A HEALTHTRUST PUBLICATION

The Source

SECOND QUARTER 2019
VOLUME 14 | NUMBER 2

INNOVATION GRANT DEADLINE EXTENDED TO **JUNE 3.**
See page 64.

Tammy Snowden & Andrea Hunnicutt, CMRP

HIDDEN SAVINGS

Ardent Health Services' Focus on Purchased Services Uncovers Millions in Savings

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In Cost, Quality & Outcomes Programs

RAISING THE BAR
Updated Certification Requirements Seek Elevated Quality & Consistent Care

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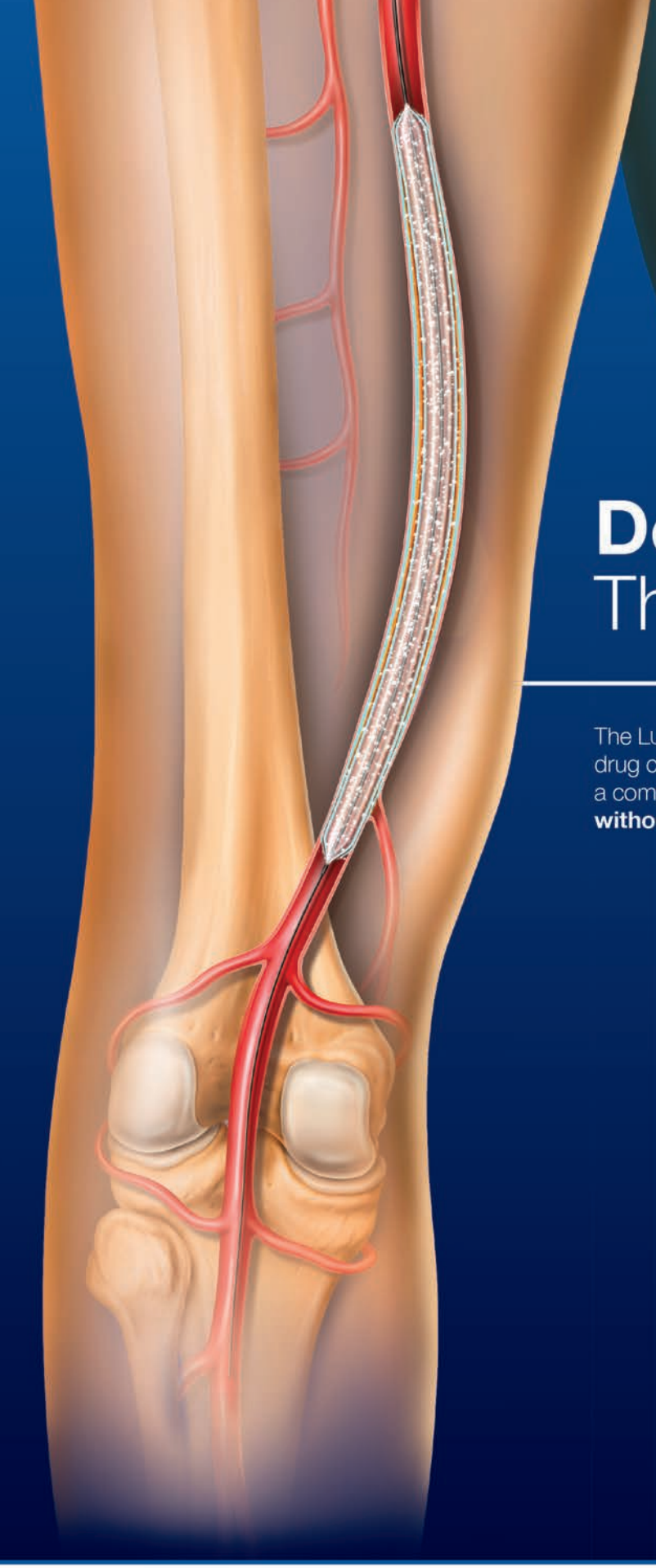
In Value-based Reimbursement
2019 Developments



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On the Cover:
L to R: Tammy Snowden & Andrea Hunnicutt, CMRP

Photography by Steven St. John

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HealthTrust is committed to strengthening provider performance and clinical excellence through an aligned membership model, and the delivery of total spend management advisory solutions that leverage our operator experience, scale and innovation. Headquartered in Nashville, Tennessee, HealthTrust (www.healthtrustpg.com) serves approximately 1,500 acute care facilities and members in more than 35,500 other locations, including ambulatory surgery centers, physician practices, long-term care and alternate care sites.

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Preparing for the Next 20 Years

BUILDING ON TWO DECADES OF FOUNDATIONAL HISTORY & BUSINESS GROWTH

As highlighted in the Q1 edition, the official acknowledgment of HealthTrust's 20-year milestone commences this quarter with the publication of our first annual report. We will continue to commemorate our platinum achievement throughout 2019, including an in-person celebration with member attendees during the HealthTrust University Conference, on Monday evening, Aug. 12, in Nashville.

WELCOME KINDRED HEALTHCARE

As part of our continued growth in the area of total spend management, I am pleased to welcome Kindred Healthcare to the HealthTrust membership. Headquartered in Louisville, Kentucky, Kindred Healthcare is a specialty hospital and rehabilitation company providing services in 45 states. We look forward to a long relationship, supporting their patient care mission by providing access to quality products and supply chain efficiencies, as well as working with the Kindred team to enhance their operational performance.

PHARMACY OPTIMIZATION

HealthTrust manages one of the largest purchasing programs for pharmaceuticals in the GPO market, with billions of dollars of pharmacy spend on the IDN side through HealthTrust, as well as billions of dollars of spend in the employer/pharmacy benefits management space through our CoreTrust business. Historically, this has been delivered through two separate teams within HealthTrust. **Michael Berryhill**, HealthTrust COO, recently announced the reorganization of our pharmacy program into a single function, focused on strategy and execution of pharmacy optimization.

Michael Berryhill

HealthTrust Senior Vice President **Joey Dizenhouse** now leads the Pharmacy Services Group. With more than 20 years of experience in the health/pharmacy insurance field, he has worked with some of the nation's largest IDNs and employers and has particular expertise in designing employee benefits/PBM group purchasing programs. Joey officially joined HealthTrust in 2016 after several years of consulting with us.

Joey Dizenhouse

As part of this redesign strategy, Joey and his team conducted a rigorous RFP process and selected OptumRx as HealthTrust's exclusive pharmacy care services partner. OptumRx will provide pharmacy benefit solutions intended to support better health outcomes, improved consumer experiences and lower costs. Combined with HealthTrust's portfolio and pharmacy capabilities, this partnership will enable us to deliver programs that incorporate transparency, flexibility and alignment of incentives between the PBM, employer and patient.

STAFFING RECOGNITION

Another area of our business—HealthTrust Workforce Solutions—was recognized in the first quarter with a "Best of Staffing Client Award" by ClearlyRated for endorsements received from its client organizations. Presented in partnership with CareerBuilder and Indeed, "Best of Staffing" recognition is based on Net Promoter Score—a measure of how likely clients are to recommend an agency to a friend or colleague. With a mission of helping hospitals and health systems fill critical labor vacancies, HealthTrust Workforce Solutions received high ratings from nearly two-thirds of its surveyed clients, indicating they would recommend the agency to others. The rating is significantly higher than the staffing industry average of 35 percent for agencies participating in the annual survey in 2018. Congratulations to president and CEO of HealthTrust Workforce Solutions **Brendan Courtney** and his team on this recognition.

Brendan Courtney

HEALTHTRUST EUROPE

HealthTrust Europe (HTE) is a market-leading total spend management company, delivering the highest quality products and services at market competitive pricing, including double-digit savings across many categories. Since inception as HTE in 2011, its offerings have expanded to also include pharmacy automation, drug contracting, purchased services/outsourced

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2. Mahida, N, et al (2013). First UK evaluation of an automated Ultraviolet-C room decontamination device (Tru-D). *Journal of Hospital Infection*, 05(005), 1-4.
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HealthTrust contract #6629

Purpose-driven Collaboration

DRIVING IMPROVEMENTS TO CLINICAL ANALYTICS, PATIENT CARE & TRIPLE AIM INITIATIVES

As I traveled the country meeting with a number of providers in my first year as CMO, the need for clinical data and analytics has never been more paramount. In late Q4 of 2018, HealthTrust held a collaborative summit focused specifically on the topic, with member participation from Beaumont, Community Health Systems, Franciscan Health, HCA, LifePoint Health, Scripps Healthcare and Trinity Health.

HealthTrust members, Physician Advisors and internal subject matter experts representing pharmacy and traditional provider service lines offered their insights on the effort already underway to renovate HealthTrust's clinical data and analytics solutions. The collaboration helped to identify and prioritize key performance indicators for each specialty and to outline the data sources and dashboard requirements.

The day ended with a number of mock-up wireframes completed, along with a wish list describing an ideal state for such considerations as data preferences, filtering capabilities, functionality and mobile accessibility. Special thanks to these experts who helped inform the future of our performance dashboards. I look forward to sharing more in the coming months regarding improved foundational analytics and, in the not too distant future, the opportunity for subscription-based analytics.

CENTERS OF EXCELLENCE SERIES

I am pleased to kick off in this edition the first article in a series on service line centers of excellence (*see page 40*). Here, **Kelsey Duggan**, Ph.D., MBA—senior director, medical device management for HealthTrust—provides her insight on the collaboration between the American Academy of Orthopaedic Surgeons (AAOS) and The Joint Commission announced last fall.

While The Joint Commission established its Total Hip and Knee Replacement voluntary advanced certification program in 2016, the addition of AAOS' clinical expertise into standards development and requirements for measuring performance will help accredited hospitals and ASCs elevate the quality, consistency and safety of their patient care and related services.

Designed to benefit orthopedic patients across the country, the ongoing collaboration is focused on improving care and the quality of hip and knee replacement surgeries. Together, the organizations will focus on performance measurement, quality improvement activities, education, data sharing and research related to hip and knee certification.

TRENDS FOR 2019 & BEYOND

As healthcare executives refine their strategies for the remainder of 2019, **Jordan Holland** and **Laurie Norman** from Optum Advisory Services suggest there are definite themes emerging among value-based reimbursement models tying payments to quality care achievements (*see page 30*). Trends to watch for in the coming months include: more downside risk for providers; increased collaboration between providers and payers; providers finding new ways to overcome conflicting incentives; and, an increased focus on enabling physician input.

Scripps Health realized the importance of physician input by placing five experienced physicians in executive operational positions a year ago at each of its hospital campuses in San Diego County, California. The move was part of an ongoing redesign of its healthcare delivery model with the goal of assisting regional hospital chief executives and campus chief operating executives in managing day-to-day hospital activities as well as supporting systemwide initiatives. Two of those executive physicians—**Valerie Norton**, M.D., and **Jonathan Worsey**, M.D.—offer their insights after completing year-one in these operational executive roles. (*See article on page 52.*)

Cost, quality and outcomes—aka "triple aim" initiatives—are best informed with data, collaboration and the integration of supply chain and clinical initiatives (*see feature beginning on page 34*). Representing the physicians' perspective, **Mark Pinto**, M.D., and I share how today's value-based care environment underscores the importance of such integration. **Bob Taylor**—vice president of supply chain for RWJBarnabas Health and 2019 president of AHRMM—joins the conversation, adding that to be successful in this environment, "providers must improve the quality of care while simultaneously managing and reducing costs."

I hope you find value in this and all editions of *The Source*. With executive oversight of the publication, receiving your feedback is critical as we evolve the magazine and respond to member requests for content. Members are encouraged to contact us with story ideas or to join our reader panel and provide feedback on a quarterly basis. Simply email **thesource@healthtrustpg.com**

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[1]https://nrra.net/sweep/time-is-running-out-the-u-s-landfill-capacity-crisis/
[2]Data from a 2010 Clover-funded Life Cycle Analysis (LCA) conducted by RIT

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GETTY IMAGES

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These products should not be used in patients with a known sensitivity to porcine material and/or Polysorbate 20.

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Do not resterilize. Discard all open and unused portions of these devices. **Do not use** if the package is opened or damaged. **Do not use** if seal is broken or compromised. After use, handle and dispose of all unused product and packaging in accordance with accepted medical practice and applicable local, state, and federal laws and regulations.

Do not reuse once the surgical mesh has been removed from the packaging and/or is in contact with a patient. This increases risk of patient-to-patient contamination and subsequent infection.

For STRATTICE™ RTM Extra Thick, **do not use** if the temperature monitoring device does not display "OK."

PRECAUTIONS

Discard these products if mishandling has caused possible damage or contamination, or the products are past their expiration date. Ensure these products are placed in a sterile basin and covered with room temperature sterile saline or room temperature sterile lactated Ringer's solution for a minimum of 2 minutes prior to implantation in the body.

PRECAUTIONS (Continued)

Place these products in maximum possible contact with healthy, well-vascularized tissue to promote cell ingrowth and tissue remodeling. These products should be hydrated and moist when the package is opened. If the surgical mesh is dry, do not use.

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Bioburden-reducing techniques should be utilized in significantly contaminated or infected cases to minimize contamination levels at the surgical site, including, but not limited to, appropriate drainage, debridement, negative pressure therapy, and/or antimicrobial therapy prior and in addition to implantation of the surgical mesh. In large abdominal wall defect cases where midline fascial closure cannot be obtained, with or without separation of components techniques, utilization of the surgical mesh in a bridged fashion is associated with a higher risk of hernia recurrence than when used to reinforce fascial closure.

For STRATTICE™ RTM Perforated, if a tissue punch-out piece is visible, remove using aseptic technique before implantation.

For STRATTICE™ RTM Laparoscopic, refrain from using excessive force if inserting the mesh through the trocar.

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Allergan

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Removing the Barriers for Biosimilars

DESPITE A SLOW START IN GAINING MARKET ACCESS & SHARE, BIOSIMILARS DELIVER ON THEIR PROMISE

Since 2015, the Food and Drug Administration (FDA) has approved 17 biosimilars—nonbrand-name biologic drugs with no clinically meaningful differences from their reference biologic. Much like generic drugs, biosimilars are seen as economical alternatives, priced an average of 15–30 percent lower than brand-name biologics. In a 2017 report, the RAND Corporation estimated their cost-savings potential at $54 billion over 10 years. But to realize those savings, approved biosimilars first have to get to the market launch phase. To date, only seven have hit that milestone.

SLOW TO LAUNCH

A biologic patent cliff is expected in 2020, which should accelerate market launches for some of these approved drugs. Many others may still be tied up in litigation with reference drug manufacturers attempting to thwart biosimilar competition.

Take Genentech's Herceptin, a therapy for early-stage breast cancer. In 2017, global sales for the drug totaled $7.2 billion. Three biosimilars of the innovator product have been approved in the United States, but none has made it to market. Instead, they're each facing lawsuits from Genentech claiming at least 40 patent infringements.

Even when biologic manufacturers haven't filed suit, they've tried to block biosimilars in other ways, notably by offering steep rebates to payers in exchange for preferred status on their formularies. This type of anti-competitive behavior is alleged in a pair of lawsuits filed against Johnson & Johnson, maker of Remicade. The first claim was filed by Pfizer, which manufactures the biosimilar Inflectra, and the second by retailers Kroger and Walgreens. Both cases are still pending, but experts say a decision in Pfizer's favor could help clear the way for future biosimilars.

Jason Braithwaite, PharmD, MS, BCPS

Legacy manufacturers may be stalling availability of these copycat drugs, but neither providers nor patients have protested.

"In many ways, it's the generic market all over again," says **Jason Braithwaite**, PharmD, MS, BCPS, senior director of clinical pharmacy services at HealthTrust. "When generics first came out, they were not adopted quickly. It took some time for providers and patients to get comfortable with these products. We're definitely seeing the same thing with biosimilars."

LIFEPOINT HEALTH'S EXPERIENCE

Ken Gagnon, PharmD, BCPS, vice president of pharmacy services for LifePoint Health, oversees his organization's biosimilar conversions. In 2017, when the system switched from Remicade to Inflectra, Gagnon faced not just reimbursement challenges, but also a lot of provider resistance. With more recent conversions—from Epogen/Procrit to Retacrit and from Neulasta to Fulphila—the process has been smoother.

Ken Gagnon, PharmD, BCPS

"You're always going to see innovator biologic companies do everything they can to hold on to market share," Gagnon says. "But I think biosimilar manufacturers learned a lot from the Inflectra launch. They got smarter and preempted a lot of potential reimbursement issues by going earlier to commercial payers to make their case for preferred formulary status."

At the same time, the provider community has become more accepting of biosimilars.

"We have worked hard to educate our providers on the safety and efficacy of these products," Gagnon says. "The most challenging part is helping providers feel comfortable with them. But once they do, they are not turning back to the branded product."

However, patient resistance can still slow biosimilar adoption. Many biologics treat debilitating chronic conditions such as Crohn's disease and rheumatoid arthritis, and

Continued on page 12

Confused by the difference between generics and biosimilars?

According to the FDA, a generic must be "bioequivalent," meaning made up of the same active ingredients as the brand-name drug. A biosimilar, on the other hand, needs to be "highly similar" to the reference product—except for small differences in clinically inactive components. Their dissimilarities should be clinically insignificant in terms of safety and effectiveness.

GETTY IMAGES

Find out what surprisingly common skin complications could be costing you

UP TO 75%

of ostomy patients have Peristomal Skin Complications (PSCs)[1]

PSCs are associated with:

1. Higher overall healthcare costs[2,3]
2. Greater readmission and length of stay[2,3]
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*As compared with Hollister skin barriers without ceramide in a clinical trial.[6]

References: 1. Smith AG, Lyon CC, Hart CA. Multidisciplinary care of stoma problems in stoma patients. *Br J Nurs.* 2002;11(5):324-330. **2.** Taneja C, et al. Clinical and economic burden of peristomal skin complications in patients with recent ostomies. *Journal of Wound, Ostomy and Continence Nursing.* 2017;44(4):350-357. **3.** Hollister Data on file. **4.** Nichols TR, Inglese GW. The burden of peristomal skin complications on an ostomy population as assessed by health utility and the physical component summary of the SF-36v2(R). *Value Health.* 2018;21(1):89-94. **5.** Bell CM, Chapman RH, Stone PW, et al. An off-the-shelf help list: a comprehensive catalog of preference scores from published cost-utility analyses. *Med Decision Making.* 2001;21:288-294. **6.** Colwell JD, et al. A randomized controlled trial determining variances in ostomy skin conditions and the economic impact (ADVOCATE Trial). *Journal of Wound, Ostomy and Continence Nursing.* 2018;45(1):37-42.

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Continued from page 10

patients whose symptoms are well-managed with the reference drug might be reluctant to switch. That's especially true when counterintuitive reimbursement structures don't offer them a compelling enough reason to do so.

NEW REIMBURSEMENT CHALLENGES

Under new rules for Medicare Part B reimbursement at 340B facilities *(see article in the Q2 2017 issue)*, patient copays will end up being higher for biosimilars than biologic drugs.

Previously, the reimbursement structure for all drugs was average sales price (ASP) plus 6 percent. The new formula is ASP minus 22.5 percent—a move to counter profits made by 340B facilities able to purchase drugs at a steep discount while getting reimbursed for the original price.

BIOSIMILARS WITH HEALTHTRUST CONTRACTS

CATEGORY	BIOSIMILAR PRODUCT (SUPPLIER)
PEGFILGRASTIM	FULPHILA (MYLAN, CONTRACT 4537)
FILGRASTIM	GRANIX (TEVA, CONTRACT 6236)
INFLIXIMAB	INFLECTRA (PFIZER, CONTRACT 4576) ; RENEFLEXIS (MERCK, CONTRACT 2317)

But there's a catch. The rule exempts drugs granted pass-through payment status, which is available to all biosimilars and gives manufacturers a three-year pricing advantage to encourage use of their drugs.

"With this new rule, biosimilars could grow more appealing to providers," Braithwaite says. "But the same can't be said for patients, who would be saddled with a higher copay for what is supposed to be a cheaper drug."

Another change to the reimbursement landscape for biosimilars involves the Medicare Part D coverage gap. After the initial coverage period and before catastrophic coverage kicks in, Part D participants have to pay out-of-pocket for their prescriptions. Previously, coinsurance was 30 percent for branded drugs and 37 percent for generics and biosimilars. Branded manufacturers also had to provide a 50 percent discount, but biosimilar manufacturers did not. This arrangement made biologics the better buy for patients in the coverage gap.

Continued on page 14

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GETINGE

Continued from page 12

The new rule levels the playing field by moving biosimilars into the same category as branded drugs. Coinsurance for both is now set at 25 percent, but the discount has been increased—for both biologic and biosimilar manufacturers—to 70 percent. This change is a win for patients and plans, but the impact on the biosimilars market is uncertain. Biologic manufacturers possibly will offer steeper rebates to make their products preferred. Biosimilar manufacturers, limited in the discounts they can offer so soon after launch, might also shy away from participating in Medicare Part D.

HEALTHTRUST'S STANCE

Despite the challenges and unknowns, HealthTrust remains committed to advancing biosimilars among its membership. "If biosimilar adoption doesn't accelerate, there is a huge risk that companies will drop out of the market and stop manufacturing these cost-saving products," Braithwaite says. "That's why we continue to promote biosimilars over brands in all scenarios."

HealthTrust currently has contracts for four biosimilars in three categories—filgrastim, infliximab and, most recently, pegfilgrastim. (*See chart on page 12.*) Single- and dual-source agreements have secured the best pricing from manufacturers.

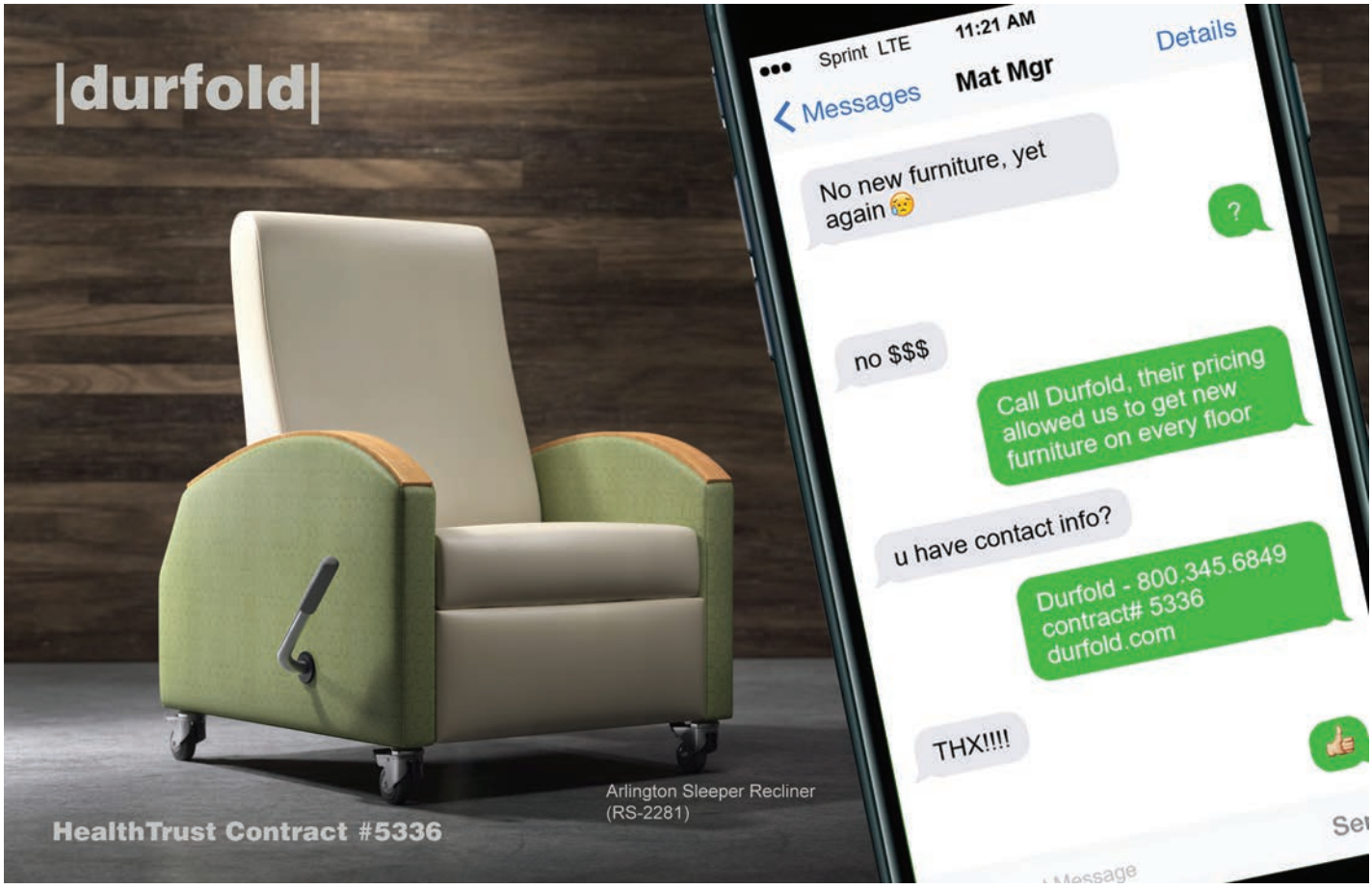
Before awarding a contract, HealthTrust conducts an extensive payer analysis to ensure a biosimilar will be covered by the majority of payers across all regions. A new consideration is how the contracting strategy could differentially affect 340B facilities, says **Joshua Curtis**, MBA, assistant vice president of pharmacy strategic sourcing at HealthTrust.

To protect members when payers will not cover the biosimilar, contracts with biosimilar manufacturers include payment protection programs. Providers will be entitled to a replacement product after two denials from a payer.

Joshua Curtis, MBA

"It's a good bargaining chip," Curtis says. "If they want most or all of our business, we need some guarantees that our members won't be left footing the bill."

Gagnon says he doesn't expect strategies like these will be needed for long. "We had a little bit of a rocky start, but as more biosimilars come on the market and providers become increasingly comfortable with these lower-cost products, our hospitals and patients—and the healthcare system as a whole—stand to benefit greatly." ●



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Hastening Healing

REGENERATIVE TISSUE SHOWS PROMISE FOR TREATING THE CHRONIC WOUND EPIDEMIC

Skin substitutes can be an effective method to treat the most difficult chronic wounds, some of which can take years, if not decades, to heal. In addition to hastening healing, regenerative tissue provides an alternative to using patients' own tissue that introduces the risk of creating a secondary wound, according to **Aron Wahrman**, M.D., section chief of plastic surgery at Philadelphia VA Medical Center.

"Chronic wounds are a major challenge for patients and a significant cost for society," Wahrman says. In the United States, an estimated 5.7 million patients are affected with venous, diabetic and pressure ulcers and other chronic wounds—all of which can become infected and possibly result in amputation or death. Chronic wound patients endure severe physical pain, emotional distress, reduced mobility and social isolation. Financially, more than $20 billion a year is spent on the treatment of chronic wounds, and an additional $12 billion on the care of scars.

Aron Wahrman, M.D.

HUMAN, ANIMAL & SYNTHETIC-BASED OPTIONS

Bioengineered skin substitutes for wound healing were first developed in the early 20th century. In the 1970s, cultured epidermal autografts were created from patients' own skin cells. The first dermal substitutes hit the market in the 1980s.

Today, skin substitutes are sometimes made using cells from the inner part of the human placenta (amnion) or the outer membrane (chorion), or from neonatal foreskin. In other cases, tissue from pigs, sheep or cows is used. According to HealthTrust's recent clinical evidence review (CER) on regenerative tissue, other promising products on the horizon include:

- Biologic skin substitutes made from animal or human tissue that are coated in antibiotics or deliver growth factors
- Synthetic skin products that get absorbed by the body
- Stem cell products
- Manipulation/application of patient's adipose/stem cells
- Adhesives

Treatment approaches likely to grow in popularity include platelet-rich therapies using patients' own blood to assist with healing and dermatome technologies allowing for the harvest of small autologous skin grafts.

"I'm optimistic about technologies that will take a very small piece of patients' skin, almost biopsy size, and leverage it to create a skin culture type of substitute," says Wahrman, a HealthTrust Physician Advisor. "There's probably nothing better than what you're born with. If you can do something with patients' own tissues, alone or in combination with other elements, that's like the holy grail."

Despite the lack of solid scientific research, the consensus among experts is that chronic wound patients generally benefit more from human tissue products than animal-based products, according to HealthTrust's CER.

NO ONE-SIZE-FITS-ALL SOLUTION

Denise Dunco, MSN, RN

Denise Dunco, MSN, RN, manager of physician services at HealthTrust, says there is no "clear winner" among the regenerative cellular products available. "They all have similar characteristics to improve the outcome of the wound. To some degree, product selection is based on patients' comorbidities and their underlying disease. It's a trial-and-error process," she explains. "Doctors will try one thing and, if it doesn't work, they'll try another. There is not any good clinical evidence that supports what to use or when to use it."

In Wahrman's opinion, "Many skin substitutes are good; a lot of them have their pluses and minuses, but nothing is perfect or 100 percent successful." He points out that some technologies need a lot of preparation, such as defrosting or soaking, but how "difficult or daunting" they're perceived to be varies among practitioners. "They may just say, 'I like this product so much it's worth the extra effort.'"

Wahrman also notes that clinicians sometimes misuse or overuse skin substitutes.

It's not that the products themselves fail, he says, but often the wrong product was chosen. Wahrman stresses that practicing physicians must be judicious about the products they use, practice

Continued on page 18

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Continued from page 16

good follow-up and select patients who will likely adhere to treatment plans. "Many patients with chronic wounds are diabetic, so they have to be compliant with their medication, their diet and, in particular, with not smoking—that's critical," he adds.

The CER also discusses qualities of ideal tissue-based products for chronic wounds, including the ability to resist or treat infection, induce blood flow to the wound and prevent body fluid loss. They should also have low or no antigenicity, meaning they work with, rather than against, the body's immune system to promote healing. Additionally, tissue-based products should be compatible with other therapeutic modalities, such as vacuum-assisted closure and negative-pressure wound therapy.

COST AND REIMBURSEMENT

As with any medical product or service, clinicians need to factor cost and reimbursement into their decision-making. "What drives product selection is the cost of the product, clinic overhead and the local wage index, which is determined by the Centers for Medicare & Medicaid Services," Dunco says. It's also important to remember that an expensive skin substitute could provide more value than a cheaper product that is applied more frequently.

Reimbursement for skin substitutes varies widely by product type and assigned Q-code, treatment setting and local coverage decisions, but precertification is typically required.*

Most Medicare Advantage plans limit coverage to Dermagraft, an FDA-approved, bioengineered, human dermal substitute used for the treatment of diabetic foot ulcers (DFUs), and Apligraft, an FDA-approved bioengineered living cell therapy indicated for venous leg ulcers and DFUs due to blood flow insufficiency. Many private insurance plans deny coverage for other cellular and/or tissue products. "Every patient seems to be a new adventure in terms of what can or cannot get covered," Wahrman says.

As clinicians choose which products best meet the needs and preferences of their patients, Wahrman suggests keeping these factors in mind: pain control, allergies or sensitivities, odor control, ease of use, frequency of dressing changes required, and compatibility with the activities of daily living. Finally, clinicians need to get a sense of how the patient feels about the wound and how they would respond to a scar.

Although scarring is not ideal, Wahrman is quick to point out that the aim of chronic wound treatment is healing the injury rather than restoring normal appearance. "To a patient who's been struggling for a long time, a healed wound is the most beautiful thing in the world, even if the skin doesn't look completely normal." ●

Visit the Physician Services section of the member portal to read the clinical evidence review on regenerative tissue.

**Documentation for payment must include relevant HCPCS codes 15271–15278 and the correct Q-code when high-cost products are applied.*

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A Balanced Technique

OLDER ANALGESICS IN COMBINATION OUTMATCH EXPENSIVE, NEW NON-OPIOID ALTERNATIVES

In the midst of alarming headlines about the ongoing opioid epidemic, healthcare providers are turning to non-opioid alternatives and a multi-pronged, patient-centric strategy to manage the acute and chronic pain of patients. "Pain is a highly personal experience," wrote Ofelia Elvir-Lazoa and Paul White in a 2010 article in the peer-reviewed *Current Opinion in Anesthesiology*. "It involves multiple mechanisms that ideally require treatment using a multimodal (or 'balanced') analgesic technique."

TRIED-AND-TRUE CHOICES

The goal of multimodal pain management is to change provider thinking so that opiates are not always the first choice. "We've forgotten how to manage pain with other drugs, some of which have been on the market for decades," says **Jason Braithwaite**, PharmD, MS, BCPS, senior director of clinical pharmacy services at HealthTrust. "Clinicians haven't done a good job of optimizing the use of these other agents—what I like to call the 'oldies but goodies.' "

Older analgesics such as acetaminophen, anticonvulsants, antidepressants and nonsteroidal anti-inflammatory drugs, including ibuprofen, can be combined to effectively manage pain and help to drastically decrease, if not eliminate the need for opioids.

Prescribing three drugs that work in different ways is more effective than prescribing a single opioid blocking one pain pathway and escalating the dosage over time. But "everyone's gotten a little bit comfortable solely prescribing opiates for pain," Braithwaite says. "A multimodal pain management strategy takes a little more thought; you have to space out the dosages so patients get optimal pain relief while avoiding the side effects that can occur with high doses of a drug."

The approach can sometimes eliminate the need for opioids entirely. For certain surgeries and severe breakthrough pain, multimodal tactics incorporate opioids but at lower amounts and for shorter periods of time. In both cases, patients tend to move from an acute care setting to home more quickly because over-the-counter pain relievers and non-opioid prescriptions have few access barriers.

"EVERYONE'S GOTTEN A LITTLE BIT COMFORTABLE SOLELY PRESCRIBING OPIATES FOR PAIN. A MULTIMODAL PAIN STRATEGY TAKES A LITTLE MORE THOUGHT."

Jason Braithwaite, PharmD, MS, BCPS | Senior Director, Clinical Pharmacy Services | HealthTrust

CONSIDERING NEW OPTIONS

In recent years, the Food and Drug Administration has given market approval to non-opioid options such as Exparel (liposomal bupivacaine), a long-acting analgesic. However, the drug has not been shown to improve pain management or reduce opioid use when compared to a multimodal pain strategy. And, at $285 a dose, it's not an economical option.

"The first thing HealthTrust looks at is safety and efficacy," Braithwaite explains. "And, from those perspectives, there haven't been major improvements with Exparel. We promote innovation in patient care, but in this case, we just see an added expense."

Ofirmev (IV Tylenol) is another debated alternative to opioids. At $40 a dose, it's significantly more expensive than oral tablets, liquids or suppositories, which run just a few cents per dose. "It's another example of a drug that hasn't shown added safety

Continued on page 22

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[1]Safdar N, Maki D.G. The pathogenesis of catheter-related bloodstream infection with noncuffed short-term central venous catheters Intensive Care Med. 2004; 30:62-67

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PATIENT CARE ENVIRONMENT OF CARE **INTERVENTIONAL CARE**

Continued from page 20

or efficacy but has significantly increased patient costs," Braithwaite says. While Tylenol is an old standby, the intravenous version has only been shown to improve the onset of pain relief—not overall pain relief.

SPARKING CONVERSATION

One unforeseen benefit from the launch of these new products is growing interest among providers in multimodal pain strategies and learning to optimize drugs that have been available for decades.

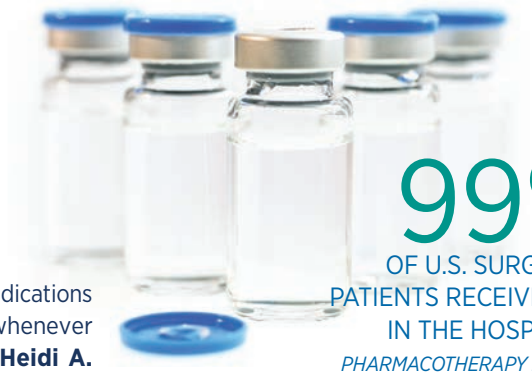
"The new drugs coming out have spurred a lot of discussion that has improved how we approach pain relief," Braithwaite says. "That's made a big impact on patient care and reducing opioid dependence overall."

Many clinicians still see a role for opioids, though a much more limited one than in the past—less often and at lower dosages—a strategy that can address pain without creating long-term dependence.

Non-opioid analgesics like Exparel may bill themselves as the future of recovery, but to get a glimpse into where pain management is headed, don't look to the new drugs hitting the market. The best multimodal approach for patients uses drugs that have stood the test of time. ●

CASE STUDY

Beaumont Health Pursues Opioid Alternatives for Emergency Patients



99%
OF U.S. SURGICAL PATIENTS RECEIVE OPIOIDS IN THE HOSPITAL.
PHARMACOTHERAPY 2013 STUDY

1 IN 15
OF THESE PATIENTS GO ON TO BECOME OPIOID-DEPENDENT.
ANESTHESIA & ANALGESIA 2012 STUDY

Beaumont Health, Michigan's largest healthcare system, is participating in a collaborative project with other hospital systems throughout the Midwest to reduce opioid prescriptions for common pain syndromes in patients who present to the emergency department (ED). All nine EDs at Beaumont Health joined the ALTO Project (**AL**ternatives **T**o **O**pioids), which the Colorado Hospital Association started as a pilot program to reduce the administration of opioids in EDs. The successful pilot recorded a 36 percent reduction in opioid administration over a six-month period.

Heidi A. Pillen, PharmD

"Our goal is to be 'opioid-sparing,' so we're trying to follow certain modalities prior to moving to medications containing opioids whenever appropriate," says **Heidi A. Pillen**, PharmD, director of pharmacy, clinical services and medication use policy, Beaumont Health. "Prior to our February 1 go-live date, we conducted extensive nursing, physician and pharmacy education; developed order sets approved by the pharmacy & therapeutics committee, and rolled out a public relations campaign."

For its study, Beaumont Health targeted six common pain syndromes: renal colic, musculoskeletal pain, acute and chronic radicular low back pain, headache, extremity fracture/joint dislocation and chronic abdominal pain/gastroparesis. It also identified non-opioid pathways for pain management such as typical multimodal analgesic agents, including acetaminophen, ibuprofen, gabapentin and lidocaine patches, along with more novel approaches like trigger point injections, intranasal lidocaine and ketamine, and analgesic ketamine infusions.

"While it is too soon to chart our results, we do have several anecdotal reports of patients with chronic pain syndromes expressing excellent pain relief following use of the ALTO protocols," Pillen adds. ●

"OUR GOAL IS TO BE 'OPIOID-SPARING,' SO WE'RE TRYING TO FOLLOW CERTAIN MODALITIES PRIOR TO MOVING TO MEDICATIONS CONTAINING OPIOIDS WHENEVER APPROPRIATE." **Heidi A. Pillen**, PharmD | Director of Pharmacy, Clinical Services, Medication Use Policy | Beaumont Health

To learn more about the ALTO Project and to download training resources, visit: https://cha.com/quality-patient-safety/opioid-safety-updates/colorado-alto-project.

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1. Hertig JB, Degnan DD, Scott CR, Lenz JR, Li X, Anderson CM. A comparison of error rates between intravenous push methods: a prospective, multisite, observational study [published online ahead of print September 8, 2017]. J Patient Saf. doi:10.1097/PTS.0000000000000419.

Speedier ID

ACCELERATE PHENO SYSTEM DELIVERS FASTER BLOODSTREAM INFECTION RESULTS

HealthTrust's Innovation Summit enables suppliers to present new technology and medical breakthroughs to clinical experts within the membership. HealthTrust values products that improve clinical outcomes, reduce lengths of stay, decrease infection rates, and speed up procedures and results.

The Accelerate Pheno system from Accelerate Diagnostics **(Contract 42829)** is one such innovation. Presented at the 2017 Innovation Summit, the system provides rapid species identification (ID) and antimicrobial susceptibility testing (AST) results for the most commonly identified organisms in bloodstream infections.

SHORTENING THE ID WINDOW

Bloodstream infections are linked to prolonged hospitalizations and increased patient morbidity and mortality—unpleasant, expensive consequences for both hospital systems and patients. Since antimicrobial-resistant pathogens—those arising from overuse of broad-spectrum antibiotics—can be difficult, if not impossible, to treat, a good first step in improving outcomes is to diagnose antimicrobial susceptibility. This will isolate the drugs most likely to be effective in treating a patient's particular infection.

Previously, it took laboratories between 48 and 72 hours to positively identify antimicrobial susceptibility from blood cultures. That's time wasted on starting antibiotic stewardship interventions aimed at reducing microbial resistance and the spread of intractable infections. According to **Dolly Kay**, MBA, MLS (ASCP), a portfolio director with HealthTrust, the Accelerate Pheno system shortens that window considerably.

Dolly Kay, MBA, MLS (ASCP)

Fully automated, the system performs both identification and AST directly from positive blood cultures within four to six hours. "We are taking away steps that slow down identification," says **Michael Overa**, MBA, BSMT, senior director of lab services at HealthTrust. "Instead of waiting 18 to 24 hours for an organism to grow, we can take it directly from the bottle."

SUPPORTED BY CLINICAL STUDIES

A 2017 study published in the *Journal of Clinical Microbiology* found the length of time to identification and time to susceptibility using the Accelerate Pheno system were decreased by 23.47 and 41.86 hours, respectively, compared to those for the standard of care. The study also found the easy-to-use system reduces hands-on time for ID/AST of common blood pathogens and allows results to be released more quickly.

Michael Overa, MBA, BSMT

The system automatically cleans each sample using a process called gel electrofiltration. When identifying polymicrobial infections, it reduces the need to grow cultures overnight before testing.

With the system, the minimum inhibitory concentration (MIC) results—which provide the exact information needed to pinpoint the most effective antibiotic for each patient—is also available within hours. Everything needed to get identification and MIC-based susceptibility results is contained in a single, disposable kit.

PRESCRIBING THE RIGHT ANTIBIOTIC SOONER

According to Kay, HealthTrust moved quickly to get Accelerate Pheno on contract once members of HealthTrust's Laboratory Clinical Advisory Board watched presentations of the system in action and evaluated it in laboratory settings. "Our motivation was to avoid cultivating superbugs and getting patients the right antibiotic from the beginning," she says.

The Accelerate Pheno system was the first significant advancement in the analysis and identification of blood cultures. Solving the time and accuracy issue with blood culture identification and AST has improved physicians' confidence when prescribing antibiotics to their patients.

"Getting patients diagnosed more quickly and getting the right antibiotic on board sooner can decrease care-level escalations, such as the need for patients to be transferred from a regular bed to an ICU bed," Kay adds. ●

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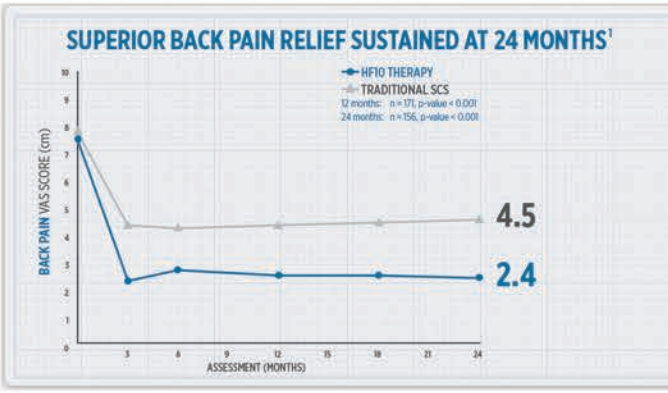

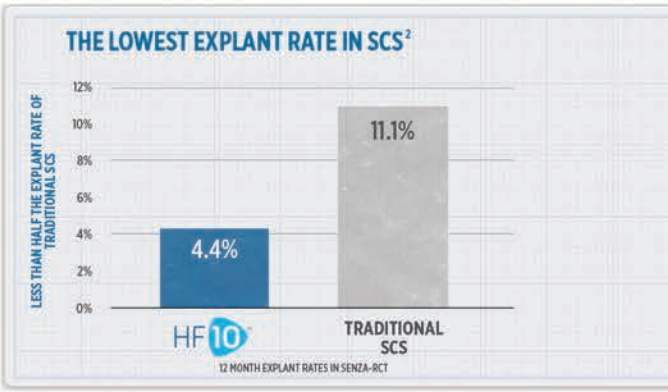

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1. Kapural L, et al. Comparison of 10-kHz high-frequency and traditional low-frequency spinal cord stimulation for the treatment of chronic back and leg pain: 24-month results from a multicenter, randomized, controlled pivotal trial. Neurosurgery. 09 2016.
2. Al-Kaisy A, Van Buyten J-P, Smet I, Palmisani S, Pang D, Smith T. Sustained effectiveness of 10 kHz high-frequency spinal cord stimulation for patients with chronic, low back pain: 24-month results of a prospective multicenter study. Pain Med. 2014;15:347-354.
3. Nevro patient satisfaction survey data. Data on File. Calculated 01/29/19. To request survey data, contact TherapyOptimization@nevro.com

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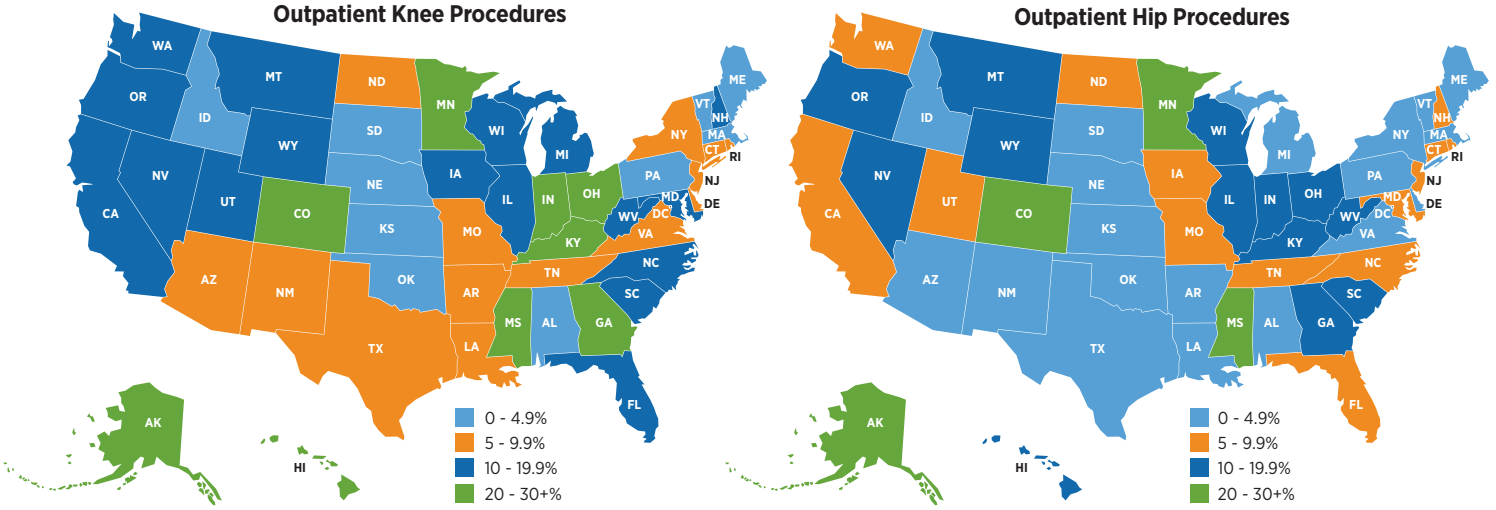
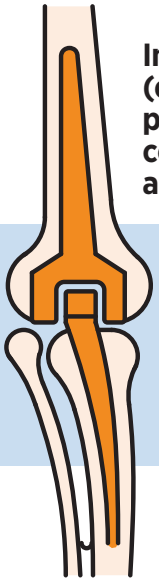
Planned orthopedic surgeries are increasingly common among Americans ages 35 to 64, costing more than $25 billion in 2017—an increase of 44 percent over the past eight years. As data increasingly reveals, knee and hip procedures performed in an outpatient versus an inpatient setting can result in savings of 30 to 40 percent.

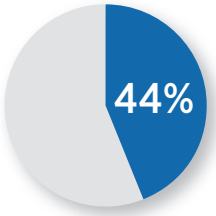
Percent of Outpatient Knee & Hip Procedures by State, 2017



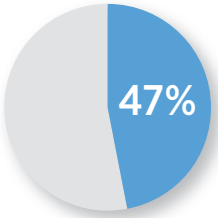


In 2017, planned (elective) orthopedic procedures for commercially insured adults cost

$25 BILLION



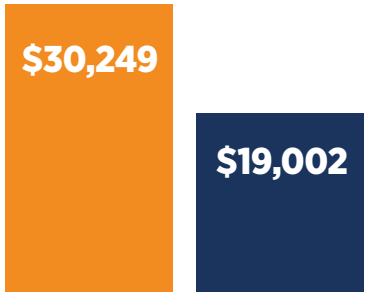
Increase since 2010



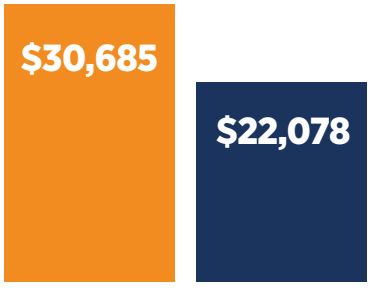
Percent of total orthopedic care spending

30 to 40% Cost Savings for Knee & Hip Procedures Performed in an Outpatient Setting

2017 average price for **KNEE REPLACEMENT**



2017 average price for **HIP REPLACEMENT**



Of all 2017 procedures performed in an outpatient setting

11% KNEE | **8%** HIP

23% 2013 / **36%** 2017

PERCENTAGE OF IMPROVEMENT IN OUTPATIENT COMPLICATION RATES (NOW LOWER THAN INPATIENT COMPLICATION RATES)

Source: *"Planned Knee and Hip Replacement Surgeries Are on the Rise in the U.S." Published January 23, 2019, by Blue Cross Blue Shield. Report focuses on the under-65 commercially insured population.*

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4 Trends in Value-based Reimbursement

MORE DOWNSIDE RISK & GREATER PHYSICIAN INPUT AMONG DEVELOPMENTS FOR 2019

Prodded by new programs and policies instituted by the Centers for Medicare & Medicaid Services (CMS), increasing numbers of healthcare providers are shifting from fee-for-service reimbursement to value-based care.


Jordan Holland

"Rates aren't going to get any higher per unit or per service," says **Jordan Holland**, director at Optum Advisory Services. "Most hospitals we talk to struggle to break even on Medicare, which is problematic considering demographics shifting more toward that federal program. There's a difficult future ahead if you're thinking of medical services as a widget and charging a fee for each service."

Definite themes are emerging among value-based reimbursement models tying payments to quality care achievements. Among the trends for 2019 and beyond:

1 MORE DOWNSIDE RISK FOR PROVIDERS

The CMS has implemented several innovative programs over the past decade to encourage the transition toward value-based care, including the Hospital Value-based Purchasing Program, Hospital Readmission Reduction Program and the Hospital-Acquired Conditions Reduction Program. They all financially reward healthcare providers to improve the care they give Medicare beneficiaries.

Most of the CMS programs offer bonus payments for meeting stated quality goals while delaying the downside risk on providers for years. However, newer value-based models are requiring that providers bear the financial consequences of falling short on their goals more quickly.

One such program is Pathways to Success, the latest version of the Medicare Shared Savings Program, Holland notes. Another is the Bundled Payments for Care Improvement Advanced model, launched in October 2018. It is designed to improve patient outcomes and reduce readmissions by challenging providers to beat cost as well as quality targets over 90-day clinical episodes of care. Similarly, the Comprehensive Primary Care Plus medical home model is giving medical practices advance bonus payments to improve chronic disease management, which is theirs to keep or lose depending on the quality of performance.

Moving forward, the CMS will continue to push more risk to providers, Holland reports. One likely reason is the growing body of evidence showing Medicare will be "closing in on bankruptcy by 2026."


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2 MORE COLLABORATION BETWEEN PROVIDERS & PAYERS

The CMS value-based care programs are affecting the private payer market, Holland says, prompting providers to get closer to the premium dollar and payers to aim for more direct access to patients.

Greater collaboration among providers and payers is the prediction of **Laurie Norman**, MSN, APRN, senior director at Optum Advisory Services. "In some cases, we may see provider-sponsored health plans where the payer organization runs the insurance, but it's branded by the provider."

Laurie Norman, MSN, APRN

Provider-sponsored health plans (PSHPs) are not a new concept. Since 2010, more than 40 provider organizations have formed new health insurance companies or acquired existing health plans. But a 2017 study from the Robert Wood Johnson Foundation (RWJF) called it a difficult market plagued by heavy financial losses and plan exits. A follow-up analysis by Deloitte was more optimistic, suggesting PSHPs can be at the forefront of the changing healthcare market.

But scale, tenure and choice of markets matter, says Deloitte's Maulesh Shukla, who authored the paper. His analysis found that the most successful PSHPs can check all three of these boxes—they had weathered various financial cycles, amassed more than 100,000 enrollees, and were serving some of the more challenging patient populations, such as the elderly and the poor. Connection to community was also another indicator of success.

Holland explains, "In some markets, where provider organizations are viewed as high quality and better connected to their patients, the payers and providers may work together to capitalize on that positive perception."

3 PROVIDERS FINDING NEW WAYS TO OVERCOME CONFLICTING INCENTIVES

Healthcare consolidation is already rampant, but Holland sees "horizontal coordination" giving way to more "vertical integration," where a health system buys or builds non-hospital healthcare facilities in a single region. "More providers are diversifying their asset base in a specific market by investing in surgery centers, urgent care centers and long-term care facilities," he says.

According to Fitch Ratings, hospitals and health systems owned between 25–30 percent of ambulatory surgery centers in 2017, up from 20 percent in 2011. Meanwhile, 36 percent of respondents to Healthcare Appraisers' 2018 ASC Valuation Survey indicated they sold a controlling interest in an ASC to a hospital or health system.

Vertical integration incentivizes hospitals to refer more patients to services outside of the acute care setting and, as a result, bends the cost curve, Norman adds. Organizations that offer only acute care are less likely to send patients out of the ER to an urgent care clinic owned by a competitor.

4 INCREASED FOCUS ON ENABLING PHYSICIAN INPUT

Improving population health and patient outcomes, while appropriately managing resources, are the central goals of value-based care—and, they require physician input.

According to Deloitte, "Physicians have long focused on quality of care ... but now

55%

Roughly 1,550 hospitals (55%) will receive a bonus from Medicare in fiscal year 2019 under the Hospital Value-based Purchasing Program, according to the CMS. The results are slightly worse than fiscal year 2018 when just under 1,600 hospitals (57%) earned bonuses.

—Modern Healthcare

have to pay attention to resource utilization as well, with the goal of reducing the overall cost of care. To succeed, they need data on healthcare costs, tools to analyze costs related to outcomes and aligned financial incentives."

One of the simplest ways for hospitals to better align with physicians is to make them more aware of administrative priorities. A value-based strategy will most likely be unsuccessful if physicians are caught off guard. Many organizations have hit roadblocks at the implementation phase because they didn't get physicians on board with all of the proposed changes at the outset. Their "eyes were bigger than their stomach for value-based care," as Holland puts it. "A smooth transition starts with proper governance," he adds, "and providing physicians with a seat at the table from the beginning."

Achieving physician alignment is first launched with conversations between administrators and physicians about what each group finds important and meaningful, Norman says. Administrators need to explain their challenges and what they're trying to solve, and let physicians know what was done in the past hasn't worked well enough for the hospital to consistently meet financial targets. They might tell physicians that " 'together we need to find common ground to bend the cost curve and figure out the most cost-effective way to provide the appropriate level of care.' "

Talk to cardiologists about how they are taking care of patients in the cath lab and whether there are other approaches that could accomplish the same results for a lower cost, Norman suggests. Or, discuss the use of bone cement with orthopedic surgeons and whether there are ways to achieve desired outcomes while spending less.

"If you frequently receive pushback from physicians, it can be a nonstarter and a conversation ender," Holland says. "With the clinically integrated network model, you can dig deeper into those barriers and talk about how to fix or change things to achieve goals."

Holland's experience suggests an approach of "nothing about the physicians, without the physicians" tends to be successful. Hospital administrators can help facilitate shared decision-making with their physicians to improve alignment.

Simply giving physicians a voice is not enough, Norman says. The most successful hospitals also share the gains of value-based care with the physicians who help make it happen. "Some organizations do not provide any benefit or savings to physicians, but that's a flaw," she notes.

To reduce the cost of care over time, hospital administrators must build long-term, intentional relationships with physicians grounded in ongoing communication and shared rewards.

"Often when we help health systems develop physician alignment strategies, physicians are very weary of being asked to do additional work without additional compensation," Holland notes.

"All programs need to run through the fair market, and facilities need to appropriately pay for physician time. If you want your partnership to be successful and to last, you have to make sure everything you're doing is financially transparent." **S**

-15.8%

Hospitals that keep operating business as usual will have a -15.8 percent margin by 2021.

—Health Catalyst

PHYSICIAN ENGAGEMENT IN CQO PROGRAMS

A clinically integrated supply chain can help your hospital or health system deliver better care for less. Three experts explain why physician participation is a critical success factor in that transformation.

GETTY IMAGES

Every hospital and health system in the United States wants to deliver more value to patients, to payers and to themselves. To uncover hidden value, forward-looking hospitals and health systems are integrating their supply chain operations with their clinical operations through formal CQO (cost, quality and outcomes) programs. In short, these providers make every supply chain decision with equal parts clinical feedback and financial input.

The Source convened a virtual roundtable discussion with two physicians and a supply chain leader and asked them to share their thoughts on how healthcare providers can optimize their CQO programs while also engaging their physicians in the process.

MARK PINTO, M.D., MBA—Pinto is a practicing orthopedic surgeon and the medical director of surgical services and orthopedic service lines for Trinity Health in Livonia, Michigan. He works with eight Clinical Excellence Councils at Trinity Health, each of which partners with the system's supply chain leaders to build a clinically driven supply chain for its 94 hospitals in 22 states.

BOB TAYLOR, MBA, CMRP—Taylor is senior vice president of supply chain for RWJBarnabas Health based in West Orange, New Jersey. Taylor oversees supply chain operations for the system's 12 hospitals in the Garden State. He chairs the board of the Association for Healthcare Resource & Materials Management, which in 2018 published a 20-page white paper (www.ahrmm.org/resources/white-papers/pdfs/ahrmm18-cqo-summit-white-paper.pdf) on CQO and the clinically integrated supply chain.

JOHN YOUNG, M.D., MBA, CPE, FACHE—Young is the chief medical officer for HealthTrust. In his role, Young champions clinical integration in supply chain decision-making to advance the clinical and financial performance of HealthTrust's 1,500+ member hospitals.

What trends in healthcare today are making CQO initiatives more important now than five years ago?

PINTO: I think everyone would agree that the current cost trend in healthcare is unsustainable. For hospitals and health systems, that means trying to bring down the cost of care while also trying to provide the same level of care that patients expect. That means digging into your cost structure and looking at areas where you can find more value. And a big part of your cost structure is your supply chain and the cost of all the medical supplies, equipment and devices.

TAYLOR: The shift to value-based healthcare increases the importance of CQO initiatives. Health plans no longer pay you just on the type of service or the volume of service but on the quality and the outcome of that service. To be successful in that environment, you have to improve

the quality of care while simultaneously managing and reducing cost. In that scenario, you don't want to overpay for something that gives you the same results as something less expensive. At the same time, you don't want to pay less for something that results in lesser quality or outcomes.

YOUNG: We have seen a number of mergers and acquisitions over the past five years, leading to large healthcare systems with diverse supply chain processes. True system integration requires the supply chain to be viewed as a strategic asset in the system's overall performance and value proposition.

> **"TRUE SYSTEM INTEGRATION REQUIRES THE SUPPLY CHAIN TO BE VIEWED AS A STRATEGIC ASSET IN THE SYSTEM'S OVERALL PERFORMANCE AND VALUE PROPOSITION."**
>
> **John Young**, M.D., MBA, CPE, FACHE | Chief Medical Officer | HealthTrust

Can CQO make a big difference in the clinical and financial results of a hospital or health system?

PINTO: Yes, absolutely. I think that any time you're doing a better job of "minding the store," you're going to have better outcomes in patient care and on your balance sheet. I don't think it's just nickels and dimes. The opportunities now are huge because of all the variability. We assume we all get the same outcomes from the same procedures for the same costs. But if you look around, you see that some of us are getting superior outcomes for remarkably less expense.

TAYLOR: It's not just the invoice costs of medical supplies, equipment and devices that we're talking about. It's the clinical outcomes of using those items that can make a big difference, too. If the product or service results in a longer length of stay, complications or readmissions, those are real costs that should be attributed to the purchase cost of the product. Under value-based purchasing, payers reward you for better outcomes and can penalize you for worse outcomes such as avoidable infections or readmissions.

YOUNG: There's no doubt that CQO can make a significant reduction in total health expenditures not only within the four walls of the hospital, but in the outpatient setting as well. CQO also helps advance a transparent, data-driven culture that physicians are attracted to and want to participate in. This drives the relationships needed to deliver the highest value to patients.

Why is physician participation critical to the success of CQO programs?

PINTO: For anything to work, you have to engage the end users, and in this case, those are physicians. They are the people actually doing the work. More than anyone else, they are the ones who are motivated to do the right thing for patients. And, they're also motivated to be the best at what they do. When you consider those three things, their participation is perhaps the most critical component to a clinically integrated supply chain.

TAYLOR: Physicians are the ultimate drivers of patient care in the healthcare delivery system. It's essential that we work with them as closely and collaboratively as possible to identify what the doctors need from a clinical standpoint to provide the best possible care for their patients. It's our job to present them with information and options that meet their clinical requirements.

YOUNG: In a value-driven environment, quality and patient outcomes are equally important, if not more so, than cost. Physicians need to be at the table to ensure that quality stays at the forefront of the conversation when discussing supply chain strategies.

How can hospitals and health systems effectively engage physicians in their CQO initiatives?

PINTO: One of the most important things is to set up a formal relationship with your physicians before your first "ask." Don't let the first time they hear from you be when you want to take away their favorite device, implant or product. That sets up an adversarial relationship from the beginning. Engage physicians by setting up a system to regularly talk to them about what they need and how your supply chain can help them do their jobs. If you want that engagement, you have to establish trust first.

TAYLOR: You also have to meet your physicians at their doorstep. They're extremely busy. Not all of them can participate on a standing physician committee that meets on a regular basis. To improve their engagement, you need to communicate with them through multiple venues—whether that's onsite, offsite, email or video conference. They all want to do the right thing, but you have to make it as easy as possible for them to participate in your CQO initiatives.

YOUNG: I agree. Overall governance is really important to not only tackle supply chain issues, but also to lead the health of the entire enterprise. Service line leadership—whether it's clinical excellence committees as in Dr. Pinto's system, or other clinical council constructs—is becoming more common to engage the appropriate physician stakeholders. Physician champions who are empowered to actively engage in the process and help create the strategies moving forward are paramount to success with a clinically integrated supply chain. Physician-led value analysis is a great example of a process that benefits from physician champions.

How do hospitals and health systems keep physicians motivated to reach their CQO objectives?

PINTO: You need to show physicians the data and be transparent about where it came from, how it was collected and how you are reporting it. The hospital and physician need to agree on whether you're looking at the right data for the project you're trying to evaluate. If you do make a change in an implant, a device or an instrument, you

Continued on page 39

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Indications and Usage

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.

Important Safety Information

wilate® is contraindicated in patients with known hypersensitivity reactions, including anaphylactic or severe systemic reactions, to human plasma-derived products, any ingredient in the formulation, or components of the container. Anaphylaxis and severe hypersensitivity reactions are possible. Thromboembolic events may occur. Monitor plasma levels of FVIII activity. The most common adverse reactions (≥1%) in patients with VWD were hypersensitivity reactions, urticaria, and dizziness. The most serious adverse reactions in patients with VWD were hypersensitivity reactions.

Please see accompanying Highlights of Prescribing Information for additional important information.

References: 1. Berntorp et al. Haemophilia. 2009;15:122-130. **2.** wilate® full Prescribing Information. Hoboken, NJ: Octapharma; rev 2016.

HealthTrust Contract #4861

Date of preparation: 3/2019. WIL-0192-COT

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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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Continued from page 36

need to track the same data and share it with your doctors to show them any changes in outcomes or costs. If you can show them that what you did led to better care at lower costs, your physicians will be motivated to look for other opportunities within the supply chain.

TAYLOR: You won't have any momentum if the first slide at your initial meeting is a big dollar sign. This is about providing cost-effective care that produces good outcomes. You want to always speak about it in those terms. To maintain your momentum after that first meeting and all subsequent meetings, you need to agree on next steps. And, you need to follow up on all the items that you agreed upon. If you don't, your physicians may see this as just window dressing, and they'll check out.

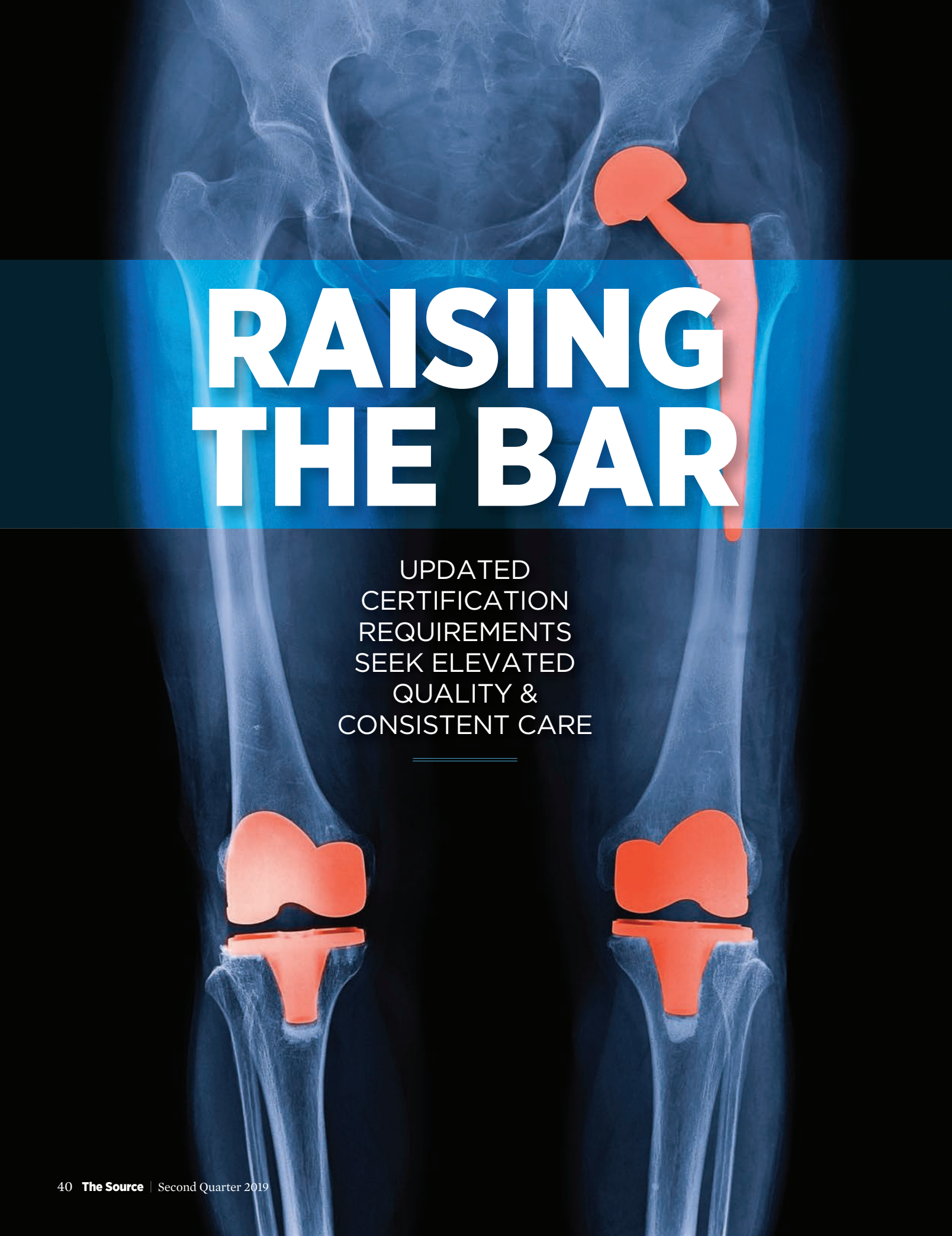
YOUNG: Identifying and reducing unwarranted variation requires not only high-quality data, but also some time set aside for education. CQO can be complex initiatives to tackle, with diverse data sources—clinical, financial, supply chain—each looking at pieces of the care delivery system in different ways. Allow time for understanding to develop and be as inclusive as possible with your physicians (whether independent, employed, etc.) to make sure all key stakeholders are involved in what is essentially change management as a long-term strategy.

What other best practices have you seen at hospitals and health systems that do CQO the right way?

PINTO: They organize their CQO programs by medical specialty. That allows them to have experts in one specialty talking to other experts in the same specialty about the things they both use in their practices. Those conversations are more credible and meaningful. Successful programs also have physicians and supply chain leaders working together. It's not top down. It's better to collaborate with someone than have someone tell you what to do. I know physicians prefer collaboration when it comes to supply chain issues.

TAYLOR: There has to be a culture of collaboration. The preferred practice is one in which the supply chain is clinically integrated and part of the interdisciplinary partnership of patient care delivery. We want to put the patient at the center of what we do and ensure our decisions are best for the patient and their care. Doing this helps ensure broad support and buy-in and the achievement of the best possible outcome.

YOUNG: Leading organizations keep the focus on what's best for the patient in terms of quality and outcomes, while simultaneously having candid discussions about variation in care and standardization efforts driven by evidence. This allows the cost discussion to develop naturally as a byproduct of reducing variation to improve performance and patient outcomes, knowing that what's best for the patient is ultimately what's best for the hospital and health system. **S**



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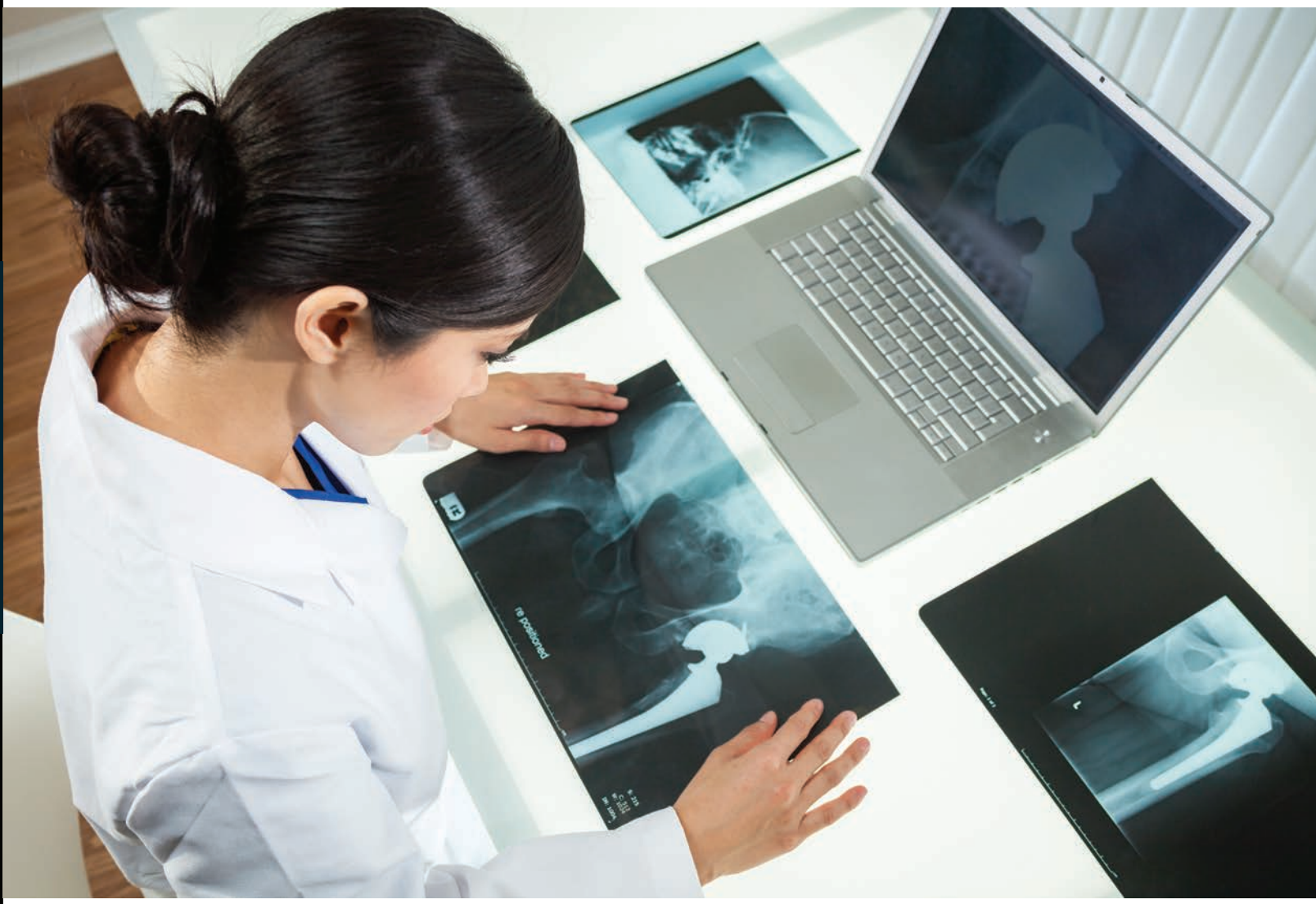

GETTY IMAGES

The Joint Commission & The American Academy of Orthopaedic Surgeons (AAOS) recently collaborated to revise total hip & knee replacement certification standards.

Given the many uncertainties of the continuously changing industry, healthcare leaders recognize the value of distinguishing themselves from the competition—especially in a crowded, consumer-first marketplace. For C-suite leaders looking to not only differentiate themselves, but also publicize their ability to meet higher standards of quality, safety and efficacy, seeking accreditation as a center of excellence (COE) is a strategic move that can help kick-start progress in meeting these wide-ranging goals.

Kelsey Duggan Ph.D., MBA

That's where prized certifications (such as those from The Joint Commission) come into play—especially as the criteria for COEs can be something of a gray area, notes **Kelsey Duggan**, Ph.D., MBA, senior director, medical device management for HealthTrust.

Though COEs are broadly defined as specialized programs that provide high concentrations of expertise and focused resources within healthcare organizations, "in general, there is no governing body and there are no standardized requirements for becoming a COE," Duggan explains. "So, specific organizations, including private insurers and employers, have developed criteria for their own COE designations."

Duggan is echoed by the Advisory Board, which writes: "Hospitals self-designate services as 'centers of excellence' with varying rigor of standards."

Since creating unbiased guidelines for your own hospital's COE can be overwhelming and considered less legitimate, hospitals and healthcare organizations are beginning to rely on regulated COE programs and standards such as those developed by The Joint Commission.

Established in 2016, The Joint Commission's Total Hip and Knee Replacement (THKR) Certification is a voluntary advanced certification program aimed at critical access hospitals, accredited

hospitals and ambulatory surgery centers (ASC) that wish to enhance the consistency, safety and quality of their services and patient care.

Awarded for a two-year period, the THKR certification increases focus on clinical, evidence-based patient care related to quality of life issues, pain management, functional limitation in mobility and return to normal daily activities. Simultaneously, the certification also addresses the growing number of patients who undergo THKR surgeries and, perhaps most important, provides hospitals and ASCs with a framework in which to improve patient outcomes.

> "As payers look to narrow their networks, it will be important for facilities to demonstrate quality, outcomes and efficiency related to joint replacement."
>
> **Kelsey Duggan**, Ph.D., MBA | Senior Director, Medical Device Management | HealthTrust

Designated pathways for providers within this framework are threefold: establishing a consistent approach to care and removing variation or risk of error; supporting team collaboration across the continuum of care; and a commitment to higher standards of clinical service.

Higher Standards of Care

In the past, The Joint Commission has narrowed its focus for orthopedic certification by refining specific areas like fall rates, enhanced patient education, length of stay, surgical site infections, pain management and early ambulation.

The American Academy of Orthopaedic Surgeons (AAOS) and The Joint Commission collaborated in the fall of 2018 to update the existing THKR certification standards with the intention of incorporating greater clinical oversight and performance measures.

Now in effect since Jan. 1, 2019, Duggan says The Joint Commission's THKR certification is important for a variety of reasons, including the added competitive edge.

"As payers look to narrow their networks, it will be important for facilities to demonstrate quality, outcomes and efficiency related to joint replacement if they want to be included," Duggan explains.

Investing in COE certifications can also help hospitals and healthcare systems boost patient volume and physician satisfaction by holding themselves accountable to higher degrees of care.

"Both patients and providers will be attracted to the facility that is committed to the continuous improvement of their orthopedic service line," Duggan says.

The standout difference in the updated THKR requirements, Duggan notes, is the mandatory participation in the American Joint Replacement Registry (AJRR)—the world's largest national registry of hip and knee replacement data. The recent registry requirement will become effective July 1, 2019.

AAOS recently integrated with the AJRR to create a "family" of registries for the purpose of collecting,

Continued on page 44

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analyzing and reporting data to be shared and used to improve quality and outcomes. Though there are some similar, well-established registries in England, Australia and Sweden, Duggan says the United States' efforts to bolster a registry is relatively new.

"Participation in the AJRR will provide near real-time feedback reports and summary statistics," Duggan explains. "And the scale allows for meaningful national benchmarking and peer-to-peer comparisons."

A Seamless Continuum of Care

Earning a THKR certification is no small task. Organizations must undergo rigorous onsite reviews by experts from The Joint Commission in order to evaluate compliance in a number of focus points, including advanced, disease-specific care standards and orthopedic consultations, among others.

The hospitals and organizations that receive the THKR accreditation are required to collect and report monthly data on a variety of measures, including home discharge, day of surgery postoperative ambulation, health status assessment and more. Each of these measures span the continuum of each patient's care so they are dependent on hospitalwide collaboration and teamwork. Duggan notes that certifications like THKR hold hospitals accountable to meeting and maintaining those higher standards.

PREPARING FOR ACCREDITATION

Looking to undertake accreditation from The Joint Commission? It's critical that facilities work closely with the payers of the patients who have, for instance, total hip and knee (THKR) procedures. Doing so means that providers can be certain of compliance. HealthTrust has created checklists detailing eligibility and certification requirements as well as strategies for success to assist members seeking joint and spine accreditation from The Joint Commission. *To explore HealthTrust's tools, contact* ***Kim Wright****, RN, AVP Clinical Data Solutions, at* ***kimberly.wright@healthtrustpg.com****.*

"For example, early mobilization has been shown to reduce complications and improve outcomes," Duggan says. "Efforts to get a patient up and moving successfully on the day of surgery often begin prior to surgery through patient education and prehab. On the day of surgery, the surgeon must meet with both the anesthesiologists and the physical therapists on the floor to ensure the patient is awake and is able to be seen by the appropriate staff at the proper time for same-day ambulation." **S**

For more information on The Joint Commission's orthopedic certifications, visit: www.jointcommission.org/certification/orthopedic_certifications_help_you_achieve_excellence.aspx.

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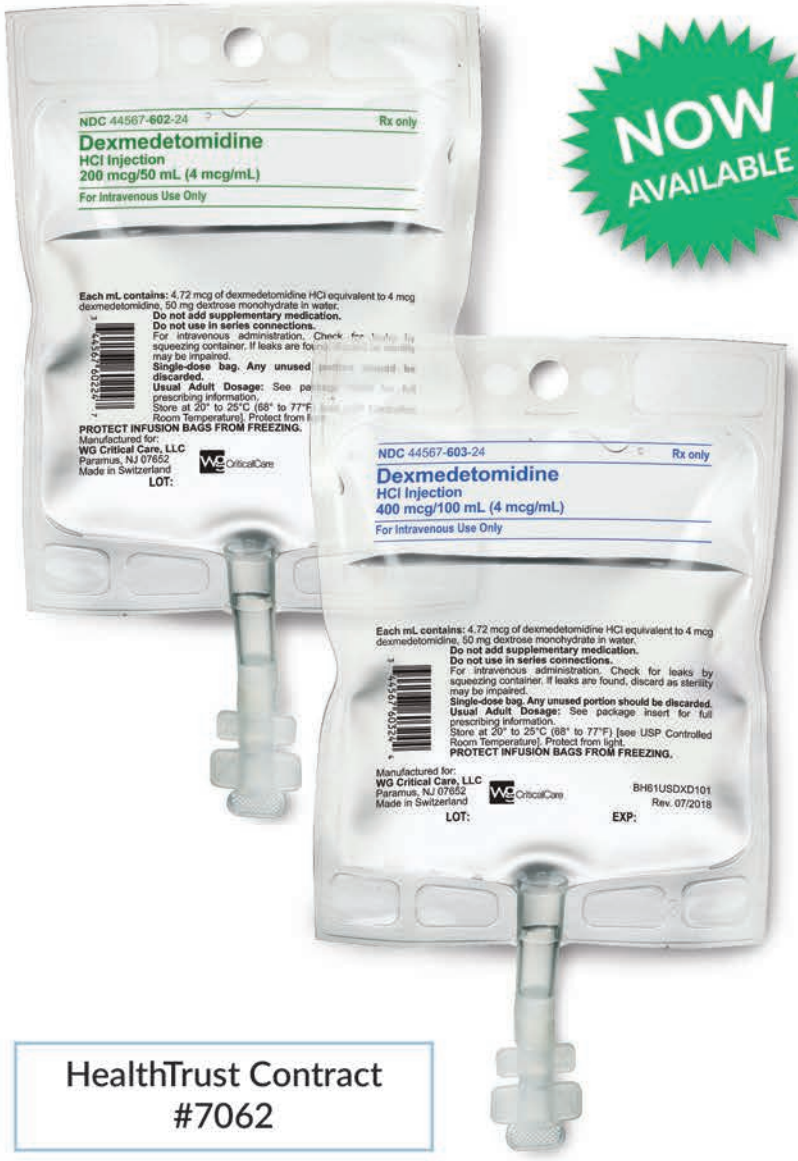

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Dexmedetomidine HCl Injection (In 5% Dextrose)	603-24	400 mcg/100 mL	100 mL	100 mL Premix Bag	4 mcg/mL	24	10191720	5490867	3404209	5764311	468298

Indication and Usage

- Sedation of initially intubated and mechanically ventilated patients during treatment in an intensive care setting.
- Sedation of non-intubated patients prior to and/or during surgical and other procedures.

Important Safety Information: Continuously monitor blood pressure, heart rate and oxygen levels during administration. Bradycardia, hypotension, transient hypertension and arousability may result. The most common adverse reactions are hypotension, respiratory depression and bradycardia.

References: 1. Dexmedetomidine HCl Injection [package insert] 2. On file WG Critical Care, LLC (To request source, call customer service at 1.888.493.0861 or email us by visiting wgccrx.com)

TEAMWORK TOOLS

YOUR Q2 GUIDE TO STRATEGIC PURCHASED SERVICES CONTRACTING & THE BENEFITS OF PHYSICIAN OPERATIONS EXECUTIVES

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MEMBER SUCCESS STORY: After Ardent Health Services discovered purchased services consumed nearly half of its $2 billion annual non-labor spend, several of its hospitals, including Albuquerque, New Mexico-based Lovelace Health System, began to give the category a renewed focus. In the past five years, Lovelace has added a dedicated, full-time purchased services contracts administrator and partnered with HealthTrust's inSight Advisory–Purchased Services to realize $2 million in savings.

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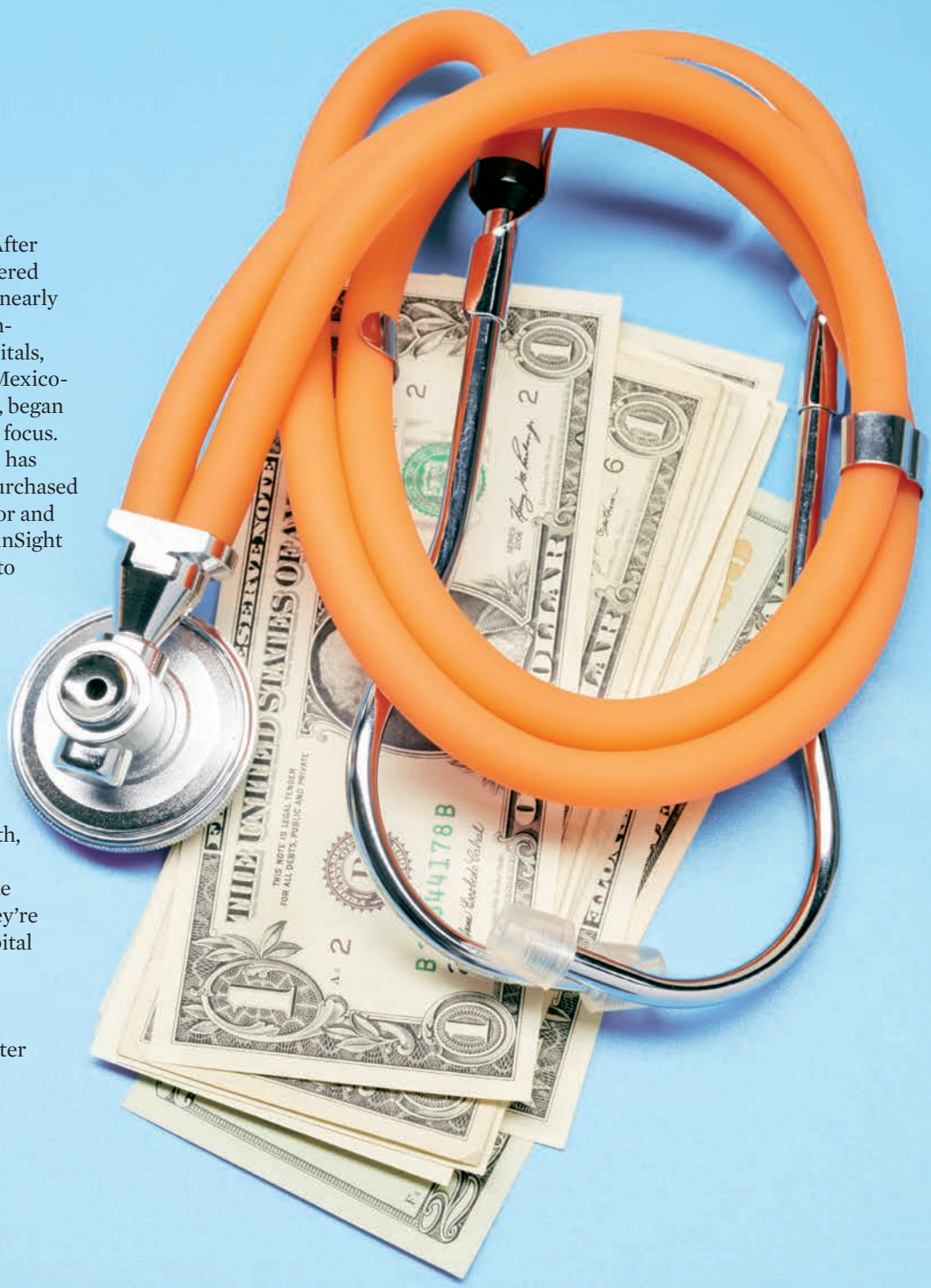
LEADERSHIP LINK: A year into their roles as physician operations executives at San Diego-based Scripps Health, **Valerie Norton**, M.D., and **Jonathan Worsey**, M.D., spoke with *The Source* about how they're bridging the gap between hospital administrators and physicians, helping the two groups better understand one another's perspectives and achieve greater alignment in cost, quality and outcomes goals.



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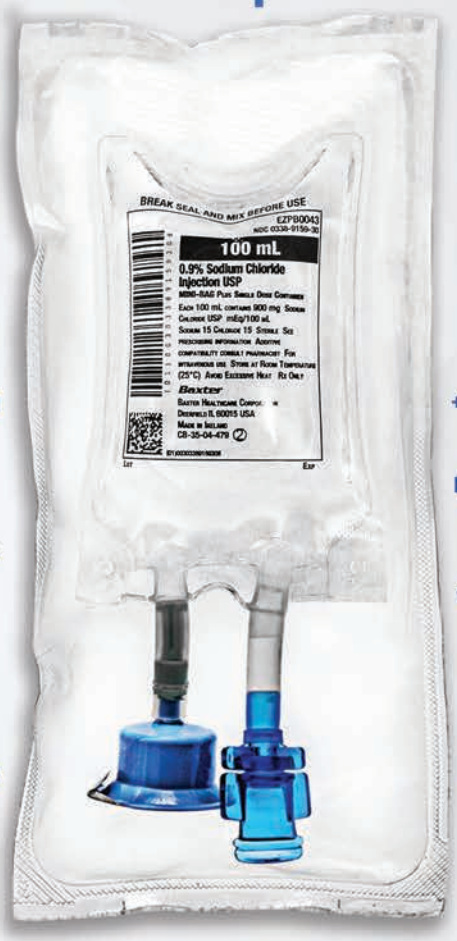

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Tapping a Hidden Source of Savings

ARDENT HEALTH SERVICES' FOCUS ON PURCHASED SERVICES UNCOVERS MILLIONS IN SAVINGS

Most contracting strategies start with a focus on categories such as med/surg supplies and physician preference items to cut costs. But purchased services is often another largely untapped source of savings in the healthcare supply chain that touches every department in a hospital.

This broad and diverse category—covering everything from food services to facilities management—typically accounts for at least one-third of a hospital's non-labor spend.

Nashville, Tennessee-based Ardent Health Services, which operates 31 hospitals in seven states, discovered that purchased services consumed nearly half of its $2 billion annual non-labor spend. Nowhere is that focus more on display than at Albuquerque, New Mexico-based Lovelace Health System, which started to take a look at the purchased services category in 2014, with the addition of a dedicated, full-time purchased services contract administrator. **Andrea Hunnicutt**, CMRP, assistant vice president of supply chain for the five-hospital system, estimates the decision to concentrate on this category resulted in $2 million in savings.

"We started by putting a few of our purchased services contracts into a benchmarking tool, which made us realize that this category had a tremendous amount of low-hanging fruit," Hunnicutt says. "It brought to light the fact that this was an area that really needed to be examined closely."

THE VALUE OF CENTRALIZATION

Contracts for purchased services are easily overlooked because they traditionally fall outside of a supply chain leader's area of responsibility and are instead managed by various people


Andy Motz

throughout the hospital. But that's a mistake, says **Andy Motz**, HealthTrust's assistant vice president of supply chain consulting and inSight Advisory–Purchased Services.

"Purchased services tend to be very relationship-based, with department directors often writing and signing their own contracts or sometimes using only a handshake to bind the agreement," he explains. "But there's a lot of value that comes from centralizing all of your purchased services contracting under supply chain."

By going through typical supply chain strategies, like a formalized bidding process, hospitals can ensure they're paying the right price for each purchased service, Motz adds. Supply chain oversight also can help ensure standard terms and conditions, as well as quality control measures, are included in contracts. Volume-based contracting for the same purchased service can generate savings for multiple departments and dramatic reductions are possible, for both single hospitals and multi-facility IDNs—especially if purchasing is currently limited to just one or two suppliers.

Lovelace Health System is on track for about $350,000 in purchased services savings in 2019, thanks in part to a partnership with HealthTrust's inSight Advisory Services that began last year.


Left to right: Tammy Snowden & Andrea Hunnicutt, CMRP, Lovelace Health System

Led by Motz, the HealthTrust team has helped Lovelace Health System implement new contracts for blood products and elevator maintenance. Future plans include dialysis services and linen and laundry services.

At the start of the engagement, Motz's team worked with all of Ardent to implement the use of an analytics tool that groups purchased services spend so users can quickly identify contracting opportunities. The tool, from HealthTrust technology partner Valify, is used in tandem with inSight Advisory Services. It helps organizations identify, benchmark and track savings. It also aggregates accounts payable data and then makes comparisons across facilities within and outside of a health system.

"THE CHALLENGE IN THE PURCHASED SERVICES SPACE IS THE INABILITY TO QUICKLY ANALYZE MARKET CONDITIONS AND CAPTURE SPEND. WITH THIS ANALYTICS TOOL, TASKS THAT WOULD TAKE THREE MONTHS CAN NOW BE DONE IN A WEEK OR TWO."

Tom Chickerella | Vice President of Materials Management | Ardent Health Services

"These contracts and invoices are spread out all over multiple sites and departments," Hunnicutt says. "There's not enough time in the day to scrutinize everything. That's why a tool like this is so valuable. It helps us get a grasp on where we need to focus."

Benchmarking speeds up timelines and provides perspective, says **Tom Chickerella**, vice president of materials management for Ardent Health Services.

"The challenge in the purchased services space is the inability to quickly analyze market conditions and capture spend," Chickerella says. "With this analytics tool, tasks that would take three months can now be done in a week or two."

Comparison shopping is also more difficult with services than with supplies, Motz notes. "If you look at a glove, no matter where you buy it, it's still a glove. Purchased services are far less standardized, so they need to be evaluated based on their unique characteristics."

INCREASING A FACILITY'S BANDWIDTH

After Valify helped identify contracting opportunities, together the team determined which tasks **Tammy Snowden**—who took over the purchased services contract administrator position in 2017—could handle on her own and which ones needed HealthTrust's involvement.

"A lot of the decision-making has to do with the category itself and whether we're knowledgeable enough about it," Hunnicutt says. "Other times, it's a bandwidth issue. Purchased services contracting, especially when there's a clinical implication, takes a lot of work. Tammy's only one person, and we know that the HealthTrust team can help us get across the finish line."

The likelihood of changing suppliers is another consideration because that can be "difficult, not to mention disruptive," Hunnicutt says. "Ideally, the outcome of an RFP process is staying with a good partner and getting a little more value out of the relationship."

But if a change in suppliers looks likely, partnering with the inSight Advisory Services team can be the smartest choice.

For example, consider the new elevator maintenance service agreement that took effect in December. Minor savings came from switching suppliers, amounting to just $35,000 over three years, but the level of service increased.

"HealthTrust taught us that it's not always about the savings," Snowden says. "We also need to make sure that suppliers have metrics in place so that we can hold them accountable when they are not performing as expected."

In other situations, the decision to switch can be driven purely by savings—as was the case when a longtime supplier increased its price by 40 percent. "We like them, they bend over backward to help us and there's a relationship of trust, but we have to vet the other possibilities after receiving this kind of an increase," Hunnicutt explains.

While HealthTrust took the lead on the elevator maintenance strategy, Snowden played an important role as the liaison between HealthTrust and the facilities managers, as well as the local suppliers. She set up the site visits and attended all of the meetings to stay up-to-speed on the needs of the facilities.

"FOLLOW-UP IS A KEY FACTOR IN MAXIMIZING THE VALUE THAT WAS NEGOTIATED IN THE CONTRACT."

Tom Birmingham | Corporate Director of Purchased Services and Capital Equipment | Ardent Health Services

"Tammy was instrumental in getting the four elevator maintenance suppliers on-site and in front of the facilities managers to facilitate discussions," Motz says. "Because of that teamwork, the project stayed on track and the decision to switch to a new supplier came with a full understanding of what level of service would be expected from them."

To ensure suppliers meet performance expectations, new purchased services contracts across Ardent include weekly implementation calls that roll seamlessly into regular performance reviews throughout the life of the contracts. The reviews provide

a picture of what's happening across all aspects of the supplier relationship, based on the previous month's spend, hospital feedback and key performance indicators such as savings, supplier conduct and contract pricing compliance.

"Follow-up is a key factor in maximizing the value that was negotiated in the contract," says **Tom Birmingham**, Ardent's corporate director of purchased services and capital equipment. "Without proper attention to behavior, the level of service you receive is left up to the supplier."

A WINNING STRATEGY

Despite the associated challenges, a strategic approach to purchased services contracting can have payoffs.

"The opportunities for double-digit savings in the traditional supply arena are now far and few between," Chickerella notes. "Given the share of spend it represents, purchased services has to be a part of total expense management."

To achieve success, Hunnicutt underscores the need to keep people in the loop. "We try to involve frontline staff as much as possible in the early stages, challenging them to articulate what they like and don't like about a current supplier," she says. "Ultimately, we're looking for their buy-in as well as an openness to change." ●

Andrea Hunnicutt, CMRP, assistant vice president of supply chain for Lovelace Health System, has three tips for developing a purchased services contracting plan.

1. **Dedicate internal resources to the purchased services category.**
2. **Have clear, strong data to help inform the decision-making process.**
3. **Communicate often with stakeholders and share results.**

Q&A With Drs. Valerie Norton & Jonathan Worsey

A Triple Win Approach

In March 2018, Scripps Health appointed five experienced physicians to newly created physician operations executive positions at each of its hospital campuses in California's San Diego County. The move was part of an ongoing redesign of the healthcare delivery model by the San Diego-based nonprofit system and created the model of a physician operations executive paired with an administrator chief operations executive at each hospital. Together they share joint responsibility in managing day-to-day hospital activities, as well as supporting systemwide initiatives under two regional chief executives, one responsible for northern San Diego County and the other for the southern portion of the county.

Scripps' decision to place actively practicing physicians in administrative roles is consistent with a larger movement taking place across the healthcare industry. As hospitals and physicians scramble for their share of shrinking reimbursements, it has become increasingly crucial for them to better understand one another's perspectives and align their goals to achieve improved patient outcomes at lower costs.

Now seated for a full year as Scripps' physician operations executives, **Valerie Norton**, M.D., and **Jonathan Worsey**, M.D., spoke with *The Source* about their roles.

What were Scripps' goals in appointing physician operations executives?

NORTON: Recent literature showed that institutions and systems that had incorporated physicians as administrators and leaders were doing better overall than those that had not. This improvement was seen not only in terms of patient and quality outcomes, but also in economic results.

Physicians drive much of healthcare spending. Until you make physicians your partner in the business of running hospitals and clinics, you will never fully manage those costs in a rational, evidence-based manner that speaks to the clinical outcomes of the patient as well as the business strategies of the organization. Physicians need a peek behind the curtain at what's going on with financials, because most of them have absolutely no idea how to support any of those strategies. They want their

Continued on page 54

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Continued from page 52

institutions to be successful, but they may not understand the business imperatives or the cost structures, and they aren't aware of how things are spiraling out of control in some sectors, such as implants and pharmaceuticals. Once you show physicians ways to improve cost-effectiveness, they're almost universally happy to help.

What are some of your new responsibilities?

WORSEY: Our main responsibility is to communicate the goals, concerns and perspective of senior hospital administration to the physicians and then relay the concerns of our medical staff back to the administration. Only when everyone realizes there is already significant alignment of purpose will we able to cooperate and collaborate to reconcile any differences that exist. We also need to ensure that our physician colleagues see us primarily as practicing physicians who also a have senior administrative position rather than vice versa. No matter how long and glittering a career a physician may have had, once they become a full-time administrator with no clinical work, they are viewed very differently.

Another important responsibility is that we, as practicing physicians, are expected to have conversations regarding cost and utilization with our physician colleagues, since they are doing the actual work and must have a voice in the decision-making. Though these discussions may not be in our respective fields, we still have a better understanding of day-to-day patient care than our full-time administrators. We speak a language our colleagues can understand and can better appreciate the pressures and constraints our fellow physicians are experiencing.

NORTON: We are here to be agents of change and influence by getting people to concentrate on the triple aim: improving the patient experience, improving population health and reducing the per-capita cost of healthcare. The crowning achievement would be best-in-the-world outcomes, with a fantastic care experience, at the least possible cost. That's what provides the best value to the patient.

It's important to forge a partnership between clinicians, administrators, managers and pharmacists to determine what your goal should be with respect to that triple aim. You can't have everything: Sometimes you can only have better quality for a higher price. At that point, it's about achieving the smallest price increase necessary to get that better quality. Sometimes you can cut costs, but only at the risk of a poor patient experience.

There are moments where you get all three and it's a win-win-win. It's up to us to find and promote the situations that are triple wins. I actually keep a list of those in my office. For situations that are not triple wins, where there are tradeoffs, it's our job to negotiate the best possible compromise.

What are some of those "triples"?

NORTON: One example is enhanced recovery after surgery, or ERAS. ERAS has been practiced in Europe for 20 years with amazing results. But in the United States, we've been slow on the uptake because incentives have not been properly aligned in our healthcare system. ERAS is the bundle of care components that optimizes the surgical experience: It's all about educating patients, setting expectations and then enhancing every detail of what happens to them weeks before surgery through their postop recovery period.

It's not about surgical technique; it's the small stuff, such as educating patients to use as few opioids as possible while they're recovering and trying to tolerate some pain so they can avoid all the complications of opioids. Those complications include increased constipation, wooziness, vomiting and feeling unsteady on their feet—the kinds of issues that keep them in the hospital longer and prevent them from recovering faster. There is a lot of literature showing that minimizing the use of opioids improves recovery. That's a big part of ERAS, and it includes the use of more non-opioid alternatives and educating patients about what to expect.

> **"WE ARE HERE TO BE AGENTS OF CHANGE AND INFLUENCE BY GETTING PEOPLE TO CONCENTRATE ON THE TRIPLE AIM: IMPROVING THE PATIENT EXPERIENCE, IMPROVING POPULATION HEALTH AND REDUCING THE PER-CAPITA COST OF HEALTHCARE."**
>
> **Valerie Norton**, M.D. | Chief Operations Executive Physician | Scripps Health

Another part of that triple win is not making patients fast before surgery. In the past, if you had an operation, you couldn't eat or drink anything after midnight the night before. It turns out that's not based on science. It's just wrong. Now we allow patients to drink clear liquids up until two hours before surgery—ideally, a beverage such as Gatorade that contains carbohydrates. When they arrive for surgery well-hydrated and in a non-fasting state, they do better. Surgery is less stressful on their body, they recover faster, and they have fewer complications and wound infections.

These strategies not only result in cost savings. Patients are happier because they have an improved understanding of the whole surgical process and feel like they're a participant in it. It's a better patient experience all around, and it ends up saving them

money because they have a shorter stay in the hospital and fewer return visits and readmissions. It's a totally out-of-the-ballpark, triple-aim win.

We're working hard on trying to spread this philosophy throughout our system. It can sometimes be an uphill battle because we're going against tradition and dogma and trying to change decades of received wisdom.

What additional value do physician administrators bring to your hospitals?

WORSEY: When it comes to talking to physicians about the way they practice medicine and asking them to consider change, I think it's far easier for us to have those conversations. The standard response of "you administrators just don't understand what I do," does not really hold true in this new arrangement.

That proved to be the case when we had an issue of overutilization of antibiotic bone cement in joint replacement as compared to accepted benchmarks. We gathered our orthopedic surgeons at the system care line and showed them data that we use a lot of antibiotic bone cement with significant added expense but with no demonstrable improvement in patient outcomes. After several meetings with our surgeons, we were able to discuss the literature and our own data from the perspective of fellow clinicians and came to an agreement on selective use following published guidelines.

Our goal is to persuade our physicians to give the same attention to cost and utilization as they already do to quality and patient satisfaction—so much so that it becomes an automatic consideration.

NORTON: Another area where we have been successful is in developing, mentoring and coaching a succession of young physician leaders. For instance, we needed a person to manage all the electronic medical record challenges that physicians are voicing and be the liaison to the IT department. I identified a brilliant physician who also has an informatics degree, and asked if Scripps Health could provide a small stipend for him to be the conduit between all the doctors and IT. Scripps agreed, and he is knocking it out of the park. Everybody loves him. He sends out tip sheets, and anytime a physician has a problem with the computer system, they contact him. It's been a tremendous win.

> **"OUR GOAL IS TO PERSUADE OUR PHYSICIANS TO GIVE THE SAME ATTENTION TO COST AND UTILIZATION AS THEY ALREADY DO TO QUALITY AND PATIENT SATISFACTION—SO MUCH SO THAT IT BECOMES AN AUTOMATIC CONSIDERATION."**
>
> **Jonathan Worsey**, M.D. | Chief Operations Executive Physician | Scripps Health

Can you offer any advice for systems wanting to incorporate physician administrators?

WORSEY: My advice for other hospital systems is to both choose your physician carefully and then design the position to be meaningful with well-defined authority, responsibilities and a real role in major decision-making.

The ideal physician for such a role is an actively practicing and well-respected clinician, with medical staff leadership experience and some existing administrative experience in areas such as cost or quality. They have to have the vision to understand and reconcile the viewpoints of the different constituents that make up a hospital and health system.

For these positions to be meaningful, they cannot simply be honorary titles. Scripps has committed to giving us access to the top-level operational and financial meetings and reports, and we have a voice in decision-making. Both of these are crucial. Finally, to be effective, the position has to be seen as one that advocates for the patients and physicians just as much as it does for administration and the bottom line. ●

Valerie Norton, M.D., has been chief operations executive physician at Scripps Health since March 2018. A specialist in emergency medicine, she has served as president of her medical group, Pacific Emergency Providers, since 2005.

Norton received an undergraduate degree from Yale University and a medical degree from the University of California at San Diego in 1991. She completed a residency in emergency medicine at UCLA in 1995. Norton was board-certified in emergency medicine in 1996. She has chaired multiple committees at Scripps, including Pharmacy & Therapeutics and Opioid Stewardship.

Jonathan Worsey, M.D., has been chief operations executive physician at Scripps Health since March 2018. He started his private practice in colorectal surgery at Scripps Memorial Hospital in La Jolla, California, in 1999.

Worsey received an undergraduate degree from the University of Cambridge and a medical degree from St. Thomas' Hospital, London, England, in 1985. He completed an internship in surgery at St. Thomas Hospital and a surgery residency at the University of Pittsburgh. He received additional training at the Cleveland Clinic Foundation. Worsey was board-certified in surgery in 1998 and in colon and rectal surgery in 1999.

Worsey is the author of 58 papers, book chapters and presentations. He is currently a reviewer of papers submitted to *Diseases of Colon and Rectal Surgery*, the journal of the American Society of Colon and Rectal Surgeons. He also serves on the Scripps' ACO board and as system medical director for value analysis.

Capturing Data With Capturis

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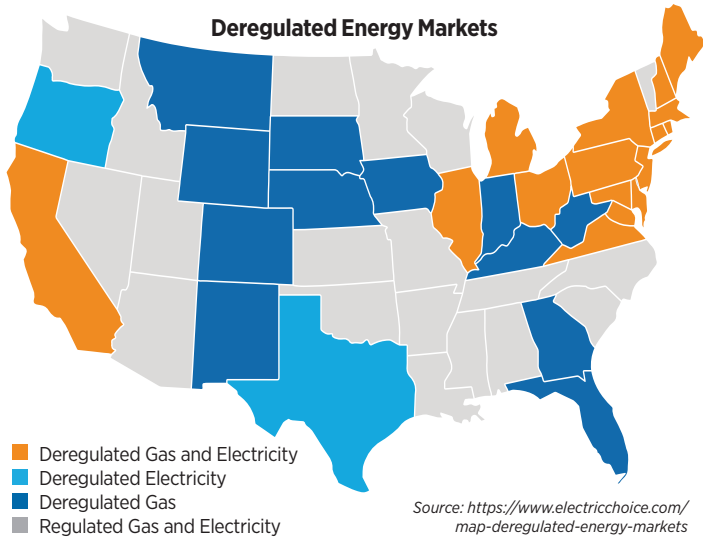
Hospitals have multiple bills to pay each month to keep the lights on, bedside machines operating and water running. Though keeping track of utility and telecom bills may not seem like much of a feat, it can be a juggling act for organizations with numerous facilities and locations. They risk having critical services terminated if payments are late or missed.

In January 2019, a critical access hospital in Kansas faced this exact scenario. After a check for its October 2018 bill bounced, and November and December passed by without payment, the utility company warned that service would be shut off unless it received remittance by a specific date. The hospital had accrued more than $28,000 in unpaid utility bills, according to a report in *Becker's Hospital Review*.

Situations like these can be prevented. Capturis, a Mandan, North Dakota-based utility information management company, provides multisite organizations with utility bill pay services in addition to consumption and cost-tracking data.

Capturis helps healthcare organizations streamline the accounts payable process, relieving employees from time-consuming tasks

Continued on page 58



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*Andrews P, et al. Early Application of Airway Pressure Release Ventilation May Reduce Mortality in High-Rick Trauma Patients: A Systematic Review of Obcervational Trauma ARDS literature. Journal of Trauma and Acute Care Surgery 2013: 75(4): 635–641

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PERIOD	ACTUAL $	BUDGET $	VARIANCE	% OF BUDGET	ACTUAL KWH	BUDGET KWH	VARIANCE
May 2018	$ 12,301.11	$ 12,249.00	$ 52.11	100.4254	112,391.71	111,000.00	1,391.71
Jun 2018	$ 13,510.29	$ 12,801.00	$ 709.29	105.5409	112,353.76	116,000.00	- 3,646.24
Jul 2018	$ 15,713.93	$ 12,470.00	$ 3,243.93	126.0139	136,779.55	113,000.00	23,779.55
Aug 2018	$ 16,029.24	$ 13,904.00	$ 2,125.24	115.2851	134,635.57	126,000.00	8,635.57
Sep 2018	$ 14,550.63	$ 12,690.00	$ 1,860.63	114.6622	121,195.72	115,000.00	6,195.72
Oct 2018	$ 13,943.22	$ 10,594.00	$ 3,349.22	131.6143	111,456.67	96,000.00	15,456.67
Nov 2018	$ 13,943.63	$ 11,256.00	$ 2,687.63	123.8773	111,042.10	102,000.00	9,042.10
Dec 2018	$ 14,367.91	$ 12,801.00	$ 1,566.91	112.2405	114,961.42	116,000.00	- 1,038.58
Jan 2019	$ 15,165.20	$ 15,748.00	$- 582.80	96.2992	120,041.78	127,681.00	- 7,639.22
Feb 2019	$ 13,077.52	$ 12,894.00	$ 183.52	101.4233	104,966.41	104,001.00	965.41
Mar 2019	$ 2,313.59	$ 12,393.00	$- 10,079.41	18.6686	18,620.69	102,241.00	- 83,620.31
Apr 2019	$ 0.00	$ 11,168.00	$- 11,168.00	0.0000	0.00	102,564.00	- 102,564.00
Subtotal:	**$ 144,916.26**	**$ 150,968.00**	**$- 6,051.74**	**95.9914**	**1,198,445.38**	**1,331,487.00**	**- 133,041.62**

BUDGET COMPARISON: Capturis provides budget comparison charts for a healthcare system's individual facilities. In this sample chart, a hospital can see the budgeted costs and kilowatt hours compared to the actual usage.

	KWH				OPTIMIZED COST				UNIT COST			COST CHANGE ANALYSIS		
CALENDAR PERIOD	CURRENT	PRIOR YEAR	DIFFERENCE	% CHANGE	CURRENT	PRIOR YEAR	DIFFERENCE	% CHANGE	CURRENT	PRIOR YEAR	% CHANGE	COST CHANGE	DUE TO USE	DUE TO $/KWH
May 2018	112,391.71	0.00	112,391.71	0.00%	$ 12,301.11	$ 0.00	12,301.11	0.00%	$ 0.1094	$ 0.0000	0.00%	$ 12,301.11	$ 0.00	$ 12,301.11
June 2018	112,353.76	0.00	112,353.76	0.00%	$ 13,510.28	$ 0.00	13,510.28	0.00%	$ 0.1202	$ 0.0000	0.00%	$ 13,510.28	$ 0.00	$ 13,510.28
July 2018	136,779.55	0.00	136,779.55	0.00%	$ 15,713.94	$ 0.00	15,713.94	0.00%	$ 0.1149	$ 0.0000	0.00%	$ 15,713.94	$ 0.00	$ 15,713.94
August 2018	134,635.57	0.00	134,635.57	0.00%	$ 16,029.25	$ 0.00	16,029.25	0.00%	$ 0.1191	$ 0.0000	0.00%	$ 16,029.25	$ 0.00	$ 16,029.25
September 2018	121,195.72	0.00	121,195.72	0.00%	$ 14,550.62	$ 0.00	14,550.62	0.00%	$ 0.1201	$ 0.0000	0.00%	$ 14,550.62	$ 0.00	$ 14,550.62
October 2018	111,456.67	0.00	111,456.67	0.00%	$ 13,943.22	$ 0.00	13,943.22	0.00%	$ 0.1251	$ 0.0000	0.00%	$ 13,943.22	$ 0.00	$ 13,943.22
November 2018	111,042.10	95,310.00	15,732.10	16.51%	$ 13,943.62	$ 9,553.18	4,390.44	45.96%	$ 0.1256	$ 0.1002	25.28%	$ 4,390.44	$ 1,576.87	$ 2,813.57
December 2018	114,961.43	109,439.23	5,522.20	5.05%	$ 14,367.92	$ 15,440.66	- 1,072.74	- 6.95%	$ 0.1250	$ 0.1411	- 11.42%	$- 1,072.74	$ 779.12	$- 1,851.86
January 2019	120,041.78	124,739.15	- 4,697.38	- 3.77%	$ 15,165.19	$ 15,980.37	- 815.18	- 5.10%	$ 0.1263	$ 0.1281	- 1.39%	$- 815.18	$- 601.78	$- 213.40
February 2019	104,966.41	103,077.19	1,889.22	1.83%	$ 13,077.53	$ 10,761.04	2,316.49	21.53%	$ 0.1246	$ 0.1044	19.34%	$ 2,316.49	$ 197.23	$ 2,119.26
March 2019	18,620.69	112,804.04	- 94,183.35	- 83.49%	$ 2,313.59	$ 11,694.12	- 9,380.53	- 80.22%	$ 0.1242	$ 0.1037	19.85%	$- 9,380.53	$- 9,763.76	$ 383.23
April 2019	0.00	106,445.01	- 106,445.01	- 100.00%	$ 0.00	$ 11,203.18	- 11,203.18	- 100.00%	$ 0.0000	$ 0.1052	- 100.00%	$- 11,203.18	$- 11,203.18	$ 0.00
Total:	**1,198,445.38**	**651,814.62**	**546,630.76**	**83.86%**	**$ 144,916.27**	**$ 74,632.55**	**$ 70,283.7200**	**94.17%**	**$ 0.1209**	**$ 0.1145**	**5.61%**	**$ 70,283.72**	**$ 62,589.03**	**$ 7,694.69**

COST CHANGE ANALYSIS: Capturis' cost change analysis chart can help hospitals and healthcare systems determine whether increases in costs were due to use or because of a change in cost per kilowatt hours.

Continued from page 56

such as receiving, auditing, documenting and processing utility bills so payment deadlines don't get missed.

"In the past, utilities were paid and handled by the hospital's accounts payable department," explains **Stephen Oberhousen**, MBA, program manager, utility bill pay services, inSight Advisory–Energy (formerly EnergyTrust). "But for the past nine years, more HealthTrust members have been turning these tasks over to Capturis."

Stephen Oberhousen, MBA

LEVERAGING DATA

Reassurance that bills are paid on time is the obvious benefit of utilizing a bill pay management service, but the real advantage is automated data capture. After payments are made, Capturis scans the invoices and posts them to a web-based portal.

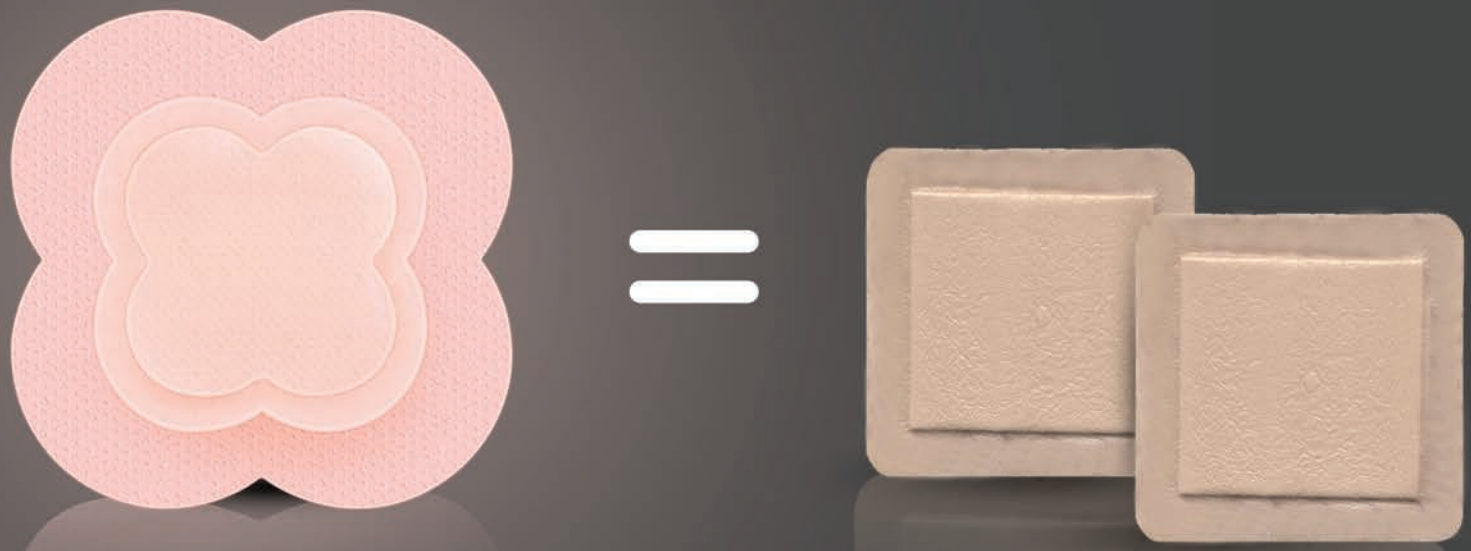
"This process gives hospital leadership better visibility and access to data analyses and benchmark reports," Oberhousen says. "The data it provides is very powerful. By making these invoices available for analysis, members can make sure they're being billed correctly and getting the price they were promised."

Hospitals can also leverage this data to secure better pricing for energy and electricity. Utility bills account for an average 1.4 percent of hospitals' operating costs, which can result in a large sum. For example, a 200,000-square-foot, 50-bed hospital in the United States spends approximately $680,000 on electricity and natural gas each year, according to *Sustainability for Healthcare Management: A Leadership Imperative* by Carrie R. Rich, J. Knox Singleton and Seema S. Wadhwa.

By improving energy efficiency, hospitals can boost their bottom line and free up funds for other expenses. Since 1998, inSight Advisory Services–Energy has helped HealthTrust members save millions of dollars, leverage data and strategically purchase deregulated natural gas and electricity. The data provided by Capturis gives facility managers a clear look at how much is being spent each year on energy *(see examples above)*.

Continued on page 60

HealthTrust contract #24201



Layers that last and lower your cost[1]

ALLEVYN LIFE foam dressing's unique 5 layers help the dressing to stay in place,[2] reduce unnecessary dressing changes and extend wear time.[1]

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For detailed product information, including indications for use, contraindications, effects, precautions and warnings, please consult the product's Instructions for Use (IFU) prior to use.

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Contact your HealthTrust Smith & Nephew Director, National Accounts
Jeremy Spencer at (704) 562-5862
jeremy.spencer@smith-nephew.com

References: 1. Joy H et al. A collaborative project to enhance efficiency through dressing change practice. Journal of Wound Care. Vol 24. No 7. July 2015 P3-4. 2. Clarke R. Positive patient outcomes: The use of a new silicone adhesive foam dressing for pressure ulcer prevention and treatment.

Continued from page 58

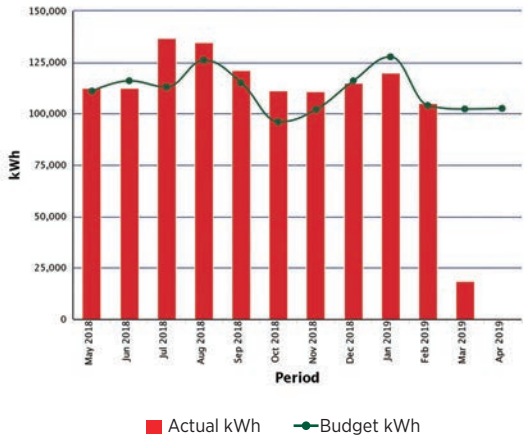
Bill Miller

"More hospitals are turning their attention toward energy expenditures," says **Bill Miller**, director, strategic initiatives, inSight Advisory Services. As they do, budgets are being analyzed, leaving financial departments to question why the facility is over or under budget each month. To show that they stuck to an overall budget, administrators sometimes take the year's energy expenses and divide them by 12, Miller says.

"That theory doesn't work—it simply masks the underlying problem," he explains. "Electricity usage will always be higher in the summer as compared to winter. Natural gas usage will be higher in the winter when compared to summer."

An ideal scenario is to neither be over or under budget, Miller says. "If a hospital is over their budget for energy expenditures, then we need to look at the data and find out why. If they're under budget, we also need to understand the reasoning. Electricity and natural gas do not generate revenue for a hospital—if a facility is $200,000 under budget, then that's $200,000 that could have gone to a revenue-generating project. That's why it's critical to use the data provided by Capturis to help members make energy procurement and budgeting decisions," he continues.

Electricity kWh Per Month Comparison



Members in deregulated energy markets—states where energy is available from suppliers other than utility companies—can choose their own electricity or natural gas provider. This allows them more options and better rates, Oberhousen explains. "We can help members lock in energy pricing for a pre-determined period of time," he adds.

HealthTrust currently assists 224 facilities in the U.S. with electricity procurement and 582 facilities with natural gas procurement (some facilities utilize both services). In 2018 alone, participating HealthTrust members—more than 40 healthcare systems—realized a combined savings of more than $21 million through the energy procurement program. ●

For more information on Capturis or inSight Advisory–Energy, contact Stephen Oberhousen at stephen.oberhousen@healthtrustpg.com.

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Donating beds. Impacting lives.™

Enhancing the lives of patients and their caregivers is what motivates us at Hill-Rom. In collaboration with HealthTrust and Project C.U.R.E., we proudly announce a bed donation program serving underprivileged communities. In connection with a new bed purchase, HealthTrust members can elect to donate their old hospital beds to Project C.U.R.E. through the bed donation program.

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HealthTrust & Hill-Rom Patient Bed Group Buy

May 1 – July 31, 2019 Contract #5332 *(beds)* & #5320 *(mattresses, pads, and covers)*

A bed donation is not required to participate in the group buy; participation in the bed donation program may vary by state. There is no additional cost to customers to donate beds. No additional discounts are associated with bed donation. Bed delivery required by September 15, 2019.

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Enhancing outcomes for patients and their caregivers.

Hill-Rom

Dennis Robb

Continued from page 4

frameworks, and flexible contracting solutions—such as information communication technology and staffing.

Working in partnership with the National Health Service (NHS), HCA Healthcare UK and private equity firms affiliated with our CoreTrust Europe GPO, **Dennis Robb** and the HealthTrust Europe (HTE) team increased its total spend under management to £1 billion in just 10 months.

The recent HealthTrust Europe and HCA Healthcare UK supply chain initiative achieved more than £5 million in savings and significant operational improvements. The work was a collaboration between HTE operations staff in Birmingham, our U.S. team and the London-based supply chain team. Together, they drove pharmacy automation and inventory control, enhanced clinical engagement, installed new IT platforms, improved data and financial analytics, and provided general data protection compliance and robust contracting.

These and many other areas of our business will continue to position HealthTrust for success over the next 20 years and beyond. Thank you for trusting us with your spend management, and clinical and operational performance improvement needs.

Ed Jones
President/CEO, HealthTrust

Share your success stories *throughout the year. Contact the executive editor of* The Source *(faye.porter@healthtrustpg.com) and let us know how HealthTrust is helping your organization meet its cost, quality and outcomes initiatives.*

AMPLIFY YOUR INFLUENCE

At HealthTrust, we use science supported by data. Others may claim big data. But they can't duplicate our experience and insight in guiding informed decision-making that supports improved care and lowered cost. Let us help you amplify your voice and turn data into action.

Empower your conversations
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HEALTHTRUST®

SHOWCASING INNOVATION AT 2020 SUMMIT

Suppliers with new technology invited to submit products

HealthTrust hosts fifth Innovation Summit, March 16–19, 2020, at the Fairmont Hotel in Dallas

The HealthTrust Innovation Summit is an avenue for suppliers with new technology to present their truly innovative products to service line clinical experts and Physician Advisors from within the HealthTrust membership. These members and advisors will help determine if the products are clinically acceptable and if the financial and operational impacts are of such value to add the products to the HealthTrust contract portfolio.

The Summit is open to both contracted and non-contracted suppliers with new technology directly related to patient care, information technology or supply chain management.

"New technology" for these purposes is classified as: A product that, as compared to existing products and as demonstrated in independent, peer-reviewed publication(s):

- Offers significant technological advancements
- Will significantly improve clinical outcomes or patient care (i.e., documented reduction in procedure time, outcomes, length of stay, readmissions, infection rates), or
- Will significantly streamline work processes and/or the economics of facility operations (i.e., increase or decrease expenses in supply chain or resource utilization)

Jan. 15, 2020 is the deadline for vendors to submit a product for consideration at: https://healthtrustpg.com/healthtrust-innovation-summit.

Products are reviewed by an internal team and those deemed to meet the new technology definition outlined above may be invited to participate in the 2020 event.

Following the Summit, the clinical advisory boards determine which product(s) should move forward into the HealthTrust contracting process.

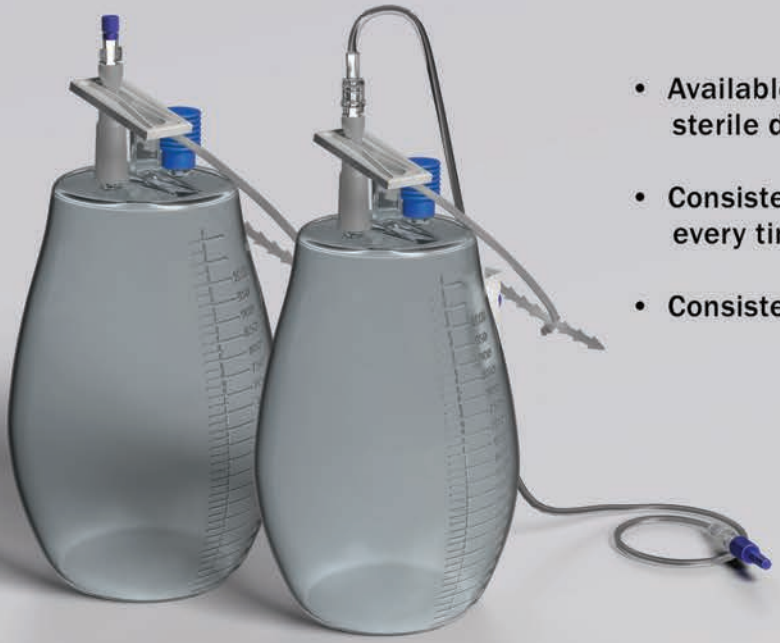
See related story on page 24. Accelerate Pheno System from Accelerate Diagnostics was part of the 2017 Innovation Summit.

Origin® Drainage Catheter

- The Origin® line of drainage catheters now features a clear hub for better visualization, an improved catheter material for insertion ease, an improved tip taper on larger sizes, large drain holes and depth marks that can confirm catheter position.
- Origin is available in General Purpose, Nephrostomy, Mini-Pigtail and Short Mini-Pigtail configurations.
- Currently available to all HealthTrust Members.

Evolution® Evacuated Suction Bottle

The Evolution line of evacuated suction bottles was born from necessity as an alternative to glass bottles and backorders. We've been there for you since the beginning.



- Available in 1,000 ml with or without sterile drain line.
- Consistently draws 1,000 ml or more every time.
- Consistent Quality. Consistent Availability.

Origin Drainage Catheters and Evolution Evacuated Suction Bottles are now available to all HealthTrust members. HealthTrust contract #6462

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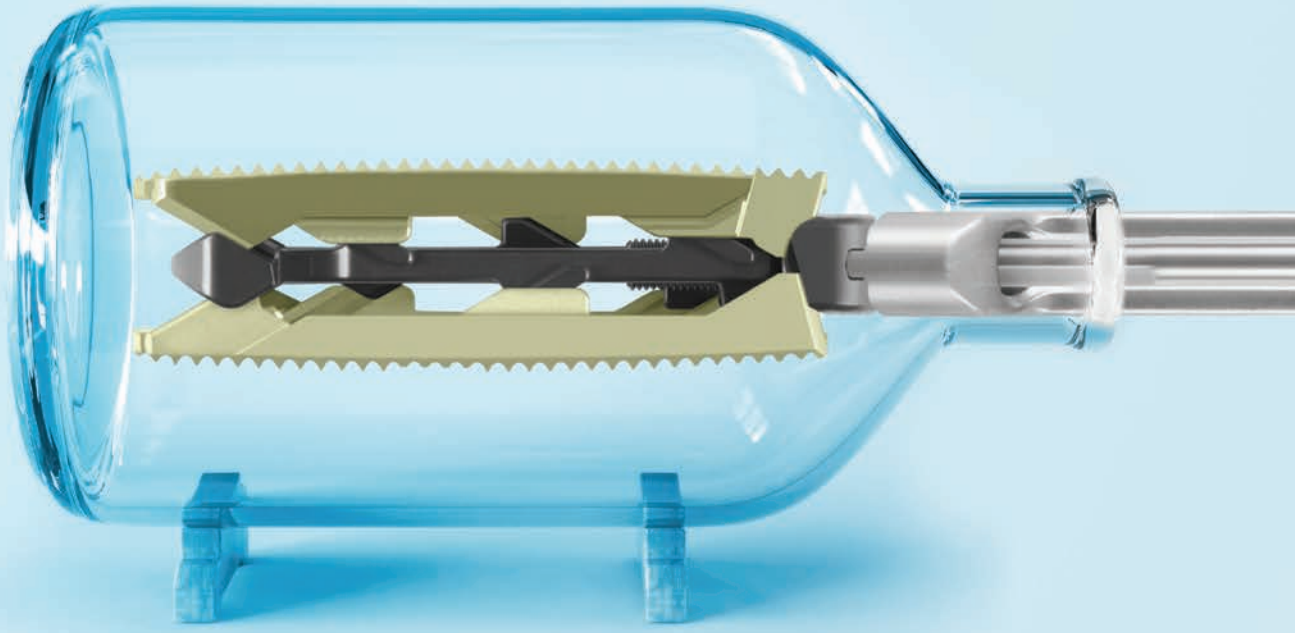

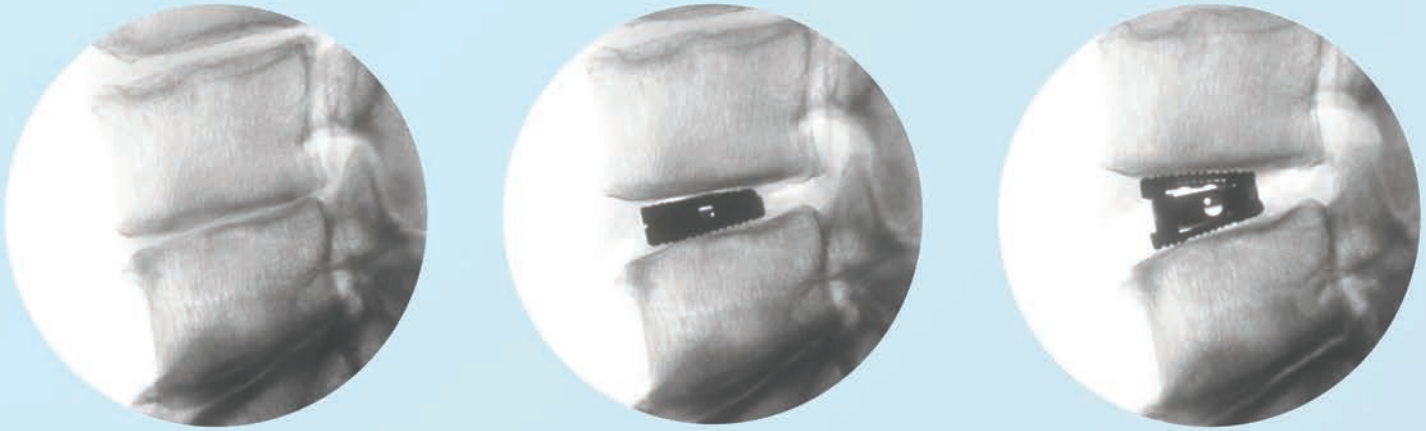

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Cadaveric images shown. Supplemental fixation required.

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