of the Q4 2016 edition for more on HealthTrust's total spend management solutions.

For years, the Centers for Medicare & Medicaid Services (CMS) has researched and developed new care reimbursement models in hopes of achieving better healthcare outcomes at a lower cost. Among the most discussed of these currently is the bundled payment—shifting more risk to hospitals but also rewarding them for collaborating with other providers to reduce complications, prevent hospital readmissions and improve the overall patient experience.

In April 2016, CMS launched its first mandatory payment bundles for joint replacement surgeries—expanding in summer 2017 to include femur fracture with hip replacement—at 698 hospitals. The approach makes it imperative that affected providers collaborate with physicians, complete a risk assessment on patients and design patient-specific care paths.

Reimbursement is based on a weighted average of three-year historical data from both the facility and the region. As the program matures, only regional data gets used to calculate a facility's "target" price, creating full-on competition among providers to outperform their peers in the market. Hospitals that hit their targets are eligible for reconciliation payments, while those that miss become subject to repayment penalties.

While the Trump administration is expected to make some changes to the Affordable Care Act, bundled payments are not likely to be dissolved. "When the new administration recognizes bundled payments are achieving the objectives to better coordinate care, reduce overall costs and improve the management of a population of patients across a defined episode of care, I don't believe they will cancel the new mandatory bundles, though they may slow their rollout," says **Todd DeVree**, director of bundled payment solutions at HealthTrust. "I think this model will continue to grow in the coming years."

MORE MANDATORY BUNDLES

In December 2016, the Department of Health & Human Services finalized its ruling on episode payment models for cardiac care that will go live in 98 randomly selected markets on July 1, 2017. In each location, acute care hospitals will be the initiators of the episodes and bear the financial risk for all related care within 90 days of a patient's hospital discharge—just like with the initial orthopedic bundles.

CMS will continue to reimburse providers on a fee-for-service basis, but at the end of each performance year make adjustments—positive or negative—based on the target price and the hospital's

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quality score. Hospitals can opt to have no downside risk for the first two performance years, but, in exchange, the potential to earn reconciliation payments is limited.

A new feature introduced through the cardiac bundles is incentive payments for hospitals that motivate patients to participate in cardiac rehab. CMS will pay selected hospitals $25 per cardiac rehab service for each of the first 11 visits and $175 per visit thereafter.

Assuming these new requirements are not rescinded by the Republican administration, hospitals must increasingly prepare to operate under bundled payment arrangements. Although bundled payments are currently mandated only for certain surgeries and geographies, providers can expect their use will eventually expand to other types of care across U.S. markets.

"MANY HOSPITALS STRUGGLE TO EFFECTIVELY ENGAGE THEIR SURGEONS. WITHOUT PHYSICIAN BUY-IN AND LEADERSHIP, THE PROGRAM WILL HAVE LIMITED SUCCESS."

TODD DEVREE, DIRECTOR, BUNDLED PAYMENT SOLUTIONS, HEALTHTRUST

INSTITUTING BEST PRACTICES

To successfully operate under the incentives of bundled payments, teamwork is essential. Physicians and hospitals need to collaborate to improve care, says **Dwight Tyndall**, M.D., spine surgeon and partner at the Center for Minimally Invasive Surgery in Munster, Indiana, and a physician advisor for HealthTrust. "Physicians are a key component in this process, as they usually have a better understanding of the type of care needed by patients undergoing various procedures."

For instance, many patients with hip and femur fractures "spend the entire 90-day post-discharge period in a skilled nursing facility. They tend to be frail and have more comorbidities," explains **Gregory Brown**, M.D., Ph.D., orthopedic surgeon at Franciscan Orthopedic Associates in Tacoma, Washington, and orthopedic service line medical director for HealthTrust.

Physician engagement and alignment are the most important components in improving coordinated care and overall success under bundled payments, DeVree says. "But many hospitals struggle to effectively engage their surgeons. Without physician buy-in and leadership, the program will have limited success," he adds.

At CHI Franciscan Health, also in Tacoma, bundled payments for total joint replacements have worked well when a team of providers works toward the same goal. To enable each patient's discharge to home, coaches or caregivers are identified early, health educators provide mandatory preoperative joint classes for patients and nurse navigators coordinate care. The team also collaborates on setting expectations for a one- or two-day hospital stay and discharge to home, which "strongly influences hospital length of stay," Brown says. After discharge, patients receive follow-up calls from a nurse navigator and have immediate access to a surgeon, nurse practitioner or physician assistant to avoid unnecessary ER visits or readmissions.

In addition to physician leadership in managing care episodes, hospitals need visibility into how well they're doing from both a quality and cost perspective if they hope to operate profitably under bundled payments. "It's hard to plan if you don't know what your costs are," Tyndall notes.

HealthTrust's inSight Advisory Services team provides physician alignment strategies and guidance, risk-adjusted and benchmarked data to identify care variations and opportunities for improvement, toolkits that help standardize care for like patients, and IT platforms to streamline the capture and reporting of patient-reported outcomes—all of which can help maximize provider performance under bundled payments. But, as stated previously, success starts with physician engagement and alignment—these remain a top challenge for many hospitals.

"There's not one approach to successfully working with physicians because every hospital is unique," DeVree says. "There are best practices for each environment and, fortunately, HealthTrust has had experience in most of them. Increasingly, members are relying on us to help facilitate those key relationships." ●

For more information on how HealthTrust can guide you through the benefits, risks and rewards of bundled payments, contact Todd DeVree at todd.devree@healthtrustpg.com.

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Prioritizing Antimicrobial Stewardship

In 2014, California became the first state to require acute care hospitals to implement antimicrobial stewardship programs in their facilities. Nearly three years later, California remains the only state in the nation with such a law—but that is set to change. In June 2016, the Centers for Medicare & Medicaid Services (CMS) announced proposed changes to its Conditions of Participation (CoP), the requirements hospitals must meet to participate in government-run health insurance programs, which include the addition of a hospital-wide antimicrobial stewardship program.

The following month, the Joint Commission released a new antimicrobial stewardship standard for acute care hospitals and long-term care facilities (http://tinyurl.com/h497yv2) that took effect Jan. 1. It outlines eight elements of performance, largely mirroring the national guidelines created by the Centers for Disease Control and Prevention (CDC) (http://tinyurl.com/lzktjxh).

CMS hasn't revealed an expected timeline for hospitals to comply with its CoP, but the comment period has passed and a proposed rule is in development.

"After the proposed rule is published, we have up to three years to publish a final rule; however, we expect to publish a final rule as expeditiously as possible," says **Lindsey O'Keefe**, a public affairs specialist for CMS.

That means healthcare organizations need to start prioritizing antimicrobial stewardship now. The CDC estimates 20–50 percent of all antibiotics prescribed in U.S. acute care hospitals are either unnecessary or inappropriate. This misuse can lead to antibiotic resistance, which the agency says is responsible for 23,000 deaths annually.

"The growing epidemic of human antibiotic resistance is not a problem that's coming in the future; it's a problem that's already here," says **Marcus Dortch**, PharmD, senior director of clinical pharmacy services for HealthTrust. "Healthcare organizations need to pay attention to the message being sent by the Joint Commission, CMS and CDC."

Mishawaka, Indiana-based Franciscan Health has already prioritized antibiotic stewardship with the development of a pharmacy-specific team and a systemwide, multidisciplinary antimicrobial stewardship team under the leadership of **Maria Adamopoulos**, PharmD, corporate clinical pharmacy manager.

The pharmacy team is made up of clinical pharmacists with an interest in infectious diseases at each of the system's 14 hospitals in Indiana and Illinois. The pharmacists act as liaisons to promote antimicrobial stewardship at the local level. The multidisciplinary team, formed last November and co-led by a clinical pharmacist and a physician, also brings the unique perspectives and skillsets of analytics, microbiology, infection prevention, IT, nursing, quality and safety to the program.

"To combat resistance, control costs and improve outcomes, antibiotic stewardship has to be a multidisciplinary effort," Adamopoulos says.

She speaks from experience. In the past, when her pharmacy team rolled out antibiotic stewardship initiatives, they didn't always get the buy-in of other departments. Now that stakeholders from multiple departments will be involved from the beginning, Adamopoulos expects they'll see more wins.

The Joint Commission's standard also prescribes a multidisciplinary approach, and identifies four key members of

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A Savings Opportunity

Antibiotic stewardship programs are more about improving care than saving money. But they can potentially cut costs. CMS estimates its proposed changes, including both antibiotic stewardship and infection prevention programs, could save hospitals up to $284 million annually. Those savings come from more judicious antibiotic use, as well as the avoidance of treating adverse drug reactions and *Clostridium difficile* (C-diff) infection. C-diff alone adds 40 percent, or an average of $7,286, in additional costs per patient, according to a study published in the Nov. 2015 *American Journal of Infection Control*.

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MARCUS DORTCH, PHARMD, SENIOR DIRECTOR OF CLINICAL PHARMACY SERVICES FOR HEALTHTRUST

Joint Commission Antimicrobial Stewardship Standard at a Glance

>> Make antimicrobial stewardship an **organizational priority**. In other words, buy-in from the executive suite is crucial.

>> Upon hire and periodically thereafter, **educate frontline clinicians** about antibiotic resistance and antimicrobial stewardship practices.

>> **Educate patients and their families** regarding the appropriate use of antimicrobial medications.

>> Create a **multidisciplinary team** to oversee antimicrobial stewardship efforts.

>> Include the **CDC's seven core elements** of an effective antimicrobial stewardship program: leadership commitment, accountability, drug expertise, action, tracking, reporting and education.

>> Use organization-approved multidisciplinary **protocols**, such as antibiotic formulary restrictions, preauthorization requirements for specific antimicrobials, and use of prophylactic antibiotics.

>> **Collect, analyze and report data** on your antimicrobial stewardship program.

>> **Take action on improvement opportunities** identified in the antimicrobial stewardship program.

Continued from page 14

the team: infectious disease physician, infection preventionist, pharmacist and nurse practitioner. The qualifier is when these personnel are "available in the setting," to provide flexibility to smaller facilities. The commission also allows members of the antibiotic stewardship team to be part-time, consulting or telehealth staff.

"The physician on your team doesn't have to be trained in infectious diseases," Adamopoulos says. "You might instead find a hospitalist who has a passion for optimizing the use of antibiotics. If you don't have enthusiastic participants, you won't be successful."

When Franciscan Health launched its antimicrobial stewardship efforts five years ago, its hospitals operated in silos. That meant 14 different formularies and a lot of variation, including in the case of antibiograms, the periodic summaries of antimicrobial susceptibilities designed to help facilities understand local threats and track resistance trends.

Today, the health system has a single formulary, a standardized template for antibiograms, and predetermined order sets optimized for antimicrobial stewardship. Then those order sets are built into the system for electronic health records.

"It can take a while to get all the moving parts in place," Adamopoulos says. "But it's necessary if you want to actually implement and practice good stewardship."

The timeline for a federal mandate for antimicrobial stewardship may be unknown, but action is imminent—and it's likely that it will cover outpatient facilities in the future. The Joint Commission is already moving its standards development work in that direction.

"Don't wait to prioritize antimicrobial stewardship in your facilities," Dortch says. "Assess your level of readiness and formulate a plan of attack based on your patient population, case mix and baseline of pathogen resistance."

From a practical standpoint, Dortch recommends supply chain leaders consider automated surveillance systems with real-time alerts, and tracking tools to identify areas for improvement and measure the impact of infection prevention initiatives.

"Take a look at those tools so that you can put in budget requests as soon as possible," Dortch says. "It can take time to get data collection processes in place that will identify areas where you have the most significant gaps." ●

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Precise Prevention?

The Pros and Cons of Ultraviolet Light Disinfection

One out of every 25 hospital patients will contract a hospital-acquired infection (HAI) during their stay, according to data from the Centers for Disease Control and Prevention. These infections may result in severe health problems or require readmissions that drive up healthcare costs.

While healthcare facilities have detailed processes in place for disinfecting rooms, the persistence of HAIs suggests there are opportunities to do more. Medical device manufacturers have introduced deep ultraviolet (UV) light-emitting diodes (LEDs), which use short-wavelength ultraviolet (UV-C) light to disinfect operating rooms and other areas to prevent the spread of HAIs.

These systems are intended to be more energy-efficient and portable than the germicidal UV systems being used by many hospitals today.

HOW IT WORKS

UV disinfection aims to stop the spread of *staphylococcus aureus* (or staph), methicillin-resistant *staphylococcus aureus*, *Clostridium difficile* (C-diff) and other pathogens by disrupting the DNA of harmful microorganisms so they are unable to reproduce. The C-diff spore can remain active on surfaces for up to three months and is the most difficult to kill, but studies show that UV light can be effective in eliminating it.

In 2014, three hematology-oncology units at the Hospital of the University of Pennsylvania participated in a 12-month study to determine the effectiveness of UV light disinfection in preventing hospital-borne infections. The study results were published in *Infection Control & Hospital Epidemiology*, the journal of the Society for Healthcare Epidemiology of America, and showed that when UV light disinfection was used to clean unoccupied patient rooms, the high-risk patients who later occupied those rooms were significantly less likely to contract C-diff.

Tru-D SmartUVC

In the study, the hospital added UV disinfection to its disinfection protocols in three units. After a typical room cleaning, the hospital's environmental services team would utilize an ultraviolet robot to further disinfect the room—reducing the incidence of C-diff infection by 25 percent among new patients in those units. Over the same year-long period, the C-diff infection rate increased 16 percent in the non-study units.

In another study, published in the June 2014 *American Journal of Infection Control*, researchers at Westchester Medical Center in Valhalla, New York, observed a 17 percent reduction in hospital-acquired C-diff with the addition of UV light disinfection following standard terminal cleaning of high-risk patient rooms.

These studies show that UV light disinfection is a promising strategy in the fight against HAIs. But potential doesn't mean proven, which is why many healthcare organizations are still

Xenex LightStrike Germ-Zapping Robot

reluctant to incorporate the technology into their facilities.

"The process is increasingly being used, but it's not commonplace," says **Ed Septimus**, M.D., medical director of infection prevention and epidemiology, HCA Clinical Services Group.

Some Tenet Health facilities are using the approach, but only sporadically, says **Nicholaos Bellos**, M.D., assistant vice president of medical operations at Tenet Health in Dallas. "We haven't collected any data yet, so we're not ready to make a definitive decision about whether to use it across the board," he says.

CONSIDERING CHALLENGES

Another reason for moving slowly to implement UV disinfection is that the equipment is expensive, Bellos says. Also, it "requires manpower to move the UV system around the room as it cleans, and staff education to get it started," he adds.

An additional sticking point is the lengthier cleaning process. "We're finding that using the UV disinfection equipment adds 30 to 45 minutes to cleaning," Bellos says.

The researchers at Westchester Medical Center found it added 25 minutes to the cleaning process. According to the Pennsylvania study, room cleaning with UV disinfection took only five minutes longer on average. In actual practice, cleaning times vary from one hospital to the next because

Continued on page 20

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every facility has its own cleaning protocols.

In addition, it's difficult to pinpoint what's causing the spread of C-diff or other spore-borne illnesses in any given hospital.

"Multiple factors contribute to C-diff rates, including disinfection of the room, antibiotic use, infection prevention and patient population," Septimus says. "So the effectiveness of UV disinfection depends on the facility; some have seen a reduction [in infections] and others have not."

Clorox Healthcare Optimum-UV System

WEIGHING THE DECISION

Despite its promise, there is no evidence supporting UV disinfection as a stand-alone method for disinfecting a patient room. It should be used only after standard cleaning and chemical disinfecting processes have been employed. Becoming proficient in basic infection prevention practices, such as hand hygiene for healthcare workers, barrier and contact precautions, equipment management, antimicrobial stewardship and active surveillance, can play a much larger role in the prevention of HAIs.

Trinity Health is switching to a sporicidal disinfectant for all rooms, and focusing on standardizing and validating the cleaning and disinfection processes, says **Meredith Hotchkiss**, regional manager of hospitality services for Trinity's western region. Eventually, the hospital group may utilize UV disinfection "as a supplementary intervention," she adds. "However, this should be a data-driven decision-making process." In outbreak cases where root-cause analysis points to environmental factors, UV disinfection may be considered.

"The first step is to ensure all basic practices are being consistently applied," Septimus says. "Jumping to technology without making sure these basic practices are being executed will only result in small changes."

HealthTrust has contracts for UV light disinfection products from the following three suppliers:

- Clorox Sales Company (HealthTrust Contract No. 6940)
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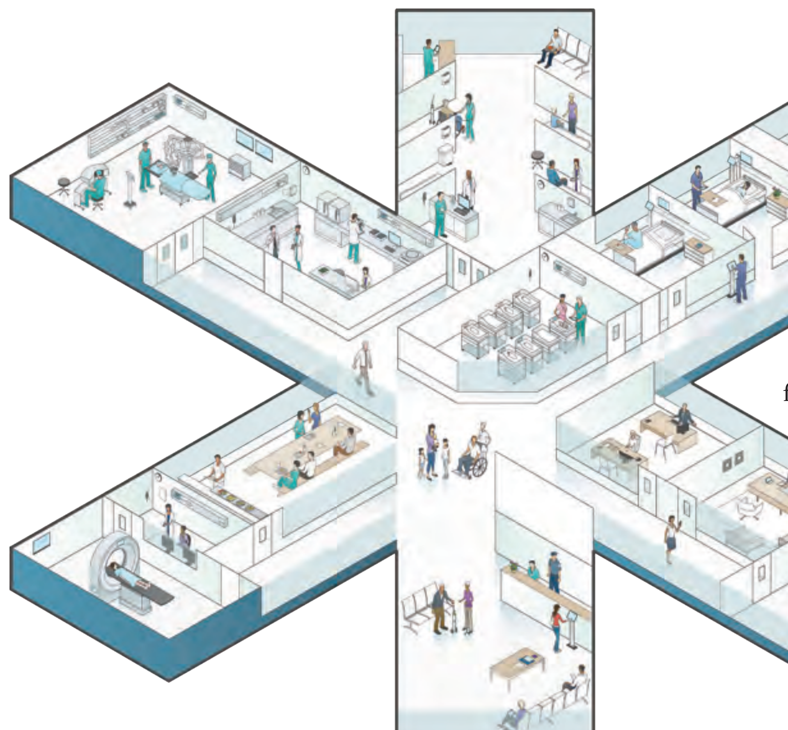

Getting an 'A' in Patient Safety

An Insider's Look at Meeting Joint Commission Guidelines

Accreditation by the Joint Commission—the largest and most prestigious of the healthcare industry's accreditation agencies—is not mandatory, but it's highly desirable. About 77 percent of hospitals in the United States currently have Joint Commission accreditation. Every three years, to maintain their Joint Commission accreditation, healthcare organizations must prove that they've met the commission's rigorous standards for performance and service.

The stakes are high—and the process is thorough and demanding.

"It's extremely nerve-wracking to go through a Joint Commission survey," acknowledges **Shaefer Spires**, M.D., an epidemiologist and physician chair of antimicrobial stewardship for Williamson County Medical Center in Franklin, Tennessee, echoing the feelings of most healthcare providers. Yet the act of preparing for a survey visit can be the necessary catalyst for ramping up a facility's quality of care and prioritizing patient safety.

WHY THE GOLD SEAL MATTERS

The Joint Commission tracks more than 250 hospital accreditation standards—and experts are constantly refining and updating them to make sure they reflect the latest evidence. The standards address everything from patient rights and education, infection control, medication management and preventing medical errors, to how the hospital verifies that its personnel are qualified and competent, and how it collects and uses data on its performance. Other types of healthcare organizations, including behavioral health organizations and home healthcare agencies, are also eligible for accreditation by meeting standards for their facility types.

Focusing on meeting the standards should be among an organization's top priorities, says **Angie Mitchell**, RN, director of nursing services, clinical operations for HealthTrust. Accreditation has financial ramifications: Many insurance companies won't reimburse an organization that isn't accredited, and hospitals lacking the designation risk losing their credibility with patients and the public.

That Gold Seal of Approval is not only validation of an organization's hard work—it's also an important symbol for patients and their families, even if they don't necessarily know everything that goes into becoming accredited, says **Michael Greer**, RN, MHA, senior director of regulatory and accreditation at LifePoint Health. "The Gold Seal shows that our hospitals have met high standards."

ALWAYS READY

The Joint Commission doesn't announce its visits in advance. The survey team makes a surprise appearance at an organization 18 to 36 months after its previous full survey.

Ongoing preparation is key, Mitchell says. "The Joint Commission can come in anytime, and you don't know until the day of."

Although it's typical for facilities to ramp up efforts when a visit seems imminent, "if you're doing what it takes for quality improvement, then a Joint Commission visit is just another day," Spires says.

In fact, everyday excellence—not a one-off scramble to meet the assignment—is the goal. To that end, the Joint Commission provides facilities with a self-assessment scoring tool to help them stay on track with standards compliance. Meeting and maintaining those standards should be "woven into the fabric of a healthcare organization's operations," as the commission says on its website.

Because the Joint Commission survey team might ask for cleaning or maintenance information during its visits, Mitchell suggests leaning on suppliers to provide those details. If suppliers offer

Continued on page 24

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*CLABSI=Central line-associated bloodstream infection

References: 1. Hayden, M. K., et al. A Randomized Cross-Over Clinical Trial to Compare 3.15% Chlorhexidine/70% Isopropyl Alcohol (CHG) vs 70% Isopropyl Alcohol Alone (Alcohol) and 5s vs 15s Scrub for Routine Disinfection of Needleless Connectors (NCs) on Central Venous Catheters (CVCs) in an Adult Medical Intensive Care Unit (ICU), Oral Abstract Presented at 2014 ID Week Conference, October 11, 2014, Philadelphia, PA. **2.** 2011 Guidelines for the Prevention of Intravascular Catheter-Related Infections, Healthcare Infection Control Practices Advisory Committee, US Centers for Disease Control and Prevention, 2011.

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PATIENT CARE ENVIRONMENT OF CARE **INTERVENTIONAL CARE**

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specialized training or value-added programs such as preventive equipment maintenance, offer that information to the survey team, she advises.

"As HealthTrust looks at contracts, the question of where and how this equipment will be used is always at the back of our mind," Mitchell says. "Is this something that the Joint Commission is going to come in and ask about?"

AUDITING FOR RISKS

No hospital runs flawlessly. All facilities—even among the nation's best hospitals—have something that can be enhanced. That's why it's important to make a self-assessment plan that includes metrics ensuring that improvement processes are in place and necessary changes are made.

Some organizations choose to contract with a consultant to gain insight into areas where they need to focus their energies. Mitchell says a consultant can bring a fresh set of eyes and an impartial view that can benefit many organizations when they're trying to determine what needs improving.

At LifePoint Health, Greer heads up a team of subject matter experts assisting LifePoint facilities in measuring up to the Joint Commission's standards. He estimates that he's on the road visiting facilities about 50 weeks of the year.

During the visits, called "survey readiness assessments," the team assesses the hospitals to identify risk areas. If they fall short in a particular area, the hospital team must develop a corrective action plan to help them get back into compliance. The subject matter experts work with facility leaders to provide support and ensure the necessary progress is made. The team returns to the hospital a few months later to conduct a follow-up survey.

The process, in place for about a decade, has been well received by LifePoint's facilities, Greer says. In fact, hospital leaders call him, eager to schedule a visit. "They consider it a value-added service," he says.

KEEPING THE MOTIVE IN MIND

The Joint Commission regularly updates its standards, requiring hospitals to monitor for changes and adjust accordingly. It can help to remember the overarching goal of Joint Commission standards: safe, high-quality patient care.

Spires underscores that these requirements aren't arbitrary, or merely bureaucratic paperwork. "The Joint Commission's motive is patient safety," he says. ●

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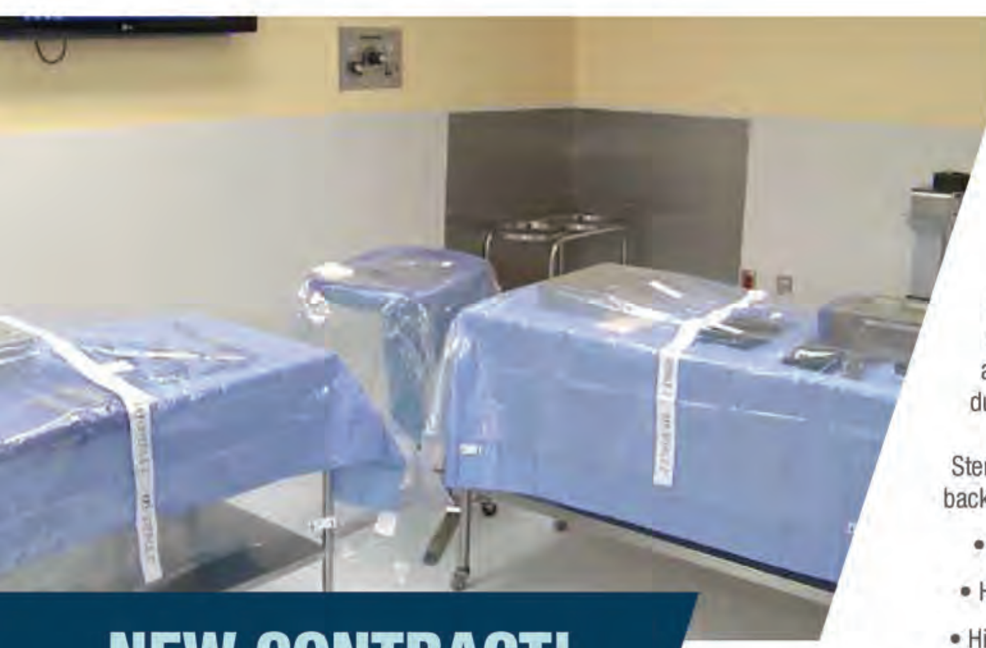

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*AORN Recommended Practices for Sterile Technique. Denver, CO: AORN, Inc; 2014: p105.

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9-1-1 EMERGENCY

HEALTHTRUST MEMBERS DEFEND AGAINST DISASTERS WITH COMPREHENSIVE AND WELL-EXECUTED EMERGENCY OPERATIONS PLANS

ATF agents join Boston police officers at the scene outside the Boston Medical Center Emergency Room following the explosions near the finish line at the 2013 Boston Marathon.

JIM DAVIS/THE BOSTON GLOBE VIA GETTY IMAGES

You can't always anticipate a disaster or emergency—in a moment's notice, a normal day can transform into a dramatic, movie-like scene. When it comes to natural disasters, such as hurricanes and tornadoes, and man-made emergencies, such as multivehicle accidents and mass shootings, it's paramount that nurses, clinicians and support staff are well-trained and prepared to respond quickly and appropriately. Advance preparation, planning and practice are a facility's lifeline to gaining control over these chaotic and often dangerous situations.

That's why hospitals are required to have an Emergency Operations Plan (EOP), a written plan that details how a facility will respond to and recover from all types of disasters. An all-hazards EOP includes six elements mandated by the Joint Commission's Emergency Management Standards: communications, resources and assets, safety and security, staff responsibilities, utilities and clinical, and support activities.

Some hospital systems, such as Nashville, Tennessee-based HCA, have created a network-wide EOP for its facilities. It's important for a hospital, even if part of a health system, to tailor its own plan, explains **Michael Wargo**, AVP of enterprise preparedness and emergency operations at HCA.

"Each facility has unique features," Wargo says. "Hospital leaders should do an assessment of their facility and infrastructure and look at hazards based on climate, geographical location and other community components."

The Joint Commission also requires organizations to test its EOP twice a year—either in response to an actual emergency or in a planned exercise. Periodic exercises can enable facilities to assess how the plan works in real time, the effectiveness of the plan's logistics, human resources, training, policies and procedures—and the limits of an emergency management system.

"These exercises give us a good look at how resilient we are," says Wargo, noting that HCA-affiliated hospitals complete more than the two mandated drills each year.

Three HealthTrust member facilities, faced with a variety of emergencies, have needed the experience of these hypothetical exercises when they were forced to shift into real-life crisis mode. Their leaders share the lessons learned on the front lines and ways all facilities can strengthen their emergency response capabilities.

HURRICANE MATTHEW: BRING IN THE CAVALRY

In October 2016, Hurricane Matthew ripped through Myrtle Beach, South Carolina, resulting in nearly $22 million in damages to city infrastructure, homes, buildings and dune walkovers, as well as in lost revenue. But in the days leading up to the storm, the leadership team from Myrtle Beach's Grand Strand Medical Center—a member of HCA's South Atlantic

GETTY IMAGES, BOSTON GLOBE / CONTRIBUTOR

HealthTrust To the Rescue

When a worst-case scenario hits your facility, it's wise to have contacts in your back pocket who can assist with disaster recovery. With HealthTrust-contracted suppliers, members will get preferential treatment after a crisis happens; emergency mitigation services, with the goal of immediately containing or reducing the effects of a disastrous event; and practical services such as air ambulances and priority access to generators and other vital supplies and equipment.

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"During emergency situations, having a fully vetted restoration partner with expertise and extensive experience working in the healthcare environment is vital to the recovery process," says **Jabin Newhouse**, SRM's account representative for HealthTrust.

Unlike with insurance plans, these services don't require a monthly premium—you're only charged when you need to engage the services. Each recovery service supplier will also provide required documentation to your insurance adjuster.

"HealthTrust has suppliers with close relationships with major carriers and can facilitate a fast claims process," says **Ward Martindale**, manager, strategic sourcing, HealthTrust Purchased Services.

Division—met daily to prepare. The team, representing multiple hospital departments called into action when the EOP is implemented, discussed the logistics of storm preparedness to ensure the facility had sufficient supplies, resources and personnel.

As the hurricane approached, the governor issued a mandatory evacuation and Myrtle Beach was put under curfew restrictions—though the hospital was exempt. Following the hospital's EOP, the staff at Grand Strand Medical Center secured extra supplies and resources, as well as decreased the patient load by canceling elective surgeries and outpatient procedures. The leadership team organized places for employees to spend the night at the hospital, using air mattresses and extra stretchers as makeshift beds and pitching tents in outpatient areas. Nurses volunteered to work all weekend, even as their own families were evacuating.

"We were aggressive in our preparations for the storm," says **Tiffany Keys**, chief nursing officer at Grand Strand Medical Center. "There wasn't a sense of impending doom, because we knew we had done everything we could do."

What the hospital couldn't do was prepare for the storm's aftermath: fallen trees, road debris, destroyed homes and transportation nightmares.

"We had 16 nurses call out on Sunday morning," Keys says. "Many of these employees were trying to sandbag to keep water from entering their homes. One nurse, who had worked all weekend, arrived home to find a tree had landed on his house. Obviously none of these nurses could come in."

During a standard emergency operations call with leadership from the South Atlantic Division office on Sunday morning, Keys relayed her staffing challenges. Division leaders escalated the need to the HCA corporate headquarters in Nashville.

Thanks to a partnership with HealthTrust Workforce Solutions, 18 multispecialty nurses—nine from Nashville and another nine from Houston, Texas—were on assignment at Grand Strand Medical Center by Sunday evening.

"To see a group of nurses who were happy, well rested and excited to help was emotional," Keys says. "It was the cavalry coming in. Because of their help, we could continue serving our community."

HealthTrust Workforce Solutions participates in calls with the HCA Emergency Operations Command Center, explains **Paula Philips**, vice president of clinical operations at HealthTrust Workforce Solutions. "Once HCA realizes a storm is coming or there's a disaster, it engages us to start monitoring the situation."

"We were staying up-to-date on what was happening in the area—everything from the weather to staffing and generators—and we had started building a pool of nurses who would be available to travel under short notice," adds **John Lowe**, the Eastern Region vice president of HealthTrust Workforce Solutions.

THE BOSTON MARATHON: THINKING ON THEIR FEET

On April 15, 2013, during the 117th Boston Marathon, two crude homemade bombs exploded near the finish line—the first at 2:49 p.m. and the second just 12 seconds later. Three spectators died from injuries sustained at the scene, and more than 250 people were wounded, some very seriously. Physicians and nurses from Boston Medical Center (BMC), as well as other Boston-area hospitals, were staffing medical tents at the race when the explosions happened.

"We received a phone call from one of the physicians in the medical tent at the finish line, alerting us that something had blown up," says **Maureen McMahon**, director of emergency management at BMC. "At that point, we started activating our emergency response plan. Within three to four minutes, we had confirmation that the explosions were bombs."

GETTY IMAGES; SEAN RAYFORD / STRINGER, ANDREW BURTON / STAFF

Continued on page 30

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Continued from page 28

Physicians immediately began tending to the wounded on-site, before transporting them to surrounding hospitals. The first patient arrived eight minutes after the explosion. Though not the closest hospital to the race route, BMC was the most easily accessible. Within a half-hour, there were 23 patients at the facility. Of those, 19 were admitted, 10 in critical condition. Five more victims with minor injuries trickled in over the next few days.

"Everyone pitched in," McMahon says. "We typically activate our Emergency Operations Plan under a variety of circumstances so that our staff are prepared and can quickly jump into action. The bombing, however, was unlike anything we had ever experienced, so our staff had to think on their feet that day. But they knew the procedures from multiple drills, so they were able to adjust to the unique conditions."

McMahon credits the incident management team at BMC for its quick response. When the emergency plan is activated, leaders from key hospital departments report to the emergency department for a briefing and are then responsible for coordinating their team. During this incident, clinicians and nurses lined the hallways, waiting to be called in to assist. It was impressive how cooperative everyone was, McMahon says, calling it a "true team effort."

What the hospital's EOP didn't account for, however, was the emotional toll the day would have on its staff.

"The bombers blew up our city, and we took it personally," McMahon says. "It affected us all. Every employee who was there that day and those who were not still remember the horror. We did a lot of work on that first day and in the days that followed to ensure our staff was not only physically OK, but emotionally OK."

This included convening a team at BMC with the sole purpose of comforting staff members. Massage chairs and "puppy vans" were brought in to help them relax. It worked.

"The puppy van turned into a new program at the hospital," McMahon explains. "Now we allow employees to bring their specially trained dogs to visit patients and staff. It brings a smile to their faces. That all started from the puppy vans after the bombing."

HURRICANE IKE: MERGE MEDICAL AND SECURITY TEAMS

A hospital evacuation during a hurricane is tricky. But evacuating 250 career criminals during a hurricane? That's the challenge **Troy Sybert**, M.D., was met with in September 2008 when Hurricane Ike plummeted the coast of Galveston, Texas.

Sybert, who is now a healthcare consultant in Johnson City, Tennessee, was then the chief medical officer of the state prison hospital, a 200-bed facility at the University of Texas Medical Branch. When he received word that the prisoners would have to evacuate the hospital, Sybert and his colleague, the prison warden, led coordination efforts.

"The biggest challenge was finding a place to take them," he says. "These were hardened, penitentiary criminals, and some hospitals were hesitant to take them because of the increased security risk."

Sybert's team nonetheless managed to transport all 250 patients to new locations within 20 hours. Some went to prison nursing facilities, while others were moved to regional hospitals that had experience treating inmates.

"We got the job done because of the relationship and understanding between the medical team and security team," he says. "As a doctor, your goal is to take care of people. It was an exciting opportunity to see how two teams with different expertise could accomplish such a major feat in less than 24 hours." **S**

See checklist on page 32.

Combating Infectious Diseases

THINK LIKE AN INVESTIGATOR

In December 2014, the first cases of the Ebola virus were detected in the United States. The deadly virus, which originated in West Africa, caused widespread panic, though there were only eight confirmed U.S. cases. While the CDC says Ebola is no longer a threat, the outbreak serves as a reminder that tested procedures are needed during an infectious disease outbreak. The key is preparation and training.

Grainger (**HealthTrust Contract No. 148**), a leading provider in the industrial supply industry, helps hospitals successfully prepare for crises before they happen, explains **Kym Orange**, the healthcare strategy manager at Grainger.

"We offer the broadest product portfolio in the market through an emergency preparedness-specific catalog, a dedicated section of Grainger.com that helps tailor plans for specific emergencies, and webinars aimed to educate hospital leadership on the latest in crisis prevention and response," Orange says.

When an emergency like Ebola—or another infectious disease—strikes, Grainger team members extend branch operation hours and assist as support resources in emergency operations centers. "We act quickly to surge inventory levels for critical products and, if necessary, prioritize specific items for first responders and first receivers," Orange says. "Through coordination and consolidation of supply chain efforts, we're able to deliver critical items to multiple locations."

When the Ebola crisis hit the United States in 2014, Grainger received a number of inquiries from HealthTrust members looking for assistance to protect healthcare workers from potential exposure. At the time, many healthcare organizations were struggling to identify and secure the appropriate personal protective equipment from their medical surge suppliers. They turned to Grainger.

"We played an integral role in bringing together HCA, HealthTrust, Grainger suppliers and manufacturers to identify, source and even develop the critical personal protective equipment needed for facilities and employees to manage the response," Orange says. "We were able to accelerate and prioritize the delivery of products to impacted facilities to keep them operating safely."

Physicians can play an important role in combating infectious diseases, says **Michael Wargo**, AVP of enterprise preparedness and emergency operations at HCA.

"Physicians should have situational awareness of what's happening in different pockets of the world," he says. "So if patients come in with flu-like symptoms and have traveled out of the country recently, they'll be asked where they went and how long after they returned that they got ill. Physicians have to be like investigators collecting information."

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Are You Prepared?

ELEMENTS OF AN EMERGENCY OPERATIONS PLAN

Developing a disaster preparation and response plan—and practicing it—is crucial to a healthcare facility's continuity during an emergency situation, experts advise. The speed and manner of disaster response are critical to a provider's recovery and rehabilitation.

Most facilities abide by a standard emergency preparedness framework, explains **Michael Wargo**, the AVP of enterprise preparedness and emergency operations at HCA, but there isn't a one-size-fits-all plan. Every facility has its own nuances, making it essential for its leaders to craft a detailed plan that is specific to the hospital's location and surroundings.

So what should your checklist include? Here are some ideas from the World Health Organization:

- [ ] **A designated command center.** Find a suitable location, whether physical or virtual, and communicate that location widely. Include representatives from administration, communications, security, emergency medicine, nursing administration, human resources, pharmacy, infection control, respiratory therapy, engineering and maintenance, laboratory, nutrition, supply chain, and laundry, cleaning and waste management. Make sure all representatives know their duties and responsibilities.

- [ ] **Communications plan.** Include a phone (text or email) tree in your plan to contact staff members. Designate a space for press conferences (away from the emergency department and command center) and appoint a spokesperson to communicate.

- [ ] **Safety and security.** Work with your security team in advance to identify areas of vulnerability. Talk with local law enforcement to determine procedures for integrating law enforcement in hospital security operations, if the situation warrants.

- [ ] **Triage.** Appoint an experienced triage nurse or clinician to oversee operations, and ensure that the triage site is close to the emergency department (ED), operating room and intensive care unit.

- [ ] **Surge capacity.** Designate areas for patient overflow and identify methods of expanding hospital inpatient capacity. Ensure staff knows to prioritize or cancel nonessential surgeries when necessary.

- [ ] **Human resources.** Keep an updated staff contact list in the plan, and establish a contingency plan for providing food, water and shelter. Mandate training for clinical areas that may be in higher demand during an emergency, such as the ED and intensive care, so staffing isn't an issue.

- [ ] **Logistics and supply chain.** Stockpile essential pharmaceuticals and supplies, such as linens, which often run out. Maintain an updated inventory of all equipment and supplies. List contact information for suppliers of emergency supplies and services, as well as a list of backup suppliers.

- [ ] **Post-disaster recovery.** Organize a debriefing for staff within 24–72 hours after the emergency incident to assist with coping and recovery. Take an assessment of damage to the hospital building, if any. Be sure to recognize your staff and volunteers for their extra efforts during an emergency response.

Print out and store on flash drives multiple copies of your Emergency Operations Plan and distribute them to team leaders. Keep them in locations, such as the trunks of cars, where members of your command center team can easily access them.

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CODE SILVER

FACILITATING A SAFE HEALTHCARE ENVIRONMENT

Incidents of serious workplace violence were, on average, four times more common in healthcare than in private industry from 2002 to 2013—putting healthcare workers at an increased risk for workplace violence, according to the Occupational Safety and Health Administration.

The majority of these violent altercations are caused by interactions with patients or someone entering the hospital with a weapon, explains **Tony York**, president and chief executive officer at Denver, Colorado-based HSS, Inc., a security firm that specializes in healthcare security.

York, author of *Hospital and Healthcare Security* (Butterworth-Heinemann, 2015), points to several incidents that have made national news: A hospital employee in California who killed two colleagues and himself after losing his job. A gunman in Alabama who wounded two hospital employees and a police officer. An armed man—on a felony warrant—holding a child in the ICU of a children's hospital in Wisconsin. These are just a few incidents that have made heightened security more crucial.

"The mission of your security program should be to facilitate a safe healing environment in which quality care can be administered," York writes. "The need for increased security has provided an unprecedented challenge in the methods and philosophies regarding protection of our healthcare organizations."

The most basic component of the healthcare protection system is a well-trained security force, he continues. The International Association for Healthcare Security and Safety (IAHSS) recently launched two new certification exams for security officers, as well as a new edition to its training manual for healthcare security officers.

Continued on page 37

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wilate® is a von Willebrand Factor/Coagulation Factor VIII Complex (Human) indicated in children and adults with von Willebrand disease for on-demand treatment and control of bleeding episodes, and for perioperative management of bleeding.

wilate® is not indicated for the treatment of hemophilia A.

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wilate® is made from human plasma and carries the risk of transmitting infectious agents.

Please see adjacent page for Brief Summary of Prescribing Information.

www.wilateusa.com

References: 1. wilate® Full prescribing information. Hoboken, NJ: Octapharma; 2015. 2. Berntorp et al. Haemophilia. 2009; 15:122-130.

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Date of preparation: 12/2016. WIL-051-CAD

HIGHLIGHTS OF PRESCRIBING INFORMATION

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

WILATE, von Willebrand Factor/Coagulation Factor VIII Complex (Human) Lyophilized Powder for Solution for Intravenous Injection Initial U.S. Approval: 2009

RECENT MAJOR CHANGES

Indications and Usage 8/2015

INDICATIONS AND USAGE

WILATE is indicated in children and adults with von Willebrand disease for:

- On-demand treatment and control of bleeding episodes
- Perioperative management of bleeding

WILATE is not indicated for treatment of hemophilia A

DOSAGE AND ADMINISTRATION

For Intravenous Use Only

- Use the following formula to determine required dosage:

  Required IU = body weight (BW) in kg x desired VWF:RCo rise (%) (IU/dL) x 0.5 (IU/kg per IU/dL)

- Adjust dosage and duration of the substitution therapy depending on the severity of the VWD, on the location and extent of the bleeding, and on the patient's clinical condition
- Dosing recommendations:

Type of Hemorrhages/Surgery	Loading Dosage (IU VWF:RCo/ kg BW)	Maintenance Dosage (IU VWF:RCo/ kg BW)	Therapeutic Goal
Minor Hemorrhages	20-40 IU/kg	20-30 IU/kg every 12-24 hours	VWF:RCo and FVIII activity trough levels of >30%
Major Hemorrhages	40-60 IU/kg	20-40 IU/kg every 12-24 hours	VWF:RCo and FVIII activity trough levels of >50%
Minor Surgeries (including tooth extractions)	30-60 IU/kg	15-30 IU/kg or half the loading dose every 12-24 hours for up to 3 days	VWF:RCo peak level of 50% after loading dose and trough levels of >30% during maintenance doses
Major Surgeries	40-60 IU/kg	20-40 IU/kg or half the loading dose every 12-24 hours for up to 6 days or more	VWF:RCo peak level of 100% after loading dose and trough levels of >50% during maintenance doses

In order to decrease the risk of perioperative thrombosis, FVIII activity levels should not exceed 250%.

DOSAGE FORMS AND STRENGTHS

WILATE is available as a sterile, lyophilized powder for reconstitution for intravenous injection, provided in the following nominal strengths per single-use vial:

- 500 IU VWF:RCo and 500 IU FVIII activities in 5 mL
- 1000 IU VWF:RCo and 1000 IU FVIII activities in 10 mL

CONTRAINDICATIONS

Do not use in patients with known hypersensitivity reactions, including anaphylactic or severe systemic reaction, to human plasma-derived products, any ingredient in the formulation, or components of the container.

WARNINGS AND PRECAUTIONS

- Anaphylaxis and severe hypersensitivity reactions are possible.
- Thromboembolic events may occur. Monitor plasma levels of FVIII activity.
- Development of neutralizing antibodies to FVIII and to VWF, especially in VWD type 3 patients, may occur.
- WILATE is made from human plasma and carries the risk of transmitting infectious agents.

ADVERSE REACTIONS

The most common adverse reactions (≥1%) in clinical studies on VWD were hypersensitivity reactions, urticaria, and dizziness.

USE IN SPECIFIC POPULATIONS

Pregnancy: no human or animal data. Use only if clearly needed.

Lactation: There is no information regarding the presence of WILATE in human milk, the effect on the breastfed infant, and the effects on milk production.

Pediatric Use: No dose adjustment is needed for pediatric patients as administered dosages were similar to those used in the adult population.

Geriatric Use: Although some of the subjects who participated in the WILATE studies were over 65 years of age, the number of subjects was inadequate to allow subgroup analysis to support recommendations in the geriatric population.

PATIENT COUNSELING INFORMATION

- Advise the patients to read the FDA-approved patient labeling (Patient Information and Instructions for Use).
- Inform patients of the early signs of hypersensitivity reactions including hives, generalized urticaria, tightness of the chest, wheezing, hypotension, and anaphylaxis. If allergic symptoms occur, advise patients to discontinue the administration immediately and contact their physician to administer appropriate emergency treatment.
- Inform patients that undergoing multiple treatments with WILATE may increase the risk of thrombotic events thereby requiring frequent monitoring of plasma VWF:RCo and FVIII activities.
- Inform patients that there is a potential of developing inhibitors to VWF, leading to an inadequate clinical response. Thus, if the expected VWF activity plasma levels are not attained, or if bleeding is not controlled with an adequate dose or repeated dosing, contact the treating physician.
- Inform patients that despite procedures for screening donors and plasma as well as those for inactivation or removal of infectious agents, the possibility of transmitting infective agents with plasma-derived products cannot be totally excluded.

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

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Healthtrust Contract #4861

Continued from page 34

Many hospitals go above and beyond compliance with state statutes that regulate security officers, requiring up to an additional 40 hours of specialized security and customer service training. Background checks and screenings for potential security officers are key to obtaining qualified personnel.

DEVELOPING A SECURITY MANAGEMENT PLAN

IAHSS and the Joint Commission recommend that healthcare facilities develop a comprehensive security plan, also known as a security management plan (SMP). IAHSS indicates this plan "should address systems, people, processes and security technology focused on the preventive, protective and response measures designed to provide a safe environment."

The Joint Commission recommends healthcare facilities consider these strategies when developing an SMP:

1. Identify risks. Form a multidisciplinary committee and conduct a risk assessment of the organization, and survey employees to determine how safe they feel while working. Maintain ongoing communication with local law enforcement agencies regarding community risk factors.

2. Evaluate environmental design. Install security cameras and panic buttons, and develop systems for signaling, alarms and monitors. Design the triage and other public areas to minimize risk of assault, and improve lighting in hallways, rooms and parking areas.

3. Promote a culture of safety. Develop a system for alerting security personnel when violence is threatened, and design staffing scenarios to prevent personnel from working alone. Ensure staff are comfortable reporting appropriate events to management and law enforcement.

4. Implement training. Work with local law enforcement to help train staff to recognize and resolve conflicts.

5. Plan for post-event activities. Promote open communication and encourage counseling if an employee has been threatened or assaulted.

York also recommends that hospitals include elements of financial planning and underscores the need to explore opportunities to work with outside law enforcement.

75%

or more of emergency physicians experience at least one violent workplace incident in a year.

"Without the framework of a strategic security policy and infrastructure, a program simply becomes one of day-to-day reaction, often resulting in a nonproductive and costly effort," York explains in his book.

Training your non-security staff is also important, adds **Chris Sonne**, director of emergency management at HSS, Inc. "Staff who are well-trained will respond and recover better. They will learn to develop situational awareness to know where to hide or exit should a threat arise."

The Joint Commission requires its accredited hospitals perform risk assessments and have plans in place for security of staff and patients. The primary goal, according to IAHSS, is to "identify and prioritize assets of the healthcare facilities' primary mission and operations, identify threats to and vulnerabilities of those assets, and develop reasonable risk-mitigation strategies to protect those assets." But this can't be done without support and assistance from hospital leadership.

"Healthcare organizations are starting to realize that security officers are critically important to ensuring safety inside the facility," York explains. "You have to ask yourself, 'How do we want security to be part of the overall mission of care?'"

SECURING THE EMERGENCY DEPARTMENT

The American College of Emergency Physicians (ACEP) reports that more than 75 percent of emergency physicians experience at least one violent workplace incident in a year. In addition, in 2013, more than 70 percent of ED nurses reported physical or verbal assault by emergency patients or visitors. This reflects an overall increase of violence in society tied to gangs, drugs and alcohol use, and a larger number of armed private citizens. The lack of quality mental health facilities also results in more patients in the emergency medical system.

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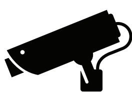

When it comes to outsourced security services that will keep your hospital personnel, patients and guests safe, HealthTrust is on the case. HealthTrust-contracted suppliers offer such services as armed and unarmed security officers that can patrol facility and parking areas, incident reporting and tracking, monitoring of security cameras, crime and violence prevention, and security awareness programs.

"Having a safe and secure environment with which to deliver treatment is essential for our members in providing their patients with high-quality care," says **Monique Hunter**, director of strategic sourcing for HealthTrust Purchased Services. "It's critical that patients, staff and visitors trust that their safety is in the forefront of our members' minds. We believe that HealthTrust's security services contracts are cost-effective solutions that can help provide member organizations with the professional quality and experience necessary to meet each facility's unique security challenges."

The following suppliers are on contract with HealthTrust: Allied Universal (Contract No. 2709), DSI Security Services (Contract No. 10456), G4S Secure Solutions (Contract No. 7065), HSS, Inc. (Contract No. 7069) and Yale Enforcement Services (Contract No. 2510).

For specific pricing, members can contact their national account representative to discuss their facility or group's service needs. All suppliers provide national coverage, but some have geographical limitations.

department, family member stress and anger, long wait times and cramped space, and you increase the odds for violence and disruption to occur.

York recommends that hospitals utilize dedicated security officers to monitor and patrol the emergency department. "Make sure they are highly visible, but also able to quickly respond to an incident," he explains.

IAHSS also suggests addressing specific security design needs for the emergency department, including:

- Entrances equipped with video monitors displaying live camera images for public viewing and awareness

- Clear distinction and signage between walk-in and ambulance entrances
- An ambulance entrance that is restricted to authorized emergency medical services and hospital personnel
- Access to medical treatment areas—including all doors, interior elevators and stairwells—controlled by and restricted to hospital personnel
- A designated safe room, equipped with a duress button, telephone and reinforced doors, which can be locked from the inside as a place for staff, patients and visitors to retreat in the event of immediate danger

York also recommends metal detectors for people entering the treatment area of the emergency department, but notes that some organizations wrestle with the idea of using them. "It's amazing the items that people carry on their person. Some people simply forget they are carrying a concealed firearm."

Experts advise that other sensitive areas—behavioral health units, pharmacies, pediatric wards—should also follow similar guidelines and look for specific ways to protect patients and staff. **S**

"The mission of your security program should be to facilitate a safe healing environment in which quality care can be administered."

Tony York, President and CEO, HSS, Inc.

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Patient Safety Strides

How to Make Safe Surgery and Smart Tracking of Surgical Instruments a Priority

The inadequate cleaning of reusable instruments ranks as one of the top 10 health technology risks for providers in 2017. In fact, it has been identified as a hazard for the past six years in a row by the ECRI Institute, a nonprofit that researches approaches to improving patient care. Meanwhile, between 2,000 and 4,000 surgical items are accidentally left behind in patients each year in the United States, according to NoThingLeftBehind.org, a national surgical patient-safety project to prevent retained surgical items.

As healthcare providers work to improve the safety of patients in the operating room and throughout the course of their treatment, they are zeroing in on better processes for processing and tracking surgical instruments.

ISTOCK

"TRACKING SYSTEMS CAN BE USED TO COUNT INSTRUMENTS SENT FOR STERILE PROCESSING, BUT THEY CAN ALSO TRACK REPAIR HISTORIES, CLEANING AND STERILIZATION PROCESSES."

PAM DELONG, DIRECTOR OF SURGICAL SERVICES AT HEALTHTRUST

REFINING THE PROCESS

Though the Joint Commission's healthcare facility reviews include proper equipment reprocessing and cleaning, many providers continue to face challenges in meeting all the criteria. While it was once common to clean surgical instruments with flash sterilization—a quick modification of conventional steam sterilization for immediate use—that approach is no longer recommended for patient safety reasons. According to the Joint Commission, flash sterilization should only be used in extraordinary circumstances.

"There are multiple steps in the process of tracking and disinfecting instrumentation and equipment for reuse," says **Pam Delong**, director of surgical services at HealthTrust. "Just one misstep could have very serious consequences. Some devices are difficult to clean and others, such as endoscopes, take multiple steps to ensure cleanliness and then disinfection."

"In recent years, the topic of instrument disinfection and sterilization has been widely discussed, and suppliers are working closely with the Food and Drug Administration and the Centers for Disease Control and Prevention to ensure that appropriate methods are in place for removing all debris, tissue and bacteria," Delong says. "Most suppliers also offer training on the cleaning and disinfection of scopes."

STEPS FOR SAFETY

Franklin, Tennessee-based Community Health Systems (CHS), which owns, operates or leases 158 hospitals in 22 states, has instituted a number of successful patient safety strategies. For example, five years ago, its affiliated hospitals began using the Stryker SurgiCount Safe Sponge technology to help ensure a more accurate, real-time count of surgical sponges in the operating room.

"Nationally, sponges account for 80 percent of retained items, and 90 percent of the time when sponges are retained the doctor was told that the count was correct," says **Pat Turner**, senior director of surgical services at CHS. "The SurgiCount technology ensures staff is counting appropriately. Our affiliated hospitals perform approximately 1 million surgical cases each year, and there has been a significant reduction in retained sponges by the utilization of this technology."

In addition to using sponge tracking technology, CHS promotes the use of a Safe Surgery Checklist, which is similar to the World Health Organization's Surgical Safety Checklist. As part of these guidelines, everyone in the room should participate during the briefing and debriefing. Before every invasive procedure, a timeout is called and team members in the operating room go through the checklist together. "The checklist incorporates a briefing among the healthcare team, and it promotes teamwork in the operating room," Turner says.

Continued on page 43

Cleaning Correctly

While the current Joint Commission standards for disinfecting instruments define the desired outcomes, they don't necessarily explain how to get there. The Association for the Advancement of Medical Instrumentation working groups are developing clear, standardized instructions for reprocessing reusable devices. In the interim, Case Medical recommends the following multistep cleaning process that includes washing, rinsing and drying:

1. To keep instruments moist, start with a multi-enzymatic spray or foamer. Do this at the point of use or when sets come down from the OR or floors to the decontamination area. This avoids the challenge of removing dried-on bioburden. Moist items are easier to clean. Enzymes start the decontamination process immediately upon application and are preferred as precleaners, or catalysts that break down soils upon contact.

2. Use a multi-enzymatic detergent for the first wash cycle of automated washers.

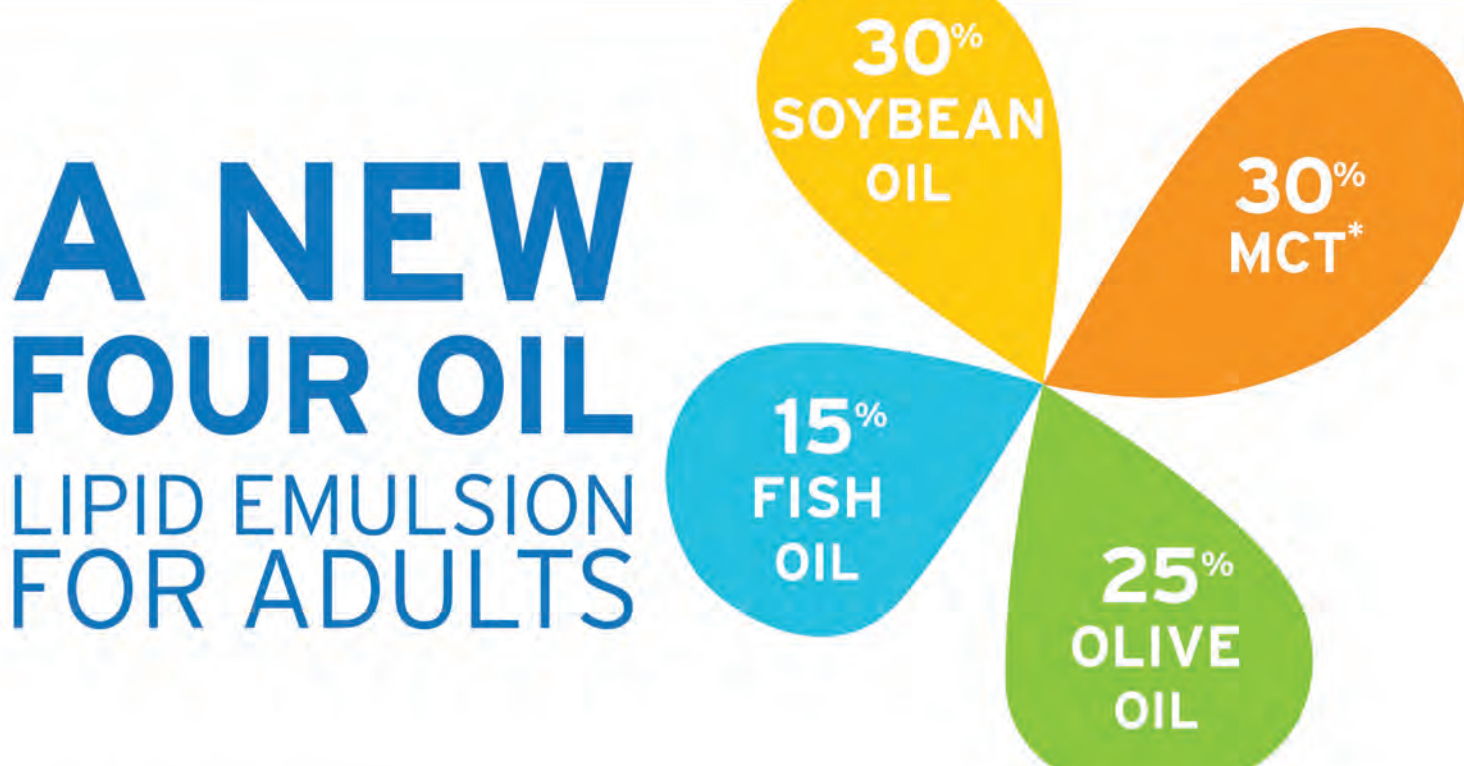
3. Thoroughly rinse. Most machines are now set with a 15-minute rinse at this step or none at all. Detergents, including enzymatic ones, are designed to lift soils off surfaces and put them into suspension so they can be rinsed away. This is a critical step for infection prevention.

4. After this rinse, follow with a pH-neutral, validated, free-rinsing detergent—especially when tap water is used for cleaning—to remove total dissolved solids and minerals, as well as any residue from the previous wash step.

5. Proceed with a thorough disinfecting rinse at greater than 90 degrees C. Many facilities use a lubricating cycle afterwards, but not all use an aqueous or water dispersible emulsion.

6. Finally, include adequate time to thoroughly dry devices in the automated washer, for a minimum of eight to 10 minutes. Wet devices can provide a medium for microbial growth as well as corrosion.

ISTOCK



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DOSAGE AND ADMINISTRATION

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CONTRAINDICATIONS

- Known hypersensitivity to fish, egg, soybean, or peanut protein, or to any of the active ingredients or excipients.
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WARNINGS AND PRECAUTIONS

Monitor for signs or symptoms of:

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- Infection, Fat Overload, Hypertriglyceridemia, and Refeeding Complications: Monitor laboratory parameters.
- Aluminum Toxicity: Patients with renal impairment, including preterm infants are at increased risk.
- Parenteral Nutrition-Associated Liver Disease: Increased risk in patients who receive parenteral nutrition for extended periods of time, especially preterm infants. Monitor liver function tests, if abnormalities occur consider discontinuation or dosage reduction.

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Continued from page 40

Also as part of the procedure, the circulating nurse introduces everybody in the room—including anesthesia professionals and supplier reps—who take turns talking about their role during the surgery, what they will do for the patient, and any other information to share about the patient or procedure.

The surgeon should say, "If you see anything that concerns you, please speak up," one quick line that helps overcome any inhibitions that junior team members may feel about speaking up in front of senior-level professionals.

Such team conversations create an open, collaborative culture in the operating room, which Turner believes helps ensure patient safety. As part of the South Carolina Safe Surgery 2015 Project, CHS has worked since 2013 with Atul Gawande and Ariadne Labs at the Harvard University School of Public Health to develop safe surgery routines, and is part of an ongoing Harvard study about how to improve the culture of safety in the operating room.

"Many CHS-affiliated hospitals also utilize critical event checklists that were created by working with staff on OR-related events such as hemorrhage and hypothermia," Turner says. "Several of our affiliated hospitals helped develop critical event checklists for events in surgery, and other departments such as obstetrics and emergency medicine."

TRACKING TRENDS

Hospitals that are focused on implementing the latest procedures to keep patients safe are seeing results, and the healthcare industry continues to fine-tune the solutions. In recent years, tracking technology has become increasingly important.

"Tracking systems can be used to count instruments sent for sterile processing, but they can also track repair histories, cleaning and sterilization processes," Delong says. "Additionally, tracking systems can assist with instrument inventory. They can locate instruments and monitor their availability for surgical cases, which helps to prevent lost instruments."

Today's tracking systems have evolved so that they now can interface with other systems and devices, such as steam sterilizers and high-level disinfection equipment, Delong says. These features have become more critical as accurate records are needed for quality assurance recordkeeping of sterilization and high-level disinfection documentation. Some advanced tracking systems can include each instrument's instructions for use (IFU) or recommended cleaning protocol, she adds.

"Appropriate sterile processing can be challenging, with the high volume of sets needing to be reprocessed, the complexity of the devices, and the numerous and conflicting IFUs and recommendations," says **Marcia Frieze**, CEO of Case Medical, a U.S. manufacturer of products for instrument processing.

Healthcare facilities should establish standardized parameters and validate their cleaning process to ensure effective decontamination is the result each and every time, Frieze says.

"A FEW EXTRA MINUTES OF REPROCESSING TIME AND ELEVATED TEMPERATURE FOR TERMINAL DISINFECTION CAN MAKE THE DIFFERENCE BETWEEN A SUCCESSFUL OUTCOME OR AN INFECTION THAT CAN BE LIFE-THREATENING."

MARCIA FRIEZE, CEO OF CASE MEDICAL

She recommends starting by reading the manufacturer's IFUs for proper care and handling.

"Keep in mind that a few extra minutes of reprocessing time and elevated temperature for terminal disinfection can make the difference between a successful outcome or an infection that can be life-threatening," she adds.

A number of "test soils" are available on the market to verify that the equipment and cleaning agent is working effectively, such as Case Medical's product for routine monitoring. (HealthTrust Contract No. 7303)

Several published guidelines are available for hospitals to ensure their instrument cleaning protocols meet the latest standards: *The Association of periOperative Registered Nurses' Guideline for Cleaning and Care of Surgical Instruments 2015* and the *Association for the Advancement of Medical Instrumentation's Comprehensive Guide to Steam Sterilization and Sterility Assurance in Health Care Facilities.* **S**

TEAMWORK TOOLS

YOUR **Q1 GUIDE** TO VIGILANCE IN FIGHTING HOSPITAL-ACQUIRED INFECTIONS AND BOOSTING PHYSICIAN MORALE AND BEATING BURNOUT

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MEMBER IN ACTION: Orthopedic surgeon and HealthTrust Physician Advisor Mitul Patel, M.D., is working diligently to make infection prevention a top priority. By combating hospital-acquired infections with evidence-based measures and technology, hospitals can reduce the risk of infection.

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LEADERSHIP LINK: When physician morale began sagging among her colleagues in the LaPorte County, Indiana-area, vascular surgeon Virginia Newman helped start the Enigma Series, an interactive continuing education program bringing physicans together to discuss medicine outside of hospital or group politics.

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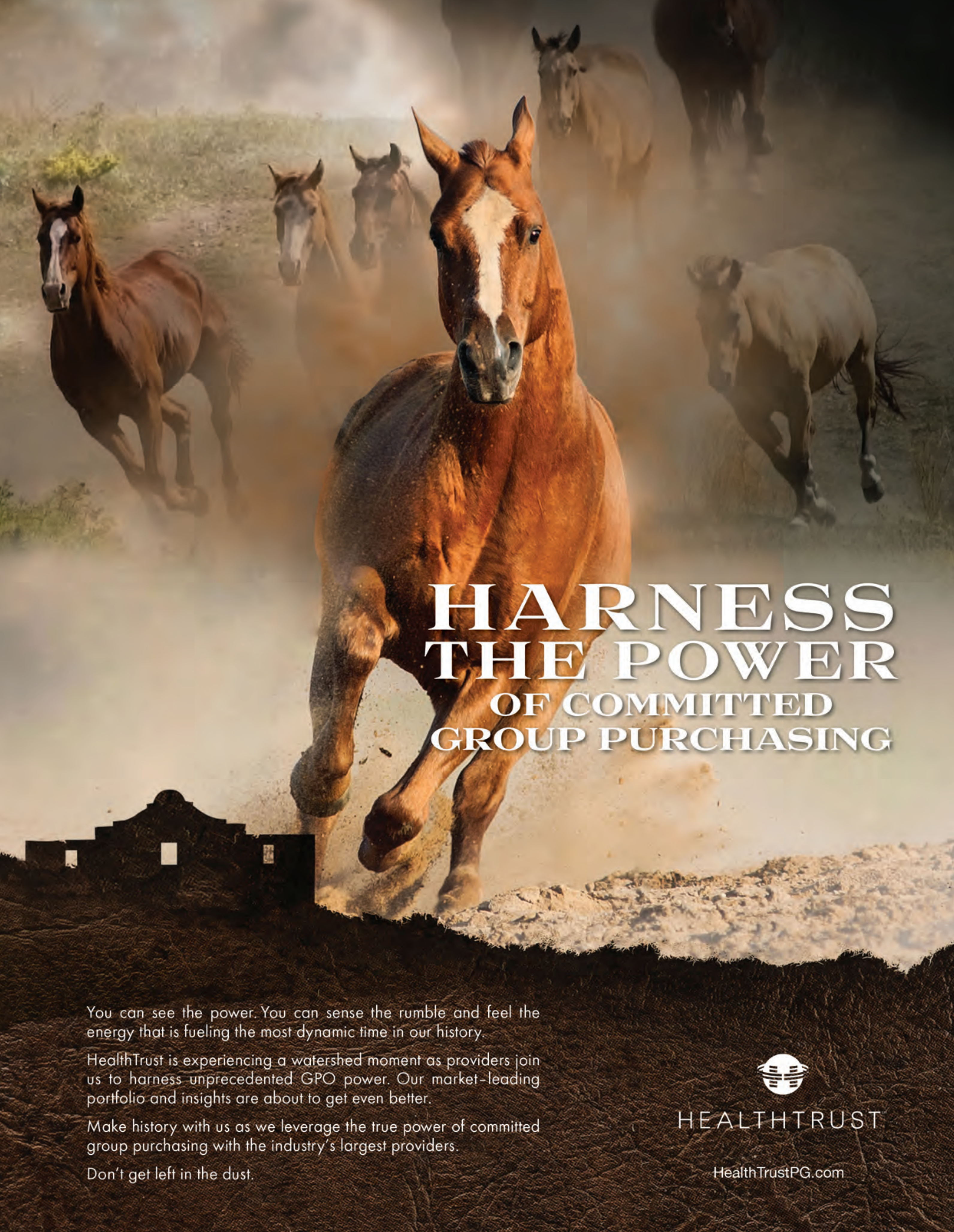
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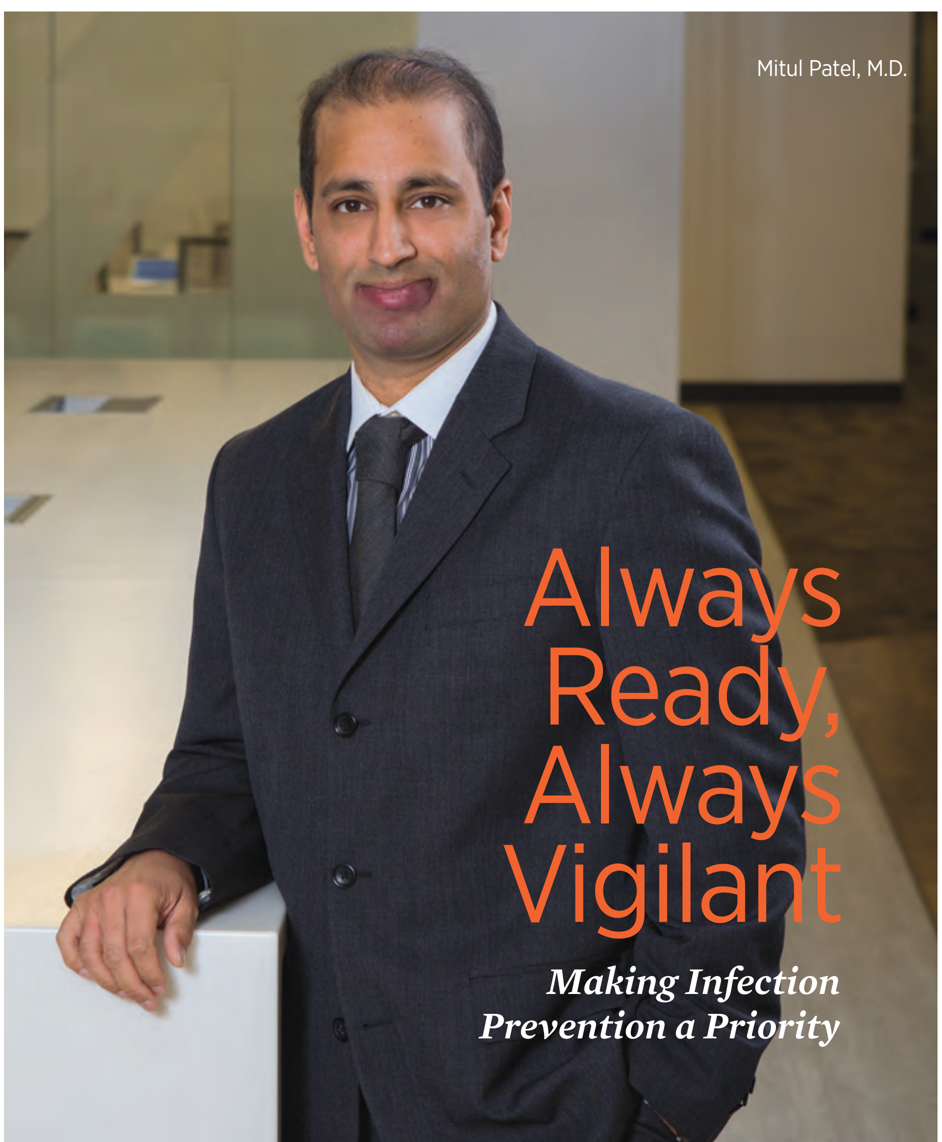
Mitul Patel, M.D.

Always Ready, Always Vigilant

Making Infection Prevention a Priority

Infection prevention is both a challenge and an urgent priority for healthcare organizations. As threats emerge, the latest research identifies—or disproves—new infection prevention strategies. Payers, meanwhile, are increasing the pressure on providers to prevent healthcare-acquired infections (HAIs).

KNOCKING OUT HAIs

Over the past decade, the healthcare industry has made significant progress in preventing hospital-acquired infections. The biggest success story is a 50 percent reduction in central line-associated bloodstream infections (CLABSIs) between 2008 and 2014, according to the Centers for Disease Control and Prevention's National and State Healthcare Associated Infections Progress Report, published in 2016 (www.cdc.gov/hai/pdfs/progress-report/hai-progress-report.pdf). Surgical site infections (SSIs) decreased 17 percent. Additionally, between 2011 and 2014, methicillin-resistant *Staphylococcus aureus* (MRSA) infections decreased 13 percent and *Clostridium difficile* (C-diff) infections were down 8 percent, as reported by the CDC.

Despite progress on the prevention front, HAIs still affect around one in 25 hospital patients on any given day and cost nearly $10 billion to treat annually, according to a 2013 study published in *JAMA Internal Medicine*. The study found that SSIs are the largest contributor to overall costs, followed by ventilator-associated pneumonia and CLABSIs.

Mitul Patel, M.D., an orthopedic surgeon at TriStar Summit Medical Center in Hermitage, Tennessee, says one of the most concerning outcomes after spinal fusion with hardware is a deep surgical site infection.

"Oftentimes, SSIs are associated with poor patient outcomes, including delayed wound healing and increased use of antibiotics, pain and lengths of stay," he says. "And SSIs can lead to multiple major revision operations."

What's more, the financial cost to the patient, provider and payer increases significantly once a surgical site infection occurs. Patel estimates it can cost 3-4 times more than the index procedure once a surgical site infection occurs.

Payers, including the Centers for Medicare & Medicaid Services (CMS), have already begun penalizing hospitals for HAIs. In 2015, CMS levied a 1 percent penalty on nearly 800 hospitals—22 percent of applicable facilities—due to their poor performance in preventing HAIs. In FY 2017, as CMS raises the performance threshold, hospitals' scores will have to be even better to avoid the penalty.

"These infections are extremely costly and they represent a growing economic burden for the American healthcare system," Patel explains. "With new payment models emerging, avoiding potentially preventable and costly postoperative complications is extremely important."

With an increasing focus on bundled episodes of care, complications following the index procedure, including infection, are typically not reimbursed. The financial burden of caring for the HAI is then on the provider.

"To avoid SSIs, it will become extremely important to stratify patients according to risk prior to surgery," Patel says.

ATTACKING WITH EVIDENCE-BASED MEASURES

Much of the recent drop in HAIs can be attributed to the bundling of various evidence-based interventions.

To prevent CLABSIs, evidence supports

SHERI O'NEAL

five different interventions: hand hygiene before catheter insertion; removing catheters when no longer needed; maximum sterile barrier precautions; chlorhexidine alcohol skin prep for insertion and maintenance; and chlorhexidine bathing of ICU patients over the age of two months.

Bundling interventions becomes even more important in the prevention of SSIs, where a long list of risk factors puts patients at heightened risk—e.g., age, high blood sugar levels, susceptibility to certain medications or medical conditions, a high volume of blood loss, lengthy procedure time and, prior to surgery, inappropriate skin prep and/or dosing of antibiotics. *(See sidebar on right for more factors.)*

> "The accurate identification of risk factors is essential to developing strategies to reduce surgical site infections. And, since many of the risk factors are directly related to the patient, optimizing patient health prior to surgery is becoming a major focus."
>
> **Mitul Patel**, M.D., orthopedic surgeon, TriStar Summit Medical Center

"The accurate identification of risk factors is essential to developing strategies to reduce surgical site infections," Patel says. "And, since many of the risk factors are directly related to the patient, optimizing patient health prior to surgery is becoming a major focus."

Since 2005, the Surgical Care Improvement Project released a set of basic quality measures in hopes of reducing the incidence of SSIs. These include the timing and appropriate choice of antimicrobial prophylaxis, the avoidance of shaving hair at the surgical site, and both maintaining patient normothermia (normal body temperature) and controlling blood glucose levels during the perioperative period.

Healthcare organizations have more recently begun to take additional steps based on newer developments in infection prevention. For example, it is now standard practice to do preoperative nasal screening for MRSA. Based on the results of the nasal screening as well as other factors, surgeons are then able to administer appropriate antibiotic prophylaxis before and after surgery, including both nasal and skin treatments, Patel says. Increasingly common are other practices that include optimizing antibiotic prophylaxis dosing based on length of a procedure and the patient's weight, and providing supplemental oxygen to patients during and after a surgical procedure. A 2014 study in the *AORN Journal* associates these steps with a 25 percent risk reduction for SSIs.

In terms of preventing joint infections, Patel is optimistic about the possibilities of nanotechnology and the introduction of antibiotic-coated implants. "These may aid in the prevention and early treatment of periprosthetic joint infections," he says. "They may also help improve eradication rates."

An important takeaway on these and other developments in infection prevention is that many of the clinical practices are still being refined. For example, chlorhexidine gluconate (CHG) bathing is recommended for critically ill patients and those undergoing cardiac surgery.

"Chlorhexidine is a broad-spectrum topical antimicrobial agent which, when used to bathe the skin, can decrease the bacterial burden and therefore reduce infections," says **Angie Mitchell**, RN, director of nursing services and clinical lead of the infection prevention specialty committee at HealthTrust. Additional studies are being conducted confirming the appropriate use of CHG bathing and limiting the potential of antibiotic resistance.

Healthcare organizations are also relying on antimicrobial stewardship teams to guide the appropriate use of antimicrobial medications, in an effort to curb antibiotic-resistant infections. According to the CDC, at least 2 million people in the United States become infected with antibiotic-resistant bacteria each year, and at least 23,000 of them die as a direct result of these infections. The Joint Commission released a new standard related to antibiotic stewardship last year, and the CMS is working on a rule change that would require antibiotic stewardship as a condition of participation in Medicare and Medicaid. *(Learn more on page 14.)*

Top Risk Factors for Surgical Site Infections

PATIENT FACTORS

- Diabetes and preoperative control of blood sugar levels
- Obesity
- Malnutrition
- Smoking
- Decreased immunity from certain medicines or medical conditions such as rheumatoid arthritis and cancer
- Previous history of infection
- Staphylococcus aureus colonization
- Certain skin conditions such as psoriasis
- Advanced age

OTHER FACTORS

- Complexity and invasiveness of procedure
- Amount of blood loss
- Procedure length
- Surgical technique and sterility
- Proper selection of antibiotics within one hour of surgery
- Proper preparation of skin prior to surgery
- Limiting traffic in the operating room
- Body temperature control

PERFECTING HAND HYGIENE

Healthcare organizations continue to struggle with an infection prevention practice that dates back to the 19th century, and countless studies have found to be the easiest, least expensive and most important way

to reduce HAIs—hand hygiene. On average, providers clean their hands less than half of the times they should, according to the CDC.

Historically, hand hygiene compliance initiatives involved visual observation, with clinicians employing a "secret shopper" approach to identifying and tracking infractions. Today, healthcare organizations are instead beginning to use technology to monitor compliance.

But there are drawbacks. One potential issue is whether the monitoring technology can be tricked into detecting compliance when hand-washing is in fact done incorrectly, such as when clinicians bump up against a sensor but don't actually wash their hands. Another is whether the monitoring technology is compatible with current soap dispensers or if modifications will be necessary.

When hand hygiene monitoring technology comes under HealthTrust contract in spring 2017, "our members will be able to initiate a program at a more appealing price point."

Angie Mitchell, RN, director of nursing services and clinical operations, HealthTrust

"Soap dispensers are not the easiest category to convert," Mitchell says. "There's sheer volume to contend with, and then potential wall repair once the new dispensers are in place."

Not all monitoring technologies rely on soap dispensers, however. One from Biovigil Systems utilizes a smart badge worn by clinicians. When someone enters a patient room, the badge turns yellow and chirps to signal that hand hygiene is required. After the clinician washes her hands, she waves a hand over the badge. If the sensor detects alcohol, the light turns green. If not, it turns red.

HealthTrust is looking to expand its contract portfolio in the area of technology that is used to monitor hand hygiene. Last fall, its infection prevention specialty committee

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invited six suppliers to present their solutions—the first contract should be awarded in the spring of 2017.

"Unfortunately, these systems are expensive, and you can't get reimbursed for hand hygiene compliance. But, with this type of technology available on contract, our members can at least initiate a program at a more appealing price point," Mitchell adds.

Within the last year, HealthTrust added a new infection prevention category—UV disinfection services—proven effective in killing C-diff, MRSA and vancomycin-resistant *Entereococcus* on hospital room surfaces. For hospitals that can't afford the capital outlay, Diamond Restorations (HealthTrust Contract No. 7294) can provide the workforce and equipment to disinfect rooms. *(Read about the latest on UV disinfection on page 18.)*

FIGHTING BACK AT THE FRONT END

A year ago, the Zika virus was barely a blip on the radar; today, the mosquito-borne disease is one of more than 75 infectious diseases and conditions under active surveillance by the CDC. To date, there have been more than 4,000 confirmed cases in the United States. The majority of those cases are travel-related, including people

(or their sexual partners) returning from affected areas. Although last November the World Health Organization declared Zika was no longer a global health emergency, that doesn't make it—and other infectious diseases—any less of a priority for providers.

"Some of these diseases can spread so quickly that they can take off even before an outbreak is recognized and a plan is put into place," Mitchell says.

So what can healthcare organizations do to protect their patients, workers and communities from the next outbreak? Practice the basics of infection prevention: Monitor infections through active surveillance, encourage vaccination for preventable diseases, and follow standard precautions such as washing hands, wearing gloves and asking patients the right questions on the front end to determine if they're contagious. ●

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PHYSICIAN Q&A: *Virginia Newman, M.D.*

Enigma Program Beats Burnout and Boosts Physician Morale

About six years ago, to combat what she saw as a dip in physician morale among her colleagues at Franciscan Alliance Michigan City, **Virginia Newman**, M.D., started the Enigma Series, a continuing medical education program in which physicians discuss medical cases with their peers. The program's successes have been far-reaching—not only helping physicians beat burnout, but even strengthening communication between physicians and hospital administration and improving decision-making around physician preference items.

What sparked the desire to start the Enigma Series?

While making rounds and spending time in the doctor's lounge of my hospital, I kept noticing that most physicians were walking around with their heads bowed and there wasn't much talking or interaction. You could feel a lot of tension among physicians in different specialties, and even among different groups within the same specialties. I decided we needed to find a way to remind one another of why we got into medicine, reaffirm the talent of our colleagues and help break down barriers between physicians.

What's a typical Enigma session like?

With the Enigma Series, we've gone from a receptive type of learning—the lectures we're all so familiar with—to an interactive type of learning, making the education process much more gratifying. Each session has between 25 and 35 physicians and a moderator who gives a short review of the case and explains current treatments. The cases are presented in a way that helps the group arrive at a diagnosis together. All cases are from the local medical community and are not disclosed before the event so as to discourage selective participation based on cases or specialties being presented.

We designed the format to facilitate as much interaction between audience members as possible. Instead of having tables in which people sit to watch a presentation, tables are configured into a large U-shape that requires people to intersperse and not separate into cliques. In this scenario, a podiatrist sits next to a heart surgeon who sits next to an infectious diseases specialist who sits next to an orthopedist.

As moderator for the first few sessions, I had to initiate the conversation and call on people. At first everyone was a little reluctant to ask a question or venture an answer and potentially look foolish, so I started by picking a specialist with some familiarity with the topic being presented. That person would start talking, then another person would chime in and someone else would say something funny. That helped everyone loosen up and naturally sparked a friendly, sometimes challenging, and often humorous conversation. Once everyone started talking, they decided they weren't all so bad and that they even liked each other!

These interactions have certainly fostered collegiality among physicians. They've also broken down preconceived biases and re-energized interest in the respective specialties. Now when we start a presentation, we can hardly go through two sentences before someone wants to contribute. That's a sign to me that it's working.

What were your goals with the program and how have those been reached?

What we wanted out of the program, we achieved—a change in physician morale and a dissolution of barriers and biases between specialties. Since a majority of physicians and medical staff return every session, we've gotten much closer as colleagues and as people. The interpersonal relationships have progressed as the program goes on.

When we see each other outside the program, the dynamic is different now. When an issue needs to be discussed, our familiarity with one another means we tend to be frank and honest and get right to the point. Reaching a solution together, or finding consensus, has become much simpler.

The most important thing that came out of Enigma is a reaffirmation of the physicians'

Virginia Newman, M.D., is a vascular surgeon at Vascular Center of the Great Lakes and Franciscan St. Anthony Health, in Michigan City, Indiana. She's the director of the Limb Preservation Center at Franciscan St. Anthony Health. Her treatment for pelvic congestion syndrome was once featured in an international blog, and she has an emerging reputation as a specialist in renal autotransplantation. Dr. Newman received her bachelor's degree from Harvard University, and medical degree from Cornell University Medical College.

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love of medicine, which counterbalanced much of their frustrations with administrative duties, lack of autonomy and shrinking reimbursement. Physician morale has definitely improved. The resurgence of interest in medical education has lead us to initiate a quarterly publication called the *Specialty Corner*, which is dedicated to the most recent and relevant advances in a particular specialty, substantiated with a bibliography, and written by physicians in a featured specialty, even if they are from competing groups.

How else has this interaction benefited your hospitals and physicians?

It has helped us administratively. Many of the physicians who attend Enigma are also part of the hospital's committee structure and are either engaged in peer review, credentialing, directorships or clinical operations groups. Let's take a cath lab subcommittee as an example of how it has helped us make decisions. Say I need to make some inventory decisions because I realize I have three balloon catheters that do the same thing. Discussing the possibility of streamlining the balloon inventory with the interventional cardiologist and interventional radiologist is a much more comfortable, non-confrontational experience as a result of the relationships built around the Enigma Series and the resulting camaraderie. Thus we can reach consensus around a common objective, which is to have what we need to provide good care while supporting the financial viability of our hospital. They aren't threatened by my opinion because we have more trust and a better personal relationship. And from that, we can work more productively on committees and better serve the interest of the medical staff as a whole.

What are some of the common tension points between administrators and physicians, and what are ways to overcome them?

What I see, having been in private practice and now as an employed physician, is the hospital's interest and physicians' interests are perceived as being separate. I think that's a misperception on the part of both parties. Physicians can't have a successful practice if they don't have a strong support system, and a hospital can't have market share or proper reimbursement models if they don't have a productive cadre of physicians doing good quality work. Their interests are actually very aligned.

So, those of us in leadership roles need to help both sides see how valuable each is to the other. We need to keep building trust and show how the interest of the hospital is intertwined with that of the physician. A happy, satisfied doctor will be more empathetic, more productive, more inclined to incorporate new initiatives into their practices, and more willing to work with administrators about quality measures. ●

Continued from page 4

with a proven business model and advisory services that help you stay relevant.

Our committed membership continues to grow, composed of the industry's most progressive healthcare providers. We recently welcomed Steward Health Care and Scripps Health to our group purchasing organization. As all providers face increasing cost pressures, we will accelerate speed to value for both organizations and assist Scripps in preserving its legacy for improved access, quality and affordability for patients. Steward selected HealthTrust for its total spend management solutions, including supply chain management services.

Providing Additional Value

I'm pleased to provide an update on the Strategic Sourcing team's portfolio refresh. The team has successfully renegotiated approximately 50 percent of our core GPO portfolio. Across the entire portfolio we will recognize over $500 million of savings in 2016 for the benefit of all HealthTrust members.

In recent years, HealthTrust has invested in two clinical data systems companies that deploy market-leading supportive research and analytics identifying the costs, quality and outcomes associated with high-cost medical device and pharmaceutical utilization. This ultimately enables us to support the goals of improving national agreement coverage and increased value in clinical and physician contract categories through clinical evidence research and physician engagement, as well as measure the impact on compliance.

To enhance those efforts and better assist you in improving healthcare delivery, we have recently brought on board a data scientist. **Ed Hickey** will be working with HealthTrust member organizations to interpret such data and determine best use in clinically integrated supply chain decision-making.

As we further our reputation as an industry thought leader, you will notice an increased HealthTrust presence at related conferences and in healthcare publications. We look forward to providing more opportunities for member education and access to information through professional society presentations, the HealthTrust University Conference, webinars, our annual Innovation Summit and this magazine.

Ed Jones
President/CEO, HealthTrust

** http://fah.org/blog/new-report-outlines-impact-of-aca-repeal-on-patients-and-hospitals. Read the full report here: http://fah.org/upload/documents/Estimating_the_Impact_of_Repealing_the_Affordable_Care_Act_on_Hospitals.pdf*

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HealthTrust Contract #2537

Continued from page 6

This in-patient rehab solution for total joint replacement patients was the brainchild of practicing orthopedic surgeon **Victor Hernandez**, M.D., who has since joined HealthTrust as a physician advisor.

The 2017 Innovation Grant award process will soon be underway, so be thinking about how you might make your facility or health system the next recipient. Innovative, scalable ideas for improving healthcare can be submitted from March 1 through May 1. (*See page 54 for information on the submission process.*) We look forward to reviewing your proposals, and the challenge of selecting this year's winner.

Please also note that we will have an unprecedented number of physician leaders and healthcare decision-makers at our 2017 Innovation Summit, all looking for groundbreaking solutions to real-world healthcare problems. The event will be held Oct. 5-6 in Ponte Vedra Beach, Florida.

If you're aware of any particularly innovative companies or products that HealthTrust should be evaluating, contact our supplier liaison **Mark Dumond**, AVP of Technology Services (**mark.dumond2@healthtrustpg.com**).

Michael Schlosser, M.D., FAANS, MBA
Chief Medical Officer, HealthTrust

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

HealthTrust Member Survey Results

2016—A Banner Year for Member Satisfaction

Along with a competitive market assessment, industry research and feedback from member business reviews, results from HealthTrust's member satisfaction survey are utilized as part of our annual planning process.

The most recent survey was offered in Q3 2016. Over 1,200 members responded to the survey with 88 percent indicating they believe HealthTrust provides a superior value in the marketplace.

We are proud to offer the industry's benchmark contract portfolio and, once again, you underscored the value of a committed purchasing model as your primary reason for partnering with HealthTrust.

While all nine areas covered by the survey saw increases in their individual scores, areas rated the highest were HealthTrust Advisory Boards, Account Management, Customer Service (Member Services) and Contract Management (Strategic Sourcing).

CUSTOMER LOYALTY SCORE REMAINS HIGH

HealthTrust is most proud of our Net Promoter Score (NPS)—a customer loyalty measurement—which has seen a steady improvement since the member satisfaction survey began in 2008. By implementing the Net Promoter model, HealthTrust is working to increase our number of "promoters" (those who would recommend us) and decrease the number of "detractors" (those who would not recommend us)—monitoring how the strategic and tactical changes we've made over the last eight years have positively moved the metric.

OPPORTUNITIES FOR IMPROVEMENT

While we are pleased with the survey results overall, we acknowledge there is always room for improvement. We will continue to invest in the areas of technology, contract category expansion and implementation support. Progress will be shared through business reviews the account management team holds with members throughout the year. ●

What's Your Big Idea?

Seeking Scalable Ideas for 2017 HealthTrust Innovation Grant

Nominations are being accepted March 1 – May 1 for the fourth annual HealthTrust Innovation Grant. The program is designed to sponsor and reward new scalable ideas from providers for advancing healthcare.

The grant is valued at $50,000, awarded as a $25K check and $25K in the form of HealthTrust service line support. The recipient will be announced during the 2017 HealthTrust University Conference to be held July 17–19 in Las Vegas, Nevada.

The application process requires nominees to detail how they would use seed money and HealthTrust service line support to implement a truly innovative initiative at their facility or IDN. The grant will be awarded to a team or department within a HealthTrust member IDN/facility (vs. an individual contributor) with a new idea for improving performance in one or more of the following areas: care delivery, health outcomes, population health, cost savings and operational efficiency. ●

APPLICATIONS ACCEPTED

March 1 – May 1

From March 1 – May 1, submit applications online at:
http://healthtrustpg.com/InnovationGrant

Note: HealthTrust will not consider initiatives with limited impact or those unlikely to be replicated at other member facilities, nor nominations that merely endorse HealthTrust services, contracts or suppliers.

Growing Library of Physician Services Resources

The Physician Services section of the HealthTrust Member Portal recently added a number of resources in support of HealthTrust's physician-led contracting approach, which can increase the clinical know-how of supply chain professionals and improve their dialogue with physicians.

Newly uploaded documents include full clinical evidence reviews to share with physicians on implantable medical devices as well as one-page evidence summaries in categories where supplier standardization or a "price cap" strategy is being

The Road to Decision-Making
CAROTID STENTS AND EMBOLIC PROTECTION
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pursued. These helpful abbreviated documents typically contain everything C-suite executives, service line directors and supply chain leads would need or want to know. For clinicians, the comprehensive reviews on which these are based provide supporting details to address specific questions about the information evaluated and/or physician experience with a particular class of products.

Resources added to the growing online library also include:

> Evidence reviews on eight recently evaluated cardiovascular product categories, with summary documents on peripheral angioplasty balloons, carotid stents and embolic protection, vena cava filters and vascular closure assisted compression devices

> An orthopedic evidence summary targeting physicians on standard and antibiotic-loaded bone cement

> New technology summaries and monthly FDA updates

> A one-page overview for supply chain professionals on how to utilize evidence review documents, and explaining the type of information they contain.

Plan to visit the Physician Services section of the Member Portal to view and download documents whenever you're in need of resources to help improve your facility's contract compliance, standardization initiatives and, potentially, savings. ●

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FDA Approves Disposable Endoscope, New Device for Stroke Prevention

The HealthTrust Physician Services team regularly reviews all FDA 510(k) approvals and premarket approvals related to physician preference products and those used in a diagnostic setting. Here's more information about two of the FDA's most recent approvals.

ST. JUDE MEDICAL AMPLATZER PFO OCCLUDER: St. Jude Medical received FDA approval for its Amplatzer PFO Occluder, indicated for percutaneous transcatheter closure of a patent foramen ovale (PFO) to reduce the risk of recurrent ischemic stroke in patients, predominantly between the ages of 18 and 60 years. The self-expanding, double disc device made from Nitinol wire mesh is inserted through a catheter via femoral access and implanted across the PFO between the right atrium and left atrium of the heart. The device can be recaptured and repositioned if needed.

FDA'S SAFETY ALERT ON GADOLINIUM-BASED MRI CONTRAST AGENTS: In 2015, the FDA issued a safety alert on gadolinium-based MRI contrast agents (GBCAs), due to unknown risk of gadolinium brain deposits after repeated administration. In response to this alert, the HealthTrust Physician Services team recently published a clinical evidence review of the effects of gadolinium accumulation in the brain. While the agency continues to evaluate the risks of GBCAs, it recommends limiting their use to clinical circumstances in which the additional information provided by the contrast is necessary. Healthcare professionals, patients and parents/caregivers are also urged to report possible side effects involving GBCAs to the FDA MedWatch program.

XENOCOR XENOSCOPE LAPAROSCOPIC SYSTEM: The FDA approved Xenocor's Xenoscope Laparoscopic System, which includes a 10–36 cm single-use, high-definition laparoscope and dongle, which converts the camera image onto the video display screen. It is indicated for endoscopy and endoscopic surgery within the thoracic and peritoneal cavities, including the female reproductive organs. Because the endoscope is disposable, this system can help hospitals avoid the risks associated with reusing a scope that may harbor bacteria even after cleaning. ●

Visit the Physician Services page on the Member Portal for more FDA approvals and clinical evidence reviews.

October 5-6, 2017

HealthTrust's Innovation Summit is open to currently contracted and non-contracted suppliers with new technology benefiting patient care, information technology or supply chain management.

SUBMISSION PROCESS:

Suppliers interested in submitting a product for inclusion in the Summit will need to submit a video product demo (10 minutes in length maximum) and application **by May 5, 2017**. A committee will screen all videos and applications and select the suppliers invited to participate in the October 2017 event.

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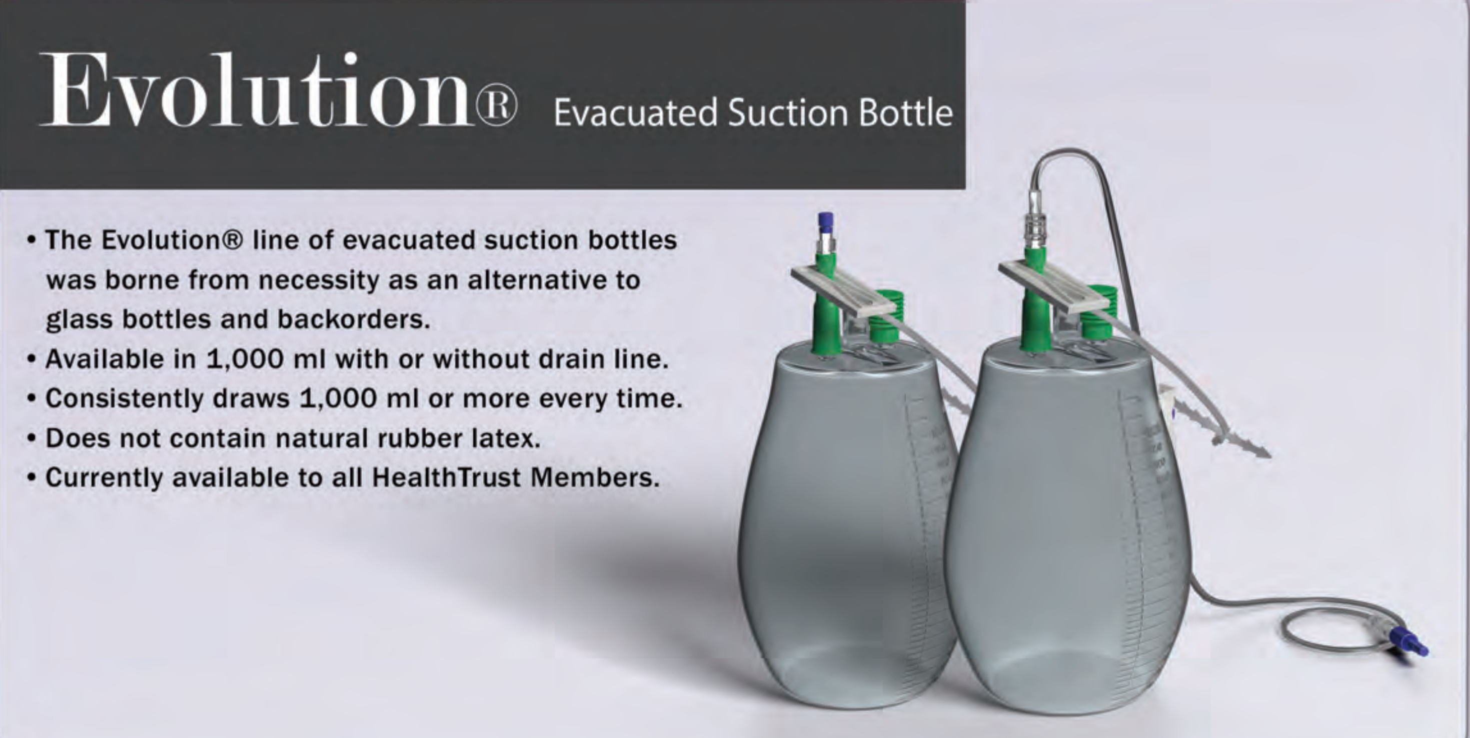

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SMALL HEART FAILURE DEVICE. BIG IMPACT ON HEALTH CARE COSTS.

The CardioMEMS™ HF System is the only FDA-approved heart failure monitoring solution clinically proven to reduce HF hospitalizations by up to 37 percent[1] when used by clinicians to manage heart failure.

The CardioMEMS™ sensor is implanted in a patient's pulmonary artery (PA) during a non-surgical procedure, and the system directly measures PA pressure in NYHA class III heart failure patients. PA pressure, an earlier indicator of HF progression than other markers, is transmitted daily to the clinician through an external wireless device, allowing adjustment of treatment earlier and without the need for a clinic or hospital visit. This is the only technology with clinical outcomes supported by multi-center randomized clinical data.

TURNING WHAT IF INTO WHY NOT.™

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1. Abraham WT, Adamson PB, Bourge RC, et al. Wireless pulmonary artery haemodynamic monitoring in chronic heart failure: A randomised controlled trial. Lancet. 2011;377(9766):658-66.

Rx Only

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

Indications and Usage: The CardioMEMS HF System is indicated for wirelessly measuring and monitoring pulmonary artery (PA) pressure and heart rate in New York Heart Association (NYHA) Class III heart failure patients who have been hospitalized for heart failure in the previous year. The hemodynamic data are used by physicians for heart failure management and with the goal of reducing heart failure hospitalizations.

Contraindications: The CardioMEMS HF System is contraindicated for patients with an inability to take dual antiplatelet or anticoagulants for one month post implant.

Potential Adverse Events: Potential adverse events associated with the implantation procedure include, but are not limited to the following: Infection, Arrhythmias, Bleeding, Hematoma, Thrombus, Myocardial infarction, Transient ischemic attack, Stroke, Death, and Device embolization.

Refer to the User's Manual for detailed indications, contraindications, warnings, precautions and potential adverse events. Unless otherwise noted, TM indicates that the name is a trademark of, or licensed to, St. Jude Medical or one of its subsidiaries. ST. JUDE MEDICAL and the nine-squares symbol are trademarks and service marks of St. Jude Medical, Inc. and its related companies. © 2015 St. Jude Medical, Inc. All Rights Reserved.

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