THE SOURCE®

ENHANCING PROVIDER PERFORMANCE & CLINICAL INTEGRATION

Q1 2022 | V 16 NO. 1 | HEALTHTRUST

IT'S ABOUT TIME

Prioritizing stroke outcomes & standardized care with a renewed emphasis on urgency

BRAINSTORMING SOLUTIONS

HealthTrust expands its stroke product portfolio

BACK TO BASICS

A resurgence of hospital-acquired infections sharpens the focus on prevention

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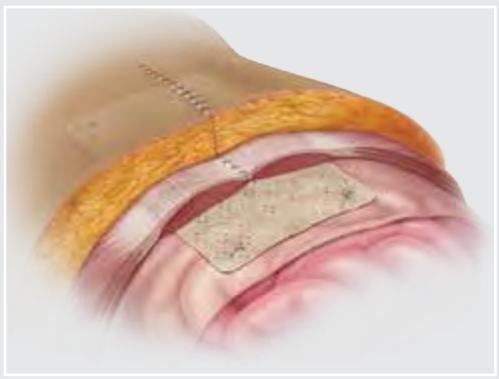
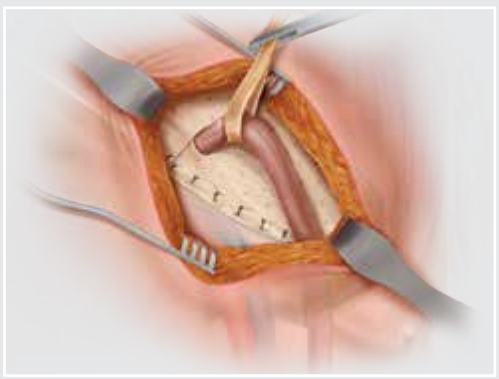
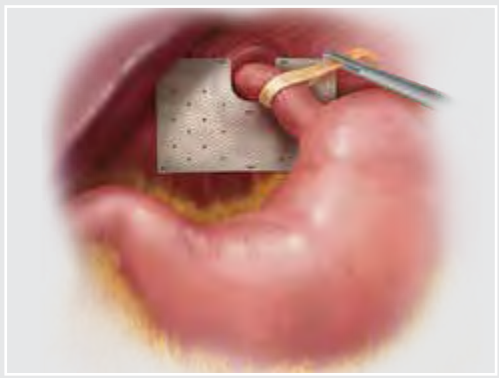
Solutions from simple to complex



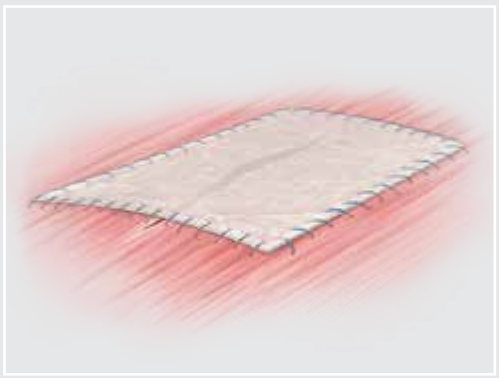
Biodesign Hernia Graft



Biodesign Inguinal Hernia Graft



Biodesign Hiatal Hernia Graft



Biodesign 4-Layer Tissue Graft

Illustrations by Lisa Clark

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FEATURES

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

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

Contact Faye Porter at **faye.porter@healthtrustpg.com** with suggestions. (Note: HealthTrust reserves the right to edit all articles and information accepted for publication.)

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HealthTrust (Healthtrust Purchasing Group, L.P.) is committed to strengthening provider performance and clinical excellence through an aligned membership model and total spend management advisory solutions that leverage operator experience, scale and innovation. Headquartered in Nashville, Tenn., HealthTrust (**healthtrustpg.com**) serves over 1,800 hospitals and health systems in the U.S. and the U.K. and more than 57,000 non-acute member locations, including ambulatory surgery centers, physician practices, long-term care and alternate care sites. On Twitter @**healthtrustpg**.

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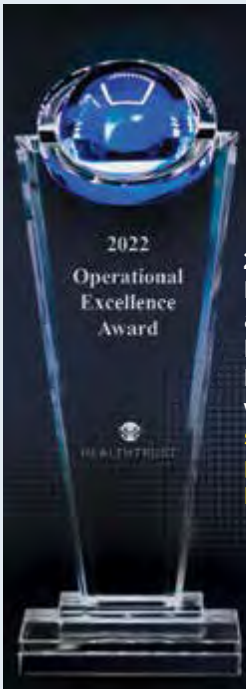
DEPARTMENTS



2022 Member Recognition Awards applications are being accepted! For more details, visit page 29 or survey.healthtrustpg.com/s3/2022-MemberAwards

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CEO perspective

Position for progress

More Americans are predicted to obtain elective surgeries and routine healthcare in 2022—potentially driving medical costs up 6.5% above 2021, according to a report from the Health Research Institute of PricewaterhouseCoopers. Now more than ever, it is critical to align healthcare leaders and physicians in optimizing spend on the high-value implants used in many of those surgeries.

To better understand your opportunities for lowering physician preference spend across service lines, I encourage you to partner with our Medical Device Management and/or Consulting teams for a complimentary analysis of your data and level of physician engagement. For providers in need of alignment, our consultants partner with your health system's leadership and physicians on shared goals and to execute custom agreements, avoid unnecessary costs and lower device spend. The team also enables a deeper understanding of procedure costs and offers advice on managing off-contract spend and the consideration of new technology.

We look forward to profiling the benefits a number of members have realized from our data-driven approach to managing medical devices in the Q2 edition. In the meantime, contact **solutions@healthtrustpg.com** or your account manager and let us know how we can assist.

2021 SURVEY RESULTS

Through the annual Member Survey, HealthTrust identifies opportunities for improvement and benchmarks the satisfaction of our membership across a number of key areas of the business.

The most recent survey was conducted in quarter three of 2021. We were pleased to see more than double the number of responses this year over 2020—so thank you to all who completed the survey. Of the members who participated, 85% believe that HealthTrust provides a superior value in the marketplace relative to other GPOs—up from 83% in 2020.

Members also expressed high levels of satisfaction with our pricing, account management support, leadership and culture, contract portfolio coverage and alignment in decision-making through our advisory boards.

Along with a competitive market assessment, industry research and feedback from member business reviews, survey results are utilized as part of our annual strategic and budget planning processes. All survey findings are reviewed in detail by each department, with action items developed to address opportunities for improvement.

I am also pleased to share that in response to member feedback from previous years, we made improvements to simplify the user experience and increase the quality of the data in our Member Analytics tool. This continuing effort has expanded to include pharmacy analytics, where new capabilities will be released in 2022. We are growing our technology investment, and in response to member feedback from 2021, we will be focused on helping members better identify and maximize savings opportunities, track progress on initiatives and locate alternative items to mitigate supply chain disruption.

The HealthTrust team is excited about the new year and the opportunity to increase the value we provide. Know that we never take for granted your trust in us. Here's to boldly moving forward in 2022—memorable for what we hope will be much more than managing the pandemic. **HT**

Ed Jones
President/CEO, HealthTrust
Publisher, *The Source* magazine

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*Calculations are derived based on relative patient group incidence rates reported in footnoted study.[1] Statistically significant ($p<0.05$). (n=146).

1. Higuera-Rueda C, Emara AK, Nieves-Malloure Y, et al. The Effectiveness of Closed Incision Negative Pressure Therapy versus Silver-Impregnated Dressings in Mitigating Surgical Site Complications in High-Risk Patients after Revision Knee Arthroplasty: The PROMISES Randomized Controlled Trial. *J Arthroplasty* (2021), doi: https://doi.org/10.1016/j.arth.2021.02.076

NOTE: Specific indications, limitations, contraindications, warnings, precautions and safety information exist for these products and therapies. Please consult a clinician and product instructions for use prior to application. Rx only.

PRA-PM-US-03119 (07/21)

CMO perspective

Mitigating disruptions

The end of a calendar year is filled with projections and forecasts across industries for the coming year. At the time of this writing, supply disruptions and cost pressures are predicted well into 2022. Just as the global pandemic disrupted the lives of people across the world, so too has a never-before-seen impact been levied on the supply chains that sustain so many economies.

Regardless of the industry, supply chains compete for many of the same natural and logistical resources. The disruption is widespread, the reasons are many, and the implications are so interconnected that it's difficult to find an area of the economy that has not been impacted by issues such as labor shortages, manufacturers challenged with access to adequate material resources to make products, and cargo ships waiting to offload for a variety of reasons, including the inability for trucking and rail to keep up.

In an effort to help mitigate potential risks to the healthcare supply chain that serves HealthTrust members, I've been asked to lead an internal supply disruption task force. You may recall the organization's efforts at the height of the COVID-19 pandemic to assist members in locating much-needed, quality personal protective equipment (PPE). During that time, our Alternative Approaches workgroup provided clinical support in evaluating the feasibility of innovative products, clinical resource documents and summaries of federal guidance on alternative practices such as PPE decontamination, then sharing that information via the HealthTrust public education site. We are taking a similar approach to supply chain disruption communications as well.

HealthTrust's committed membership, our member advisory boards and account management relationships continue to provide a critical channel of communication that enables us to act quickly and responsibly during early signs of supply disruption.

As we continue to labor over all aspects predicated by the new normal of "doing" both life and business, know that HealthTrust remains committed to providing members insight into:

- Category disruptions, including reasons for and potential timelines to recovery
- Alternative product options—both traditional alternatives and the feasibility of innovative products to solve a given challenge
- Clinical education and guidance, including conservation and alternative approaches

We look forward to continuing to serve you. In the meantime, be well. **HT**

John Young, M.D., MBA, CPE, FACHE
Chief Medical Officer, HealthTrust
Executive Publisher & Editor-at-large, *The Source* magazine

TO FIND OUT if HealthTrust has due diligence related to a new product or a non-contracted supplier, email HPG1.AdministrationCOVID19Triage@healthtrustpg.com. If your facility or health system has a need for COVID-related evidence or support, reach out to HealthTrust's Clinical Services team at clinical.research@healthtrustpg.com

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References: 1. On file WG Critical Care, LLC. To request data on file, please contact Customer Service at 1-888-493-0861 or CustomerService@wgccrx.com

WG CriticalCare

NDC #	Bar Code	Total Amount	Fill Volume	Container Type	Concentration	Pack Size	WHOLESALER ITEM NUMBERS			
							Amerisource Bergen	Cardinal	McKesson	Morris & Dickson
44567-610-10		50 mg	50 mL	100 mL Premix Bag	1 mg / mL	10	10260033	5738059	2347490	104992
44567 611-10		100 mg	100 mL	100 mL Premix Bag	1 mg / mL	10	10260032	5738067	2347508	105019

HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use MIDAZOLAM IN SODIUM CHLORIDE INJECTION safely and effectively. See full prescribing information for MIDAZOLAM IN SODIUM CHLORIDE INJECTION.

MIDAZOLAM IN SODIUM CHLORIDE injection, for intravenous use, CIV
Initial U.S. Approval: 1985

WARNING: PERSONNEL AND EQUIPMENT FOR MONITORING AND RESUSCITATION, AND RISKS FROM CONCOMITANT USE WITH OPIOID ANALGESICS AND OTHER SEDATIVE-HYPNOTICS

See full prescribing information for complete boxed warning

- **Only personnel trained in the administration of procedural sedation, and not involved in the conduct of the diagnostic or therapeutic procedure, should administer Midazolam Injection.**
- **Administering personnel must be trained in the detection and management of airway obstruction, hypoventilation, and apnea, including the maintenance of a patent airway, supportive ventilation, and cardiovascular resuscitation.**
- **Resuscitative drugs, and age- and size-appropriate equipment for bag/valve/mask assisted ventilation must be immediately available during administration of Midazolam Injection.**
- **Continuously monitor vital signs during sedation and through the recovery period.**
- **Concomitant use of benzodiazepines with opioid analgesics may result in profound sedation, respiratory depression, coma, and death. Continuously monitor patients for respiratory depression and depth of sedation.**

---------- INDICATIONS AND USAGE ----------

Midazolam in Sodium Chloride Injection is a benzodiazepine indicated for:

- continuous intravenous infusion for sedation of intubated and mechanically ventilated adult, pediatric, and neonatal patients as a component of anesthesia or during treatment in a critical care setting.

----------DOSAGE AND ADMINISTRATION --------

- For intravenous injection only. Avoid intra-arterial injection or extravasation.
- Individualize dosing and titrate to desired clinical response, taking into account patient age, clinical status, and concomitant use of other CNS depressants.
- See Full Prescribing Information for complete dosage and administration information.

--------- DOSAGE FORMS AND STRENGTHS ---------

Injection: 50 mg per 50 mL (1mg/mL) and 100 mg per 100 mL (1 mg/mL) in single-dose bags.

---------- CONTRAINDICATIONS ----------

Midazolam in Sodium Chloride Injection is contraindicated in patients with:

- known hypersensitivity to midazolam.
- acute narrow-angle glaucoma.

---------- WARNINGS AND PRECAUTIONS ---------

Cardiorespiratory Adverse Reactions: Serious cardiorespiratory adverse reactions have occurred, sometimes resulting in death or permanent neurologic injury.

Paradoxical Behavior: Agitation, involuntary movements (including tonic/clonic movements and muscle tremor), hyperactivity and combativeness have been reported in both adult and pediatric patients.

Dependence and Withdrawal with Long-Term Use: Use for several days to weeks may lead to physical dependance to midazolam. Do not abruptly discontinue midazolam. Gradually taper the dosage using a tapering schedule that is individualized to the patient.

Debilitation and Comorbid Considerations: Higher risk adult and pediatric surgical patients, elderly patients and debilitated adult and pediatric patients.

Risk of Intra-Arterial Injection: There have been limited reports of intra-arterial injection of midazolam. Adverse events have included local reactions, as well as isolated reports of seizure activity in which no clear causal relationship was established.

Impaired Cognitive Function: Because of partial or complete impairment of recall, patients should not operate hazardous machinery or a motor vehicle until drug effects have subsided.

Hypotension and Seizure in Preterm Infants and Neonates: Avoid rapid injection in the neonatal population.

Neonatal Sedation in Later Stages of Pregnancy: Benzodiazepine use during later stages of pregnancy can result in neonatal sedation. Observe newborns for signs of sedation and manage accordingly

Pediatric Neurotoxicity: In developing animals, exposures greater than 3 hours cause neurotoxicity. Weigh benefits against potential risks when considering elective procedures in children under 3 years old.

---------- ADVERSE REACTIONS ----------

The most common adverse reactions (≥15%) were decreased tidal volume, decreased respiratory rate, and apnea.

To report SUSPECTED ADVERSE REACTIONS, contact WG Critical Care, LLC at 1-866-562-4708 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

---------- DRUG INTERACTIONS ----------

Opioid Analgesics and Other Sedative Hypnotics: Risk of respiratory depression is increased

Cytochrome P450-3A4 Inhibitors: May result in prolonged sedation due to decreased plasma clearance of midazolam.

---------USE IN SPECIFIC POPULATIONS ---------

Lactation: A lactating woman may pump and discard breast milk for 4 to 8 hours after treatment with midazolam.

Lighting a fire under surgical smoke evacuation legislation

Establishing better rules & processes for the well-being of patients & healthcare workers

While it may seem counterintuitive, some of us can still remember when smoking cigarettes was permitted in hospitals. (The Joint Commission banned it from accredited hospitals in 1993.) But if you work in a hospital operating room today, you'll find that smoke is still a part of the daily work experience. Smoke is created from surgical procedures, and staff and patients subsequently breathe in harmful chemicals and particles that may have the equivalent impact of smoking an entire pack of cigarettes.

Fortunately, organizations are sparking change to protect patients and healthcare workers, and suppliers are improving products to make it a reality.

WHAT IS SURGICAL SMOKE?

Surgical smoke is produced when devices such as electrosurgical units, lasers and ultrasonic devices are used on body tissue to dissect or ablate tissue, or provide hemostasis. Surgical smoke occurs in hospitals, ambulatory care centers, clinics and doctors' offices.

"When a surgeon uses one of these devices to cut or dissect human tissue, it creates a plume of smoke," says **Marty Higgins**, MS, RN, CNOR, Service Line Director of Perioperative Services at CHRISTUS Health. "The issue is what's in that plume."

HOW SURGICAL SMOKE IS HARMFUL

Some particles in surgical smoke are proven to be carcinogenic.

According to a 2012 study published in the *Journal of Plastic, Reconstructive & Aesthetic Surgery*, spending one day working in an OR can have the same effect as smoking up to 27 cigarettes.

We don't yet know the impact of surgical smoke on healthcare workers, as more research is needed. In the last

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few years, though, institutions like the Association of periOperative Registered Nurses (AORN) and Stryker, a large medical device manufacturer, have been examining the harmful elements of surgical smoke. Take HPV virus, for example. As the virus is surgically lasered off a patient, the virus particles are released into the plume of smoke, which is then inhaled by the people in the OR. Staff members wear surgical masks, but those don't adequately filter out the smoke particles. "Any particle that is less than 10 microns can be considered irritating to the lungs," explains Higgins.

Research cited by AORN indicates that perioperative nurses report respiratory problems such as allergies, sinus infections, asthma and bronchitis at twice the rate as the general population.

A RESPONSIBILITY OF PROTECTION

One strategy that healthcare systems can take to promote a safer perioperative work environment is through widespread implementation of a surgical smoke evacuation system. "Healthcare organizations have a responsibility to protect patients and staff and should have a policy in place regarding the use of smoke evacuation systems," says **Jennifer Westendorf**, MSN, RN, CNOR, Director of Surgical Services for HealthTrust.

However, she explains, historically there may have been multiple barriers preventing a hospital's ability to transition to a smoke-free environment. Some of these barriers may have been related to the cost of smoke-free devices, the limited number of smoke evacuation systems on the market, the amount of noise they generate and that the devices themselves are somewhat bulky.

But the embers are burning for change. "The emergence of COVID-19 placed a national spotlight on surgical smoke like never before," says Westendorf. "It has generated a sense of urgency to protect patients and healthcare workers."

IMPROVING PRODUCTS

Some surgical smoke evacuation systems are designed to evacuate smoke from an open procedure, while others are designed for minimally invasive procedures. They work by sucking out the smoke like a vacuum cleaner, with filtration that removes odor, poisonous gases and smoke particles from the air during surgical procedures.

Some devices have smoke evacuation options where you only need to add filters, so you don't have to purchase a different piece of equipment. One example is Stryker Neptune, which has a fluid management system as well as smoke evacuation capabilities in one piece of equipment. At CHRISTUS Health, about 85% of ORs have the Neptune, so adding the filter and handpiece is the only additional expense.

"While these smoke evacuation systems improve the situation, the healthcare industry is still in the early stages of adoption," says Higgins.

HealthTrust has multiple suppliers on contract to ensure that hospitals can select the smoke evacuation system that best meets their clinical and operational needs.

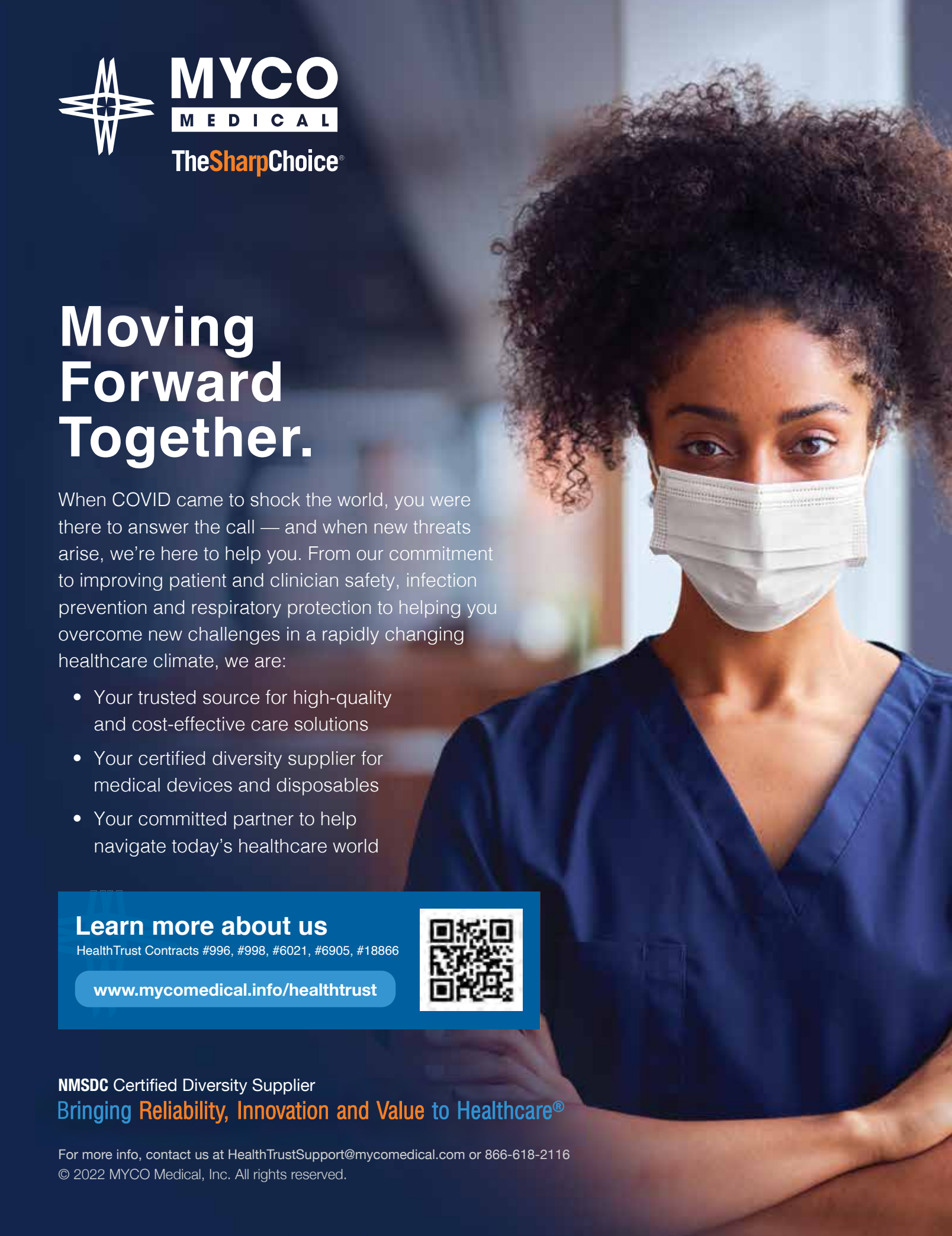
LEGISLATIVE & GRASSROOTS EFFORTS

AORN has been a longtime advocate for a smoke-free environment and is leading the charge to ensure that ORs across the country are smoke-free by law. While there is no federal mandate to reduce surgical smoke, 26 states have passed legislation since 2018. In August 2021, AORN launched a national petition to put pressure on the U.S. Occupational Safety and Health Administration (OSHA) to issue regulations requiring worker and patient protections from harmful surgical smoke. In October 2021, AORN released its latest guideline for surgical smoke safety, which provides recommendations to healthcare organizations on establishing a safe environment for both surgical patients and team members.

"AORN has a really robust guideline, and it also provides a variety of toolkits and resources to assist hospitals in developing policies and practices that will promote a safer working environment for their perioperative teams and patients," says Westendorf.

Higgins has been working with her health system leadership to increase awareness of the situation at hand. "Operating room staff may not yet be aware of this issue, but there will come a time when they are," she says. She believes this issue may look different in as soon as two years, as more states pass legislation and recommendations become more defined.

"I think what you will see in the coming months is increased awareness and increased action," says Higgins. "Hospitals don't need to have state legislation or an agency mandate to do the right thing, which is to take care of their patients and staff by providing appropriate smoke evacuation. The biggest movement will come from grassroots efforts of OR directors explaining to their C-suite executives that this is the right thing to do." **HT**



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Under pressure

The Joint Commission & healthcare systems nationwide heighten the importance of reducing pressure injuries

Once known as bedsores, skin ulcers acquired by hospital patients are now called pressure injuries. The renewed attention around these dangerous wounds is not in name only; The Joint Commission, along with hospitals across the United States, are working to better identify triggers and refine best practices to reduce pressure injuries.

AN AVOIDABLE ISSUE

According to The Joint Commission, an estimated 2.5 million acute care patients in the U.S. experience pressure injuries each year, leading to longer hospital stays, multiple readmissions and more than 60,000 deaths. Diagnosed by clinical exam, hospital-acquired pressure injuries (HAPIs) commonly occur from pressure on the tailbone or hips, heels, shoulder blades, the back of the head, the backs and sides of knees, and the sides of the ankles.

Renamed about five years ago to reflect the active role clinicians can take in preventing and treating these soft tissue ulcers, HAPIs are designated by the Centers for Medicare & Medicaid Services as "never events"—medical errors that should never occur.

According to **Jessica Corso**, BSN, RN, CWOCN, Category Program Director for Ambulatory and Acute Care, Supply Chain at Franciscan Alliance, in Lafayette, Indiana, both intrinsic and extrinsic factors play a role in the development and the worsening of pressure injuries. These include age, weight, incontinence, mobility, circulation, sensation and poor nutrition, as well as other comorbidities that might cause a patient to have a dulled sense of pain or pressure.

"Pressure injuries can happen within a couple of hours," Corso explains. "When a patient comes to one of our ERs, nursing staff complete an assessment and start offloading and turning regimens for patients with signs and symptoms of impaired skin integrity or existing wounds. Pain control may be necessary for the patient's tolerance of movement and position change. Then we worry about all the other

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parts of the body they're using to move, such as the tailbone, elbows, heels and scapula. It's beyond the area we know is compromised—it's all their skin surface areas that endure shearing and friction that require protection."

TACKLING THE PROBLEM

The Joint Commission's quality improvement arm, the Center for Transforming Healthcare, launched an ambitious project that led to a 62% drop in HAPIs between 2018 and 2020. These results—remarkable considering they occurred amid the COVID-19 pandemic—were tallied among three collaborating institutions: Johns Hopkins, Kaiser Permanente South Sacramento and Hermann Southeast hospitals.

All hospitals participating in The Joint Commission initiative identified their unique contributing factors to HAPIs, achieving an average 55% relative drop in intensive care pressure injuries in the project's first 18 months and building on that success despite the challenges of the COVID-19 pandemic.

This prominent effort reflects widespread, national interest in fighting pressure injuries by identifying their root causes, acquiring the latest clinical products and implementing standardized protocols, says Corso.

"HAPIs have always been a problem. The current state of healthcare, with a pandemic and a staffing shortage at so many hospitals, makes it that much more so," Corso explains. "Typically, the patient suffering from a pressure injury is one who can't turn themselves, so you really need all hands on deck," she adds, noting that only about 8,000 wound care-certified specialists work across the U.S., placing a bigger burden on staff members without this specialized training.

INNOVATIVE PRODUCTS

Indeed, frequently repositioning immobilized patients is the primary tactic clinicians have long used to prevent and reduce pressure injuries. These injuries can occur whether patients are lying in bed, sitting in a wheelchair or even wearing a cast for a lengthy period.

Continued on page 14

Continued from page 13

"If you're boosting people up in bed and do not achieve clearance of their body, and the surface friction and shearing occurs, this can cause a wound or worsening of an existing wound," Corso explains. "It's kind of like a carpet burn on the surface and intense tissue separation down at the bone level."

Fortunately, an increasing variety of products have been developed to boost these efforts by either removing pressure on affected areas, protecting wounds or averting infection. These products include low-air-loss mattresses—which contain air tubes that alternately inflate and deflate, simulating a patient being repositioned—as well as barrier films and moisture-wicking bandages. Corso says these specialized paddings and surfaces can prevent friction and keep skin cool and dry.

Using evidence-based research, Franciscan Alliance's "Pressure Injuries Playbook" adheres to an ambitious goal: Patients arriving at the hospital with no skin issues should not develop any during their stay, while those with existing pressure injuries should be maintained or treated to help resolve them.

In addition to using innovative products, taking common-sense measures such as changing patients' gowns, wiping down moist skin or providing moisture where needed can all help to ensure the integrity of the patient's skin. "It's a lot of responsibility to make sure your staff members are competent in using all those supplies," Corso adds. "As part of the specialty nurse's role, you are the eyes, ears and hands to teach staff and physicians how these products work and to intervene differently if they're not working as anticipated."

Understanding which products are offered is a key component to the overall success of a pressure injury reduction program.

Visit the Member Portal to find products associated with wound care under the Wound Care, Tissue category, and items to help with positioning under the Positioning Aids, Nursing category. **HT**

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

- Thrombosis may occur with immune globulin intravenous (IGIV) products, including Octagam® 10%. Risk factors may include: advanced age, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling vascular catheters, hyperviscosity, and cardiovascular risk factors.
- Renal dysfunction, acute renal failure, osmotic nephropathy, and death may occur with the administration of Immune Globulin Intravenous (Human) (IGIV) products in predisposed patients. Renal dysfunction and acute renal failure occur more commonly in patients receiving IGIV products containing sucrose. Octagam 10% does not contain sucrose.
- For patients at risk of thrombosis, renal dysfunction or renal failure, administer Octagam 10% at the minimum infusion rate practicable. Ensure adequate hydration in patients before administration. Monitor for signs and symptoms of thrombosis and assess blood viscosity in patients at risk for hyperviscosity.

Important Safety Information

Octagam® 10% is contraindicated in patients who have a history of severe systemic hypersensitivity reactions, such as anaphylaxis, to human immunoglobulin. Octagam 10% contains trace amounts of IgA (average 106 µg/mL in a 10% solution). It is contraindicated in IgA-deficient patients with antibodies against IgA and history of hypersensitivity. In patients with chronic ITP, the most serious drug-related adverse event reported with Octagam 10% treatment was a headache. The most common drug-related adverse reactions reported in >5% of the subjects during a clinical trial were headache, fever, and increased heart rate.

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

*At +2°C to +8°C (36°F to 46°F) from the date of manufacture.

HealthTrust Contract #4861

Date of preparation: 10/2021. GAM10-0292-PAD

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HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use Octagam 10% safely and effectively. See full prescribing information for Octagam 10%.

Octagam 10% [Immune Globulin Intravenous (Human)]
liquid solution for intravenous administration
Initial U.S. Approval: 2014

WARNING
THROMBOSIS, RENAL DYSFUNCTION AND ACUTE RENAL FAILURE
See full prescribing information for complete boxed warning

- Thrombosis may occur with immune globulin intravenous (IGIV) products, including Octagam 10%. Risk factors may include: advanced age, prolonged immobilization, hypercoagulable conditions, history of venous or arterial thrombosis, use of estrogens, indwelling vascular catheters, hyperviscosity, and cardiovascular risk factors.
- Renal dysfunction, acute renal failure, osmotic nephropathy, and death may occur with the administration of Immune Globulin Intravenous (Human) (IGIV) products in predisposed patients. Renal dysfunction and acute renal failure occur more commonly in patients receiving IGIV products containing sucrose. Octagam 10% does not contain sucrose.
- For patients at risk of thrombosis, renal dysfunction or renal failure, administer Octagam 10% at the minimum infusion rate practicable. Ensure adequate hydration in patients before administration. Monitor for signs and symptoms of thrombosis and assess blood viscosity in patients at risk for hyperviscosity.

----------INDICATIONS AND USAGE ----------

- Octagam 10% is an immune globulin intravenous (human) liquid preparation indicated for the treatment of chronic immune thrombocytopenic purpura (ITP) in adults; and for dermatomyositis (DM) in adults.

---------- DOSAGE AND ADMINISTRATION ----------

For intravenous use only.

Indication	Dose	Initial Infusion rate	Maintenance Infusion Rate (if tolerated)
Chronic ITP	1 g/kg daily for 2 consecutive days	1.0 mg/kg/min (0.01 mL/kg/min)	Up to 12.0 mg/kg/min (Up to 0.12 mL/kg/min)
Dermato-myositis	2 g/kg divided in equal doses given over 2-5 consecutive days every 4 weeks	1.0 mg/kg/min (0.01 mL/kg/min)	Up to 4.0 mg/kg/min (Up to 0.04 mL/kg/min)

- Patients with dermatomyositis are at increased risk for thromboembolic events; monitor carefully and do not exceed an infusion rate of 0.04 ml/kg/min.
- Ensure that patients with pre-existing renal insufficiency are not volume depleted; discontinue Octagam 10% if renal function deteriorates.
- For patients at risk of renal dysfunction or thrombotic events, administer Octagam 10% at the minimum infusion rate practicable.

----------DOSAGE FORMS AND STRENGTHS----------

Solution containing 10% IgG (100 mg/mL)

---------- CONTRAINDICATIONS----------

- History of anaphylactic or severe systemic reactions to human immunoglobulin
- IgA deficient patients with antibodies against IgA and a history of hypersensitivity

----------WARNINGS AND PRECAUTIONS ----------

- IgA-deficient patients with antibodies against IgA are at greater risk of developing severe hypersensitivity and anaphylactic reactions to Octagam 10%. Epinephrine should be available immediately to treat any severe acute hypersensitivity reactions.
- Monitor renal function, including blood urea nitrogen and serum creatinine, and urine output in patients at risk of developing acute renal failure.
- Falsely elevated blood glucose readings may occur during and after the infusion of Octagam 10% with testing by some glucometers and test strip systems.
- Hyperproteinemia, increased serum osmolarity and hyponatremia may occur in patients receiving Octagam 10%.
- Hemolysis that is either intravascular or due to enhanced red blood cell sequestration can develop subsequent to Octagam 10% treatments. Risk factors for hemolysis include high doses and non-O-blood group. Closely monitor patients for hemolysis and hemolytic anemia.
- Aseptic Meningitis Syndrome may occur in patients receiving Octagam 10%, especially with high doses or rapid infusion.
- Monitor patients for pulmonary adverse reactions (transfusion-related acute lung injury (TRALI)).
- Octagam 10% is made from human plasma and may contain infectious agents, e.g. viruses and, theoretically, the Creutzfeldt-Jakob disease agent.

---------- ADVERSE REACTIONS----------

Chronic ITP: The most common adverse reactions reported in greater than 5% of subjects during a clinical trial were headache, fever and increased heart rate.

Dermatomyositis: The most common adverse reactions reported in greater than 5% of subjects during a clinical trial were headache, fever, nausea, vomiting, increased blood pressure, chills, musculoskeletal pain, increased heart rate, dyspnea, and infusions site reactions.

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

----------DRUG INTERACTIONS----------

The passive transfer of antibodies may:
Confound the results of serological testing.
Interfere with the immune response to live viral vaccines, such as measles, mumps, and rubella.

---------- USE IN SPECIFIC POPULATIONS----------

- Pregnancy: no human or animal data. Use only if clearly needed.
- Geriatric Use: In patients over age 65 or in any person at risk of developing renal insufficiency, do not exceed the recommended dose, and infuse Octagam 10% at the minimum infusion rate practicable.

Revised: **July 2021–**

Medical Affairs:
usmedicalaffairs@octapharma.com
Tel: 888-429-4535

Reimbursement:
usreimbursement@octapharma.com
Tel: 800-554-4440 | Fax: 800-554-6744

Drug Safety:
For all inquiries relating to drug safety, or to report adverse events, please contact our local Drug Safety Officer:
Tel: 201-604-1137 | Cell: 201-772-4546 | Fax: 201-604-1141 or contact the FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

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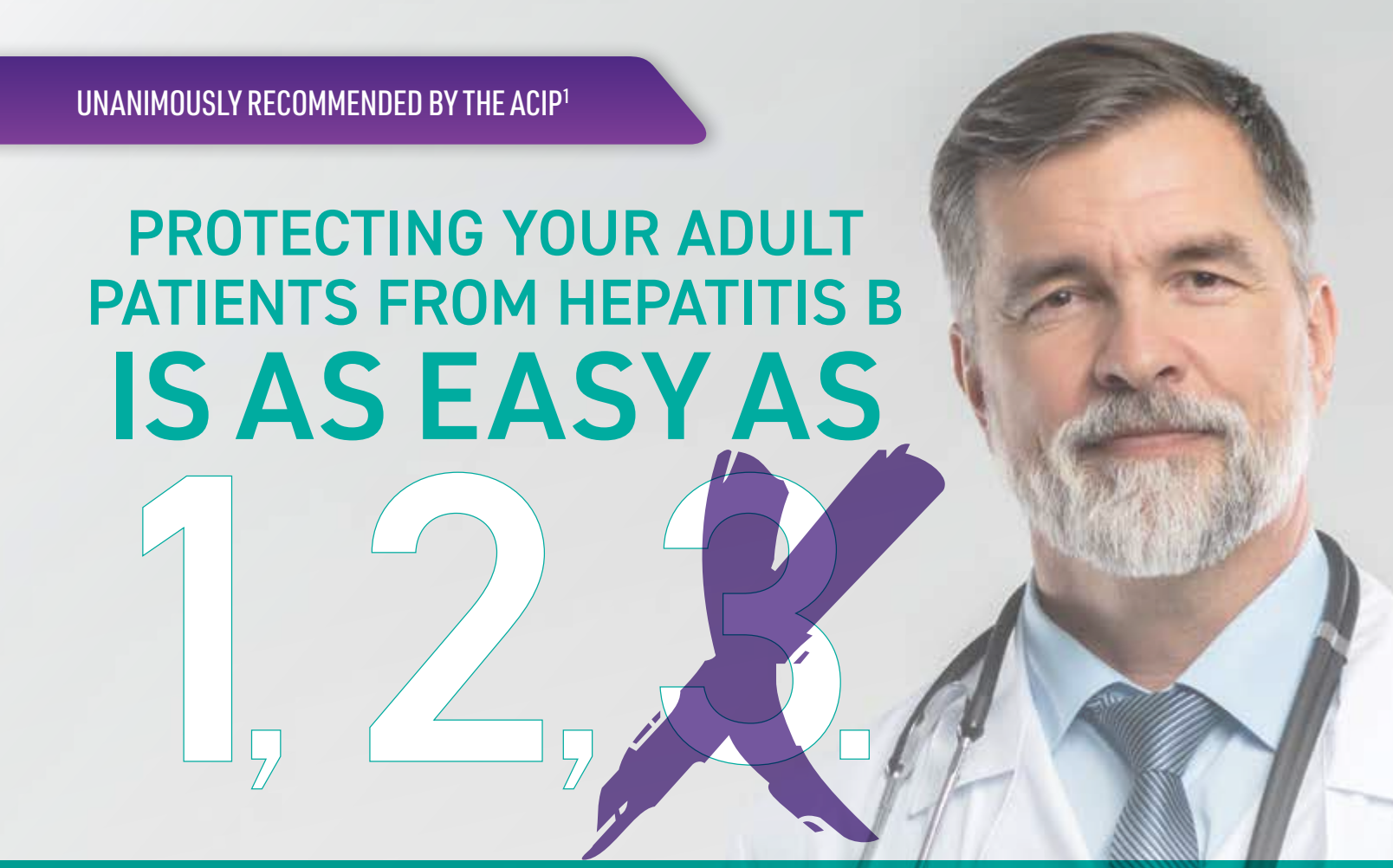
UNANIMOUSLY RECOMMENDED BY THE ACIP[1]

PROTECTING YOUR ADULT PATIENTS FROM HEPATITIS B IS AS EASY AS 1, 2, 3.



HEPLISAV-B IS THE ONLY 2-DOSE, 1-MONTH HEPATITIS B VACCINE FOR ADULTS[2,3]

INDICATION

HEPLISAV-B is indicated for prevention of infection caused by all known subtypes of hepatitis B virus in adults 18 years of age and older.

IMPORTANT SAFETY INFORMATION

Do not administer HEPLISAV-B to individuals with a history of severe allergic reaction (e.g., anaphylaxis) after a previous dose of any hepatitis B vaccine or to any component of HEPLISAV-B, including yeast.

Appropriate medical treatment and supervision must be available to manage possible anaphylactic reactions following administration of HEPLISAV-B.

Immunocompromised persons, including individuals receiving immunosuppressant therapy, may have a diminished immune response to HEPLISAV-B.

Hepatitis B has a long incubation period. HEPLISAV-B may not prevent hepatitis B infection in individuals who have an unrecognized hepatitis B infection at the time of vaccine administration.

The most common patient-reported adverse reactions reported within 7 days of vaccination were injection site pain (23%-39%), fatigue (11%-17%), and headache (8%-17%).

Please see Brief Summary of full Prescribing Information on the preceding pages.

heplisavb.com

HEPLISAV-B®
Hepatitis B Vaccine (Recombinant), Adjuvanted

2 DOSES. 1 MONTH. DONE.[2]

Abbreviation: ACIP, Advisory Committee on Immunization Practices.

REFERENCES: 1. Schillie S, Harris A, Link-Gelles R, Romero J, Ward J, Nelson N. Recommendations of the Advisory Committee on Immunization Practices for use of a hepatitis B vaccine with a novel adjuvant. *MMWR Morb Mortal Wkly Rep.* 2018;67(15):455-458. **2.** HEPLISAV-B [package insert]. Emeryville, CA: Dynavax Technologies Corporation; 2020. **3.** Freedman M, Kroger A, Hunter P, Ault KA. Recommended Adult Immunization Schedule, United States, 2020. *Ann Intern Med.* 2020;172(5):337-347.

BRIEF SUMMARY OF FULL PRESCRIBING INFORMATION

HEPLISAV-B [Hepatitis B Vaccine (Recombinant), Adjuvanted] Solution for Intramuscular Injection

1 INDICATIONS AND USAGE

HEPLISAV-B is indicated for prevention of infection caused by all known subtypes of hepatitis B virus. HEPLISAV-B is approved for use in adults 18 years of age and older.

2 DOSAGE AND ADMINISTRATION

For intramuscular administration.

2.1 Dose and Regimen

Administer two doses (0.5 mL each) of HEPLISAV-B one month apart.

2.2 Administration

HEPLISAV-B is a clear to slightly opalescent, colorless to slightly yellow solution.

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration, whenever solution and container permit. If either of these conditions exists, the vaccine should not be administered.

Administer HEPLISAV-B by intramuscular injection in the deltoid region using a sterile needle and syringe.

3 DOSAGE FORMS AND STRENGTHS

HEPLISAV-B is a sterile solution for injection available in 0.5 mL single-dose prefilled syringes. [see *How Supplied/Storage and Handling* (16.1)].

4 CONTRAINDICATIONS

Do not administer HEPLISAV-B to individuals with a history of severe allergic reaction (e.g. anaphylaxis) after a previous dose of any hepatitis B vaccine or to any component of HEPLISAV-B, including yeast [see *Description* (11)].

5 WARNINGS AND PRECAUTIONS

5.1 Managing Allergic Reactions

Appropriate medical treatment and supervision must be available to manage possible anaphylactic reactions following administration of HEPLISAV-B.

5.2 Immunocompromised Individuals

Immunocompromised persons, including individuals receiving immunosuppressant therapy, may have a diminished immune response to HEPLISAV-B.

5.3 Limitations of Vaccine Effectiveness

Hepatitis B has a long incubation period. HEPLISAV-B may not prevent hepatitis B infection in individuals who have an unrecognized hepatitis B infection at the time of vaccine administration.

6 ADVERSE REACTIONS

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a vaccine cannot be directly compared to rates in the clinical trials of another vaccine and may not reflect the rates observed in practice.

A total of 9597 individuals 18 through 70 years of age received at least 1 dose of HEPLISAV-B in 5 clinical trials conducted in the United States, Canada, and Germany. Data from 3 of these trials are provided below.

Study 1 in Subjects 18 through 55 Years of Age

Study 1 was a randomized, observer-blind, active-controlled, multicenter study in Canada and Germany in which 1810 subjects received at least 1 dose of HEPLISAV-B and 605 subjects received at least 1 dose of Engerix-B® [Hepatitis B Vaccine (Recombinant)]. Enrolled subjects had no history of hepatitis B vaccination or infection. HEPLISAV-B was given as a 2-dose regimen at 0 and 1 month followed by saline placebo at 6 months. Engerix-B was given at 0, 1, and 6 months. In the total study population, the mean age was 40 years; 46% of the subjects were men; 93% were white, 2% black, 3% Asian and 3% Hispanic; 26% were obese, 10% had hypertension, 8% had dyslipidemia, and 2% had diabetes mellitus. These demographic and baseline characteristics were similar in both vaccine groups.

Solicited Local and Systemic Adverse Reactions

Subjects were monitored for local and systemic adverse reactions using diary cards for a 7-day period starting on the day of vaccination. The percentages of subjects who reported local and systemic reactions are shown in Table 1.

Table 1
Study 1: Percent of Subjects Who Reported Local or Systemic Reactions Within 7 Days of Vaccination

	HEPLISAV-B %		Engerix-B %		
	Post-Dose*		Post-Dose*		
Reaction	**1**	**2**	**1**	**2**	**3**
Local	N=1810	N=1798	N=605	N=603	N=598
Injection Site Pain	38.5	34.8	33.6	24.7	20.2
Injection Site Redness†	4.1	2.9	0.5	1.0	0.7
Injection Site Swelling†	2.3	1.5	0.7	0.5	0.5
Systemic					
Fatigue	17.4	13.8	16.7	11.9	10.0
Headache	16.9	12.8	19.2	12.3	9.5
Malaise	9.2	7.6	8.9	6.5	6.4
	N=1784	N=1764	N=596	N=590	N=561
Fever‡	1.1	1.5	1.8	1.7	1.8

Note: only subjects having data are included. Clinical trial number: NCT00435812
*HEPLISAV-B was given as a 2-dose regimen at 0 and 1 month followed by saline placebo at 6 months. Engerix-B was given at 0, 1, and 6 months
† Redness and swelling ≥ 2.5 cm.
‡ Oral temperature ≥ 100.4°F (38.0°C).

Unsolicited Adverse Events:

Unsolicited adverse events within 28 days following any injection, including placebo, were reported by 42.0% of HEPLISAV-B recipients and 41.3% of Engerix-B recipients.

Serious Adverse Events (SAEs)

Subjects were monitored for serious adverse events for 7 months after the first dose of vaccine. The percentage of subjects reporting serious adverse events was 1.5% in the HEPLISAV-B group and 2.1% in the Engerix-B group. No acute myocardial infarctions were reported. No deaths were reported.

Potentially Immune-mediated Adverse Events

Potentially immune-mediated adverse events that occurred within 7 months of the first dose of vaccine were reported in 0.2% (n = 4) of HEPLISAV-B recipients and 0.7% (n = 4) of Engerix-B recipients. The following events were reported in the HEPLISAV-B group in one subject each: granulomatosis with polyangiitis, lichen planus, Guillain-Barré syndrome, and Grave's disease. The following events were reported in the Engerix-B group in one subject each: Bell's palsy, Raynaud's phenomenon, and Grave's disease. One additional Engerix-B recipient with a history of mixed connective tissue disease had p-ANCA-positive vasculitis.

Study 2 in Subjects 40 through 70 Years of Age

Study 2 was a randomized, observer-blind, active-controlled, multicenter study in Canada and the United States in which 1968 subjects received at least 1 dose of HEPLISAV-B and 481 subjects received at least 1 dose of Engerix-B. HEPLISAV-B was given as a 2-dose regimen at 0 and 1 month followed by saline placebo at 6 months. Enrolled subjects had no history of hepatitis B vaccination or infection. Engerix-B was given at 0, 1, and 6 months. In the total population, the mean age was 54 years; 48% of subjects were men; 82% were white, 15% black, 1% Asian and 6% Hispanic; 44% were obese, 30% had hypertension, 30% had dyslipidemia, and 8% had diabetes mellitus. These demographic and baseline characteristics were similar in both vaccine groups.

Solicited Local and Systemic Adverse Reactions

Subjects were monitored for local and systemic adverse reactions using diary cards for a 7-day period starting on the day of vaccination. The percentages of subjects who experienced local and systemic reactions are shown in Table 2.

Table 2
Study 2: Percent of Subjects Who Reported Local or Systemic Reactions Within 7 Days of Vaccination

	HEPLISAV-B %		Engerix-B %		
	Post-Dose*		Post-Dose*		
Reaction	**1**	**2**	**1**	**2**	**3**
Local	N=1952	N=1905	N=477	N=464	N=448
Injection Site Pain	23.7	22.8	18.4	15.9	13.8
Injection Site Redness†	0.9	0.7	0.6	0.2	0.2
Injection Site Swelling†	0.9	0.6	0.6	0.6	0.2
Systemic					
Fatigue	12.6	10.8	12.8	12.1	9.4
Headache	11.8	8.1	11.9	9.5	8.5
Malaise	7.7	7.0	8.6	7.1	5.1
Myalgia	8.5	6.4	9.6	8.0	4.5
	N=1923	N=1887	N=472	N=459	N=438
Fever‡	0.6	0.6	0.6	0.9	0.7

Note: only subjects having data are included. Clinical Trial Number: NCT01005407
*HEPLISAV-B was given as a 2-dose regimen at 0 and 1 month followed by saline placebo at 6 months. Engerix-B was given at 0, 1, and 6 months
† Redness and swelling ≥2.5 cm.
‡ Oral temperature ≥ 100.4°F (38.0°C).

Unsolicited Adverse Events
Unsolicited adverse events within 28 days following any injection, including placebo, were reported by 35.4% of HEPLISAV-B recipients and 36.2% of Engerix-B recipients.

Serious Adverse Events
Subjects were monitored for serious adverse events for 12 months after the first dose of vaccine. The percentage of subjects reporting serious adverse events was 3.9% in the HEPLISAV-B group and 4.8% in the Engerix-B group. Acute myocardial infarction occurred in 0.1% (n=2) of HEPLISAV-B recipients and 0.2% (n=1) of Engerix-B recipients.

Autoimmune Adverse Events
Subjects were monitored for the occurrence of new-onset potentially immune-mediated adverse events for 12 months after the first dose of vaccine. Events were adjudicated as to whether they were autoimmune by an external group of experts blinded to treatment assignment. As determined by the adjudicators, new-onset autoimmune adverse events were reported in 0.2% (n=3) of HEPLISAV-B recipients: two subjects with hypothyroidism and one subject with vitiligo. None of these events was considered related to vaccination by the expert group. No new-onset autoimmune adverse events were reported in the Engerix-B group. Although not referred to the external group of experts, one HEPLISAV-B recipient was determined to have Tolosa-Hunt syndrome which is presumed to have an immune-mediated etiology. This event was not considered related to vaccination.

Deaths
One subject (0.05%) died of a pulmonary embolism in the HEPLISAV-B group and 1 subject (0.2%) died of heart failure in the Engerix-B group. Neither death was considered related to vaccination.

Study 3 in Subjects 18 through 70 Years of Age

Study 3 was a randomized, observer-blind, active-controlled, multicenter study in the United States in which 5587 subjects received at least 1 dose of HEPLISAV-B and 2781 subjects received at least 1 dose of Engerix-B. Enrolled subjects had no history of hepatitis B vaccination or infection. HEPLISAV-B was given as a 2-dose regimen at 0 and 1 month followed by saline placebo at 6 months. Engerix-B was given at 0, 1, and 6 months. In the total study population, the mean age was 50 years; 51% were men; 71% were white, 26% black, 1% Asian, and 9% Hispanic; 48% were obese, 36% had hypertension, 32% had dyslipidemia, and 14% had type 2 diabetes mellitus. These demographic and baseline characteristics were similar in both vaccine groups.

Unsolicited Medically-Attended Adverse Events
Subjects were monitored for unsolicited medically-attended adverse events, those for which a subject sought medical care, for 13 months after the first dose of vaccine. Overall, medically-attended adverse events were reported in 46.0% of HEPLISAV-B recipients and 46.2% of Engerix-B recipients. Herpes zoster was reported in 0.7% of HEPLISAV-B recipients and 0.3% of Engerix-B recipients. Unsolicited medically-attended adverse events within 28 days following any injection, including placebo, were reported by 20.1% of both HEPLISAV-B and Engerix-B recipients.

Serious Adverse Events
Subjects were monitored for serious adverse events for 13 months after the first dose of vaccine. The percentage of subjects who reported serious adverse events was 6.2% in the HEPLISAV-B group and 5.3% in the Engerix-B group. Acute myocardial infarction (AMI) was reported in 0.25% (n=14) of HEPLISAV B recipients and 0.04% (n=1) of Engerix-B recipients. An analysis of serious adverse events likely representing myocardial infarction (MI) was conducted using the standard Medical Dictionary for Regulatory Activities (MedDRA) query (SMQ) for MI. This analysis identified a total of 19 HEPLISAV-B subjects (0.3%) and 3 Engerix-B subjects (0.1%) with events included in the SMQ for MI (these events include the 15 reports of AMI). Additional evidence, including information on temporal relationship and baseline risk factors, does not support a causal relationship between HEPLISAV-B administration and AMI. Among the 19 events identified as MI in HEPLISAV-B recipients, three occurred within 14 days, nine occurred within 53-180 days, and seven occurred more than 180 days following any dose of HEPLISAV-B. Among the three events identified as MI in Engerix-B recipients, one each occurred 13, 115, and 203 days following any dose. All 19 HEPLISAV-B recipients and 3 Engerix-B recipients reported one or more baseline risk factors for cardiovascular disease.

Autoimmune Adverse Events
Subjects were monitored for the occurrence of new-onset potentially immune-mediated adverse events for 13 months after the first dose of vaccine. Events were adjudicated as to whether they were autoimmune by an external group of experts who were blinded to treatment assignment. As determined by the adjudicators, new-onset autoimmune adverse events were reported in 0.1% (n=4) of HEPLISAV-B recipients [one each of: alopecia areata, polymyalgia rheumatica, ulcerative colitis, and autoimmune thyroiditis (with concurrent diagnosis of papillary thyroid carcinoma)]. None of these events was considered to be related to vaccination by the external experts. No new-onset autoimmune adverse events were reported in the Engerix-B group.

Deaths
During the study death was reported in 25 subjects (0.4%) in the HEPLISAV-B group and 7 subjects (0.3%) in the Engerix-B group. No death was considered related to vaccination.

7 DRUG INTERACTIONS

7.1 Use with Immune Globulin
There are no data to assess the concomitant use of HEPLISAV-B with immune globulin. When concomitant administration of HEPLISAV-B and immune globulin is required, they should be given with different syringes at different injection sites.

7.2 Interference with Laboratory Tests
Hepatitis B surface antigen (HBsAg) derived from hepatitis B vaccines has been transiently detected in blood samples following vaccination. Serum HBsAg detection may not have diagnostic value within 28 days after receipt of HEPLISAV-B.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy
Pregnancy Exposure Registry
There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to HEPLISAV-B during pregnancy. Women who receive HEPLISAV-B during pregnancy are encouraged to contact 1-844-443-7734.

Risk Summary
All pregnancies have a risk of birth defect, loss, or other adverse outcomes. In clinically recognized pregnancies in the US general population, the estimated background risk of major birth defects is 2% to 4% and of miscarriage is 15% to 20%.

There are no clinical studies of HEPLISAV-B in pregnant women. Available human data on HEPLISAV-B administered to pregnant women are insufficient to inform vaccine-associated risks in pregnancy.

In a developmental toxicity study, 0.3 mL of a vaccine formulation containing 2.5 mcg HBsAg and 3000 mcg cytosine phosphoguanine (CpG) 1018 adjuvant was administered to female rats prior to mating and during gestation. These animal studies revealed no evidence of harm to the fetus due to this vaccine formulation *[see Data]*.

Data
Animal data
Developmental toxicity studies were conducted in female rats. Animals were administered 0.3 mL of a vaccine formulation containing 2.5 mcg HBsAg and 3000 mcg CpG 1018 adjuvant twice prior to mating, and on gestation days 6 and 18 (a single human dose of HEPLISAV-B contains 20 mcg HBsAg and 3000 mcg CpG 1018 adjuvant). No adverse effects on pre-natal and post-natal development up to the time of weaning were observed. There were no vaccine-related fetal malformations or variations observed.

8.2 Lactation
Risk Summary
It is not known whether HEPLISAV-B is excreted in human milk. Data are not available to assess the effects of HEPLISAV-B on the breastfed infant or on milk production/excretion.

The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for HEPLISAV-B and any potential adverse effects on the breastfed child from HEPLISAV-B or from the underlying maternal condition. For preventive vaccines, the underlying condition is susceptibility to disease prevented by the vaccine.

8.4 Pediatric Use
Safety and effectiveness of HEPLISAV-B have not been established in individuals less than 18 years of age.

8.5 Geriatric Use
Clinical trials included 909 adults 65 through 70 years of age who received HEPLISAV-B.

Among subjects who received HEPLISAV-B, a seroprotective level of antibody to HBsAg was achieved in 90% of those 65 through 70 years of age compared to 96% of those aged 18 through 64 years of age.

Safety and effectiveness of HEPLISAV-B in adults older than 70 years of age were extrapolated from findings in subjects younger than 70 years of age.

8.6 Adults on Hemodialysis
Safety and effectiveness of HEPLISAV-B have not been established in adults on hemodialysis.

17. PATIENT COUNSELING INFORMATION

- Inform vaccine recipient of the potential benefits and risks associated with vaccination, as well as the importance of completing the immunization series.
- Emphasize that HEPLISAV-B contains non-infectious purified HBsAg and cannot cause hepatitis B infection.
- Advise vaccine recipient to report any adverse events to their healthcare provider or to the Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967 and www.vaers.hhs.gov.
- Provide the Vaccine Information Statements, which are available free of charge at the Centers for Disease Control and Prevention (CDC) website (www.cdc.gov/vaccines).

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THE PERFECT STORM

COVID-19 spurred a spike in hospital-acquired infections, so hospitals return to infection-prevention basics

THE ABRUPT START OF THE PANDEMIC IN EARLY 2020 produced ripple effects throughout healthcare, including a lockstep increase nationwide in hospital-acquired infections (HAIs) related to factors surrounding COVID-19 treatment. Nearly two years later, healthcare experts are diligently working to restore lower HAI rates, analyzing lessons learned, and—with eyes wide open—preparing for future pandemics.

A study published in September 2021 by the U.S. Centers for Disease Control and Prevention (CDC) found the pandemic triggered a significant resurgence of several types of HAIs, including central-line associated bloodstream infections (CLABSIs), catheter-associated urinary tract infections (CAUTIs), ventilator-associated events (VAEs) and methicillin-resistant Staphylococcus aureus (MRSA) bacteremia.

While stunning to witness, such HAI increases were frustratingly predictable due to COVID treatments relying on medical devices such as ventilators and catheters, experts say. Still, additional insights will continue to materialize over the coming months and years, says **Stephanie Thompson**, PharmD, MBA, AVP, Clinical Services at HealthTrust.

"There were so many variables. It will be fascinating to watch the research as they unpack why," Thompson says. "This pandemic has created a new way of viewing things because it impacted everything from the hospital front door to the most critical of patients. The interdependence amongst one another, that need for collaboration, has really been called out."

A FRUSTRATING RESURGENCE

The CDC findings were based on national and state-level hospital infection ratios calculated for each quarter of 2020

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and compared to those from 2019. In the first quarter of 2020, HAI incidence was generally dropping compared to the same period a year earlier, but this trend shifted with the start of the pandemic.

The most significant year-over-year increase—of 47%—was seen in CLABSIs in late 2020. VAEs climbed by nearly 45% in the same period, likely reflecting increased ventilator usage, while MRSA bacteremia rose by nearly 34% and CAUTIs by almost 19%.

The resurgence proved especially maddening because U.S. hospitals had achieved consistent declines since 2015 through rigorous infection prevention and control efforts.

"It just tells me that what we were doing previously was really important," says HealthTrust Physician Advisor **William Sistrunk**, M.D., an infectious disease specialist at Mercy Health in Springfield, Missouri. "When you're distracted from your routine, you can backslide."

Charles Monney, MS, CIC, System Director, Infection Control and Prevention at CHRISTUS Health in Irving, Texas, agrees. "We had come so far. It's hard to see all of that great work essentially go backward," he says. "But what makes it less disheartening is that we can pinpoint the reasons and put strategies in place to get back to where we know we need to be."

COVID-SPECIFIC RISK FACTORS

What led to the pandemic-related rise in HAIs? Experts contend both hospital and patient factors likely contributed. Topping the list of hospital resource challenges were overwhelmed and exhausted providers and understaffed

Part of the back-to-basics approach includes ensuring health systems aren't caught off-guard without enough PPE.

facilities, says **Jackie Blanchard**, RN, MSN, Vice President, Infection Prevention at HCA Healthcare in Nashville. "If you think about it, many factors that impact HAIs largely fall on nursing process and workflows," she explains, calling COVID's burden on nursing the most obvious influence.

Another major contributor was strict time limits around COVID patients' bedsides to protect clinicians from infection. The measure created fewer, shorter opportunities to assess what might be going wrong with catheters or devices that could contribute to patient infection risk, Monney adds.

Additionally, devices were hooked to very ill patients longer, while relatives—who often spot problems in a loved one before they amplify—were typically barred from hospitals. "This continued during the pandemic's second and third waves, too," Monney says. "In my opinion, that really contributed to most of the increases in HAIs."

Adding COVID care to routine infection-prevention protocols posed unique challenges, Dr. Sistrunk says. "The distraction of COVID, along with teaching new protocols to handle the pandemic, became the organizations' priority," he explains. "That's another factor that led to the increase in HAIs."

Patients hospitalized with COVID constitute the most serious cases. They not only require extreme interventions for long periods, but they often have pre-existing medical conditions—which all raise the risk of HAIs, experts note.

Since HAIs can be attributed to many causes, the increase in rates raises puzzling questions. "There's a lot of speculation," Thompson points out. "Because COVID patients were so sick, were they given antibiotics that wiped out their natural flora? Some factors were not only particular to patients, but the disease itself, which required more time on ventilator support, whether invasive or not."

Dr. Sistrunk explains that critically ill COVID patients often are administered immune-modulating drugs to suppress the life-threatening inflammatory cascade known as a cytokine storm. Treating this phenomenon, which has since been understood to be viral sepsis, logically "lowers the immune system's ability to fight infection, too," he explains.

Even small tweaks in treating hospitalized COVID patients, such as "proning" or positioning them on their stomachs to maximize lung expansion, introduce specific HAI risks,

Continued on page 26

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CONFRONTING SEPSIS

Sepsis is the most costly life-threatening condition facing healthcare providers today. So who better to brainstorm solutions and share best practices than front-line clinicians?

Over a portion of two days in October, HealthTrust hosted "Sepsis Care Across the Continuum," its first virtual Collaborative Summit. Pre-event, member attendees were linked to background data on sepsis and some initial video insights from related subject matter experts (SMEs) through an online learning module.

Members participated in group sessions and virtual breakouts where they interacted with peers and SMEs, discussing the latest evidence and their health systems' current approaches to sepsis recognition, standardization and transition of care, and quality and data analytics.

Day two breakouts were designed to assist members in learning additional best practices and transferring that knowledge to developing next steps toward action plans for their health systems to address early recognition and treatment of sepsis, not just upon admission or in the emergency department, but also throughout the continuum of care.

"This type of learning through collaboration is a value-added benefit we are fortunate to host for colleagues within HealthTrust member hospitals," shares **John Young**, M.D., MBA, Chief Medical Officer for HealthTrust.

Participants came from HealthTrust member organizations that included Allspire-Atlantic & Indiana Regional Medical Center, Ardent Health Services, Beth Israel Lahey Health, CaroMont Health, Community Health System, Franciscan Alliance, HCA Healthcare, Kindred Healthcare, Steward Health Care and Tenet Healthcare.

Post-event collaboration is being encouraged through an online community created specific to this group of attendees and SMEs. As appropriate, key learnings will be shared across the HealthTrust membership.

> "The HealthTrust Sepsis Summit provided a platform to engage with other health systems to learn and share. The Summit set the stage to reinvigorate our team's focus on our sepsis care plans, with an emphasis on current clinical practice guidelines, interdisciplinary collaboration and future state optimization."
>
> – Tyler P. Stewart, PharmD, MPA, BCPS, Director, Clinical Pharmacy Programs, Kindred Healthcare

Summit subject matter experts

- **S. Shaefer Spires**, M.D. – HealthTrust Physician Advisor & Infectious Disease Specialist (Duke University Hospital)
- **Becky Oneal**, MBA, MLS (ASCP) – Director, Lab Solutions (HealthTrust)
- **Nickie Greer**, PharmD, BCPS, BCIDP – Division Infectious Diseases Pharmacist (HCA Healthcare's TriStar Division)
- **Adam Mindick**, MBA, CNMT – Director, Service Alignment & Strategy (HCA Healthcare's Clinical Operations Group)
- **Callyn Wren**, PharmD – PGY-2 Infectious Diseases Pharmacy Resident (HCA Healthcare)
- HealthTrust Clinical Services Team Members: **Karen Bush**, MSN, FNP, BC NCRP – Director, Clinical Research & Education; **Holly Moore**, RN, MSN, CCRN-K – Clinical Director; **Kimberly Wright**, RN – AVP Clinical Services

Monney says. "Prone positioning makes it harder to maintain a device," he adds. "A lot of these patients are so unstable that it also becomes very difficult to perform proper bathing. Or, they're being moved around a lot, with the opportunity for agitating a central line or Foley catheter."

BACK TO BASICS

The rise in HAIs has spurred numerous initiatives to minimize them, and some are simply common sense. Dr. Sistrunk and Blanchard agree on the need to revisit infection-prevention basics such as rigorous hand hygiene, surface disinfection and wearing face masks.

Standardized, consistent staff training is also crucial, Dr. Sistrunk says, especially as turnover rates increase. "A lot of what we do may seem monotonous, but it still needs to be done because we have new coworkers coming in all the time," he adds. "Any of the staff who touch our patients clinically need to be trained on HAI prevention. This pandemic has clearly told us that these efforts do make a difference."

CHRISTUS Health reinstated family visiting perhaps more quickly than some other systems as the pandemic continued, Monney says. "We understand how important it is to have another set of eyes—as in someone who loves that patient—so if something is amiss, they can report it," he explains.

Part of the back-to-basics approach also includes ensuring that a future pandemic doesn't catch health systems off-guard without enough personal protective equipment, other supplies or personnel. In this regard, HealthTrust reinforced its role as a trusted partner during COVID, according to members.

"When we were looking for gowns and gloves and supplies in the beginning of the pandemic, HealthTrust was great at assisting us to help our healthcare providers remain covered," Monney says.

"It's easy to say we should be prepared, but it's expensive to do," Dr. Sistrunk adds. "We need to work as a team, with HealthTrust as a partner, on how to best maintain pandemic readiness with supplies and staffing," he says.

Blanchard views HealthTrust in an "eye-opening" new light. "There's no way we would have been able to survive without the solid relationships with our HealthTrust partners," she adds. "The plethora of knowledge in sourcing skills, the way they were able to connect so many pieces and come up with solutions, was wonderful to discover and appreciate." **HT**

Trends in PATIENT EXPERIENCE

Identifying the driving forces in patient care to improve satisfaction & outcomes

HEALTHCARE, ESPECIALLY SINCE THE BEGINNING OF THE COVID-19 PANDEMIC, has been changing rapidly. Forward-looking healthcare providers must innovate in the areas of patient satisfaction, safer care and better outcomes. Understanding the latest trends in patient experience is a great place to start.

TELEMEDICINE WITH A HUMAN TOUCH

According to a recent McKinsey & Company report, the use of telehealth has increased 38 times from the pre-pandemic baseline. COVID-19 has normalized telehealth and telemedicine as part of the patient experience, with people expecting easy access to healthcare on their own terms.

"Patients today want quick access to the best healthcare they can receive and really appreciate the ability to get in touch with a provider pretty much from anywhere, anytime," says **Mike Greiwe**, M.D., CEO of OrthoLive, a telemedicine platform for orthopedic surgeons that provides orthopedic care both virtually and through its hybrid service model. "It's incumbent upon healthcare providers to offer that type of care. It's what patients want, and it's something telemedicine can deliver."

But patients still appreciate and look for a personal connection to their healthcare providers, adds **Monte J. Goldstein**, M.D., Chief Medical Officer at Virtua ASC Joint Ventures. "When the pandemic started, I think the general feeling was

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that telemedicine would really be the new norm, and that patients would be accepting of electronic contact. But what we're seeing is that patients are coming back to the personal experience to the point where medical providers can't keep up, even though telemedicine is an option," he says.

OrthoLive's hybrid virtual/in-person care model is an interesting example of how providers can scale the services they offer while still providing a human touch.

Though it currently offers predominately virtual care, the company is growing its hybrid model by working inside other providers' facilities and has plans to open up its own offices as well. This means, for example, that a rural hospital system can create an orthopedic service line and have access to experts using OrthoLive while keeping their patients inside the local health system.

"We are going more and more toward this hybrid model, where we have in-person and virtual clinics set up so patients can see trusted providers in their local communities, 24/7/365. We think that's going to be the future," says Dr. Greiwe.

CONNECTING DATA FOR DEEPER INSIGHTS

Health systems are required to measure patient experience in order to receive full reimbursement from Medicare. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a national standardized survey of patients' perspectives of hospital care. This data is useful but limited, says **Karla Miller**, PharmD, BCPP, Chief Patient Safety Officer at HCA Healthcare. That's why many health systems, such as HCA Healthcare, are moving beyond the HCAHPS survey, gathering real-time feedback from patients, and utilizing data and findings to inform quality care.

"When you look at just the HCAHPS measurement, it's hard to get an understanding of what areas you really need to drill down into. But when you combine that with real-time feedback through your rounding process, social media or grievance process, then you can get a better understanding of what's driving the patient's experience and help ensure teams

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are empowered to provide superior, patient-centered care," says Miller.

Demographic, operational and clinical data from electronic health records are also being used to better understand patient populations and their needs. "We work very hard to pull in all these data elements and use them to develop targeted initiatives, drive action plans and create tools to improve the care experience," says Miller.

Data teams learned that when patients are in the emergency department for more than a certain amount of time, they are far less likely to give positive feedback. "That makes sense, but we need to really understand why," says Miller. "Is it because they don't understand why they're there or what's taking so long? That's where you have to do a deep dive to understand how the patient survey data matches with their overall healthcare experience."

BUILDING ON COVID-19 INNOVATION

Like many hospital leaders across the country, those at Franciscan Health Crown Point, a community hospital in northwest Indiana, had to find creative solutions to the challenges of the pandemic. By leveraging technology to deliver COVID-19 care more efficiently and safely, they've been able to innovate in ways that improve patient care and experience beyond the pandemic.

One of their first concerns at the beginning of the pandemic was the availability of personal protective equipment (PPE), explains **Erik P. Mikaitis**, M.D., MBA, FACP, CPE, Vice President of Medical Affairs and a HealthTrust Physician Advisor. The team at Franciscan Health Crown Point developed a consultation process using an iPad on an IV pole where only the hospitalist, nurse and respiratory therapist would meet with a COVID-19 patient in person, and the rest of the medical team would join virtually.

"The three of them would go into the room to see the patient, and the tablet connected them to a conference room where four subspecialists and support team members could join in remotely," says Dr. Mikaitis. This reduced the amount of PPE used and also limited the number of people exposed to the virus.

From this experience, they developed a virtual "telesitter" solution for a subset of patients who required supervision but weren't on suicide precautions. "We decided to see if we could tweak the tablet process to use in that capacity," he says. They started with one certified nursing assistant (CNA) sitting with six tablets monitoring six separate rooms. "So instead of six people sitting in rooms, we had one person watching six at once. They would provide redirection through the tablet or call a nurse if required."

Franciscan Health Crown Point saw about a 45% reduction in falls during that pilot group in the first three months and reduced the staffing requirement by about 26%.

RETAIL CONVENIENCE

Retailers such as Walgreens and CVS are accelerating their expansion into healthcare. For example, Walgreens plans to open 500 to 700 primary care offices in their stores over the next five years.

The popularity of retail healthcare can't be ignored by health systems. Patients are attracted to the easy access, sometimes delivered at a lower cost than traditional providers. "It's got health systems talking about retail strategies. How do we match retail pricing? How do we engage on that level to offer that availability and access?" says Dr. Mikaitis.

Despite the increasing popularity of retail healthcare, Dr. Mikaitis thinks health systems still have the advantage—as long as they find a way to match the convenience that retailers offer. "The ball is in the healthcare system's court right now, and it's going to depend on how they react in terms of what happens in the long run," he says. "People have relationships with healthcare systems. If your primary care provider is affiliated with a health system, and that's where you have your elective surgeries or you've delivered your kids, you start building a relationship with the system."

THE WHOLE PATIENT EXPERIENCE

To truly understand and improve the patient experience, providers need to look at the whole spectrum of experiences—the complete journey a patient takes from their first interaction with the healthcare system to their last. Though historically patient experience has been seen as a care provider task, we're understanding now that its scope is much wider, explains Miller.

"It's a collaboration between the care team and everyone surrounding the patient—from the person cleaning the room to the person bringing in their meal tray. But it's also more than that," Miller says. "It's the overall experience from the time a patient starts interacting with the healthcare system all the way until they've been discharged and someone has followed up with them." **HT**

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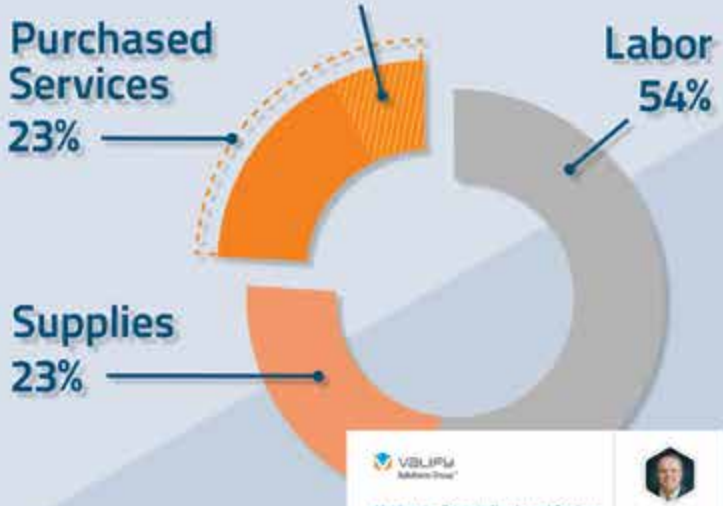

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BALANCING HUMANITY & TECHNOLOGY

In an increasingly digital world, the patient journey is becoming more convenient and efficient. But medicine will always need the human touch.

"The fundamental thing that we all need to hold onto, as physicians and as clinicians, is that very esteemed, very cherished doctor-patient relationship," says HealthTrust Physician Advisor **Jason Mouzakes**, M.D., FAAP, Professor of Otolaryngology and Pediatrics at Albany Medical Center Hospital.

Here's what healthcare providers should keep in mind about balancing humanity and technology:

1. Prioritize the patient over the technology

"How important is it to sit at the computer, elicit a history and type things in, versus the humanity of sitting across from somebody on a stool and really listening carefully to what they have to share?" asks Dr. Mouzakes.

The drive for efficiency with digital tools mustn't take away from making a personal connection with your patient. "The priority is being present and being focused, and making that person understand that their complaint or their health concern is the number one concern for you at that moment," says Dr. Mouzakes. Consider the impact of your body language, sit face-to-face with patients and put away any unnecessary digital devices during your conversation.

2. Overcome digital distance

Telemedicine comes with extra challenges when it comes to creating personal connections. "One thing that gets lost in telemedicine is the ability to look into a patient's eyes and at their facial expressions, and see how impacted they are by the story they're telling," says

Monte J. Goldstein, M.D., Chief Medical Officer at Virtua ASC Joint Ventures.

Video calls help bring back that connection and provide a unique opportunity to get to know a patient in their own home. A few minutes of small talk can really help to put a patient at ease. Active listening techniques, pausing to give patients an opportunity to open up and responding to them empathically, when appropriate, are all ways to create that one-on-one connection in person, over video or even just on the phone.

3. Take extra care with the patient portal

Patient portals have been a huge advance in the transparency of data and empowerment of patients, but, says Dr. Mouzakes, the challenge is that patients can receive test results through the portal without a doctor's guidance or analysis.

"For many of our patients, trying to interpret that data can be somewhat unsettling. I think it puts a bit more pressure on us as physicians to preempt just posting those results," he suggests, noting that if doctors take time to talk through possibilities with patients ahead of time, it can add much-needed context to test results in the portal.

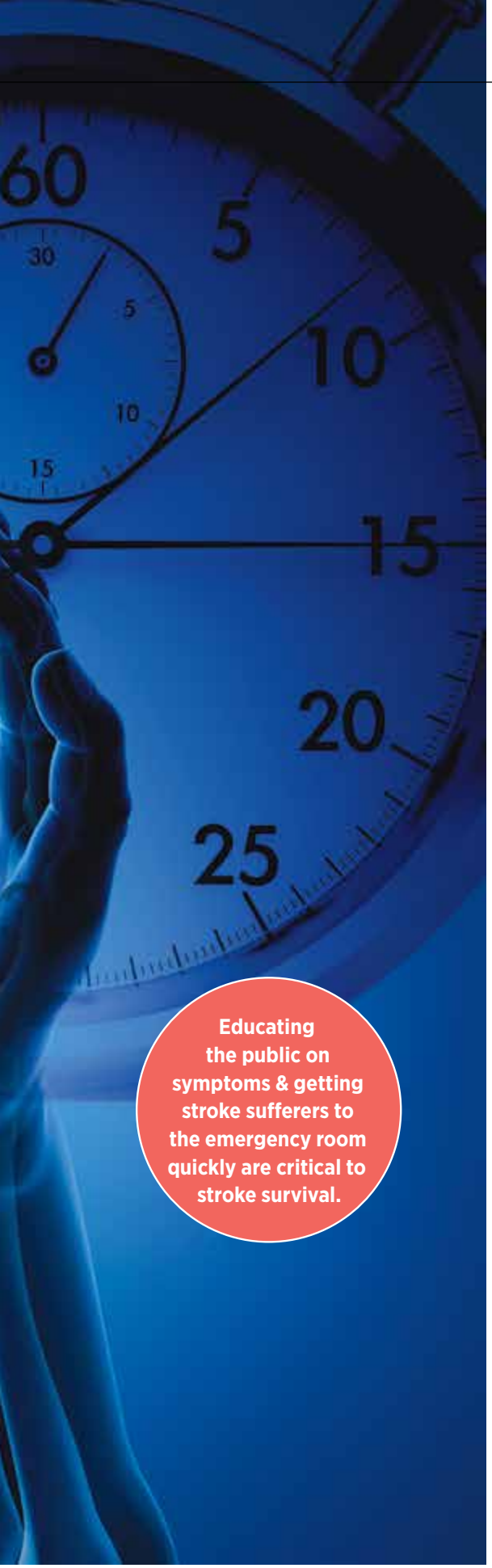
4. Understand technology & how best to use it

Technology has enormous potential to help deliver better care to patients, but hospital systems must remember that humans are still in charge of that tech and can control how it's used.

"I think we were blindsided by how quickly we would be required to use all the new technology that was given to us. We need to be better prepared, and that includes physicians, nurses and all the ancillary providers as well," says Dr. Goldstein.

It's about TIME

Prioritizing stroke outcomes & standardized care with a renewed emphasis on urgency



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ACCORDING TO THE AMERICAN STROKE ASSOCIATION (ASA), stroke outcomes have improved dramatically within the last 25 years: Mortality rates from stroke in the U.S. declined almost 40% between 1999 and 2016. This is due to significant progress in the adoption of effective treatments, prevention strategies and rehabilitation.

One reason the U.S. has made such meaningful strides in stroke care is because hospitals work to attain and maintain advanced certification from The Joint Commission. "When a hospital has stroke certification, it means the organization has adopted a standardized set of performance measures and provides high-quality care that helps reduce error and streamline processes to give lifesaving care," says **Karen Bush**, MSN, FNP, BC, NCRP, Director of Clinical Research & Education for Clinical Services at HealthTrust.

Still, there is much work to be done. Stroke continues to be one of the top 10 leading causes of death and long-term disability in the U.S., according to the Centers for Disease Control and Prevention. Someone has a stroke every 40 seconds, and someone dies of a stroke every four minutes.

"TIME IS BRAIN," SO "BE FAST"

To improve the survival rate of stroke, it is critical to educate the public about symptoms and the importance of getting stroke sufferers to the emergency room as quickly as possible—ideally, within three hours. "Time is a very important factor," says HealthTrust Physician Advisor **Daniel V. White**, M.D., a private-practice neurosurgeon. "Stroke can be very disabling, and nowadays we have treatments that can make a difference and alter the natural history."

In 2012, the ASA launched its first FAST stroke public health awareness campaign in partnership with the Ad Council. The campaign has been successful in representing the urgent nature of ischemic stroke and helping people quickly and easily recall the warning signs: **F**ace drooping, **A**rm weakness, **S**peech difficulty and **T**ime to call 911. In 2017, a report published in the American Heart Association's (AHA's) *Stroke* journal suggested that strokes were going undetected with this memory aid and recommended amending the public education program to include two additional symptoms: **B**alance and **E**yes, or BE FAST.

"Everyone should know the BE FAST acronym," says **Jenny Werthman**, Ph.D., MBA, RN, NE-BC, Director of Clinical Services at HealthTrust. Just as the AHA has promoted awareness of heart attack symptoms and the notion that "time is muscle," with stroke, it's important to know that "time is brain." According to *Stroke*, a person loses 1.9 million neurons per minute during a large-vessel ischemic stroke. For every hour that passes without treatment, the brain loses as many neurons as it does in more than three and a half years of aging.

Werthman says there are modifiable risk factors that people should watch for, such as high blood pressure, high cholesterol, obesity, smoking, diet and exercise. While some risk factors are controllable, others, like family history, age and race, are not. "We focus on impacting the ones we can change because prevention is important as well as recognition," she says.

ADVANCEMENTS IN STROKE DIAGNOSIS & TREATMENT

Remarkable advances in stroke diagnosis and treatment over the last three decades include imaging techniques, which now allow doctors to see what's happening in the brain and diagnose a stroke more quickly and accurately.

Dr. White has been a practicing neurosurgeon for 20 years. He remembers his training in the late 1990s and early 2000s, when diffusion-weighted imaging via MRI was first introduced. "With CT scanning, you couldn't diagnose a stroke until 24 to 48 hours later," he says. "With an MRI, at first, you couldn't diagnose a stroke right away, so doctors would be trying to decide if it was a transient ischemic stroke or a completed stroke." If the stroke completed, a person could be paralyzed or die.

Today, a dye injection allows doctors to quickly see the intricacies of the brain regions and pinpoint the area where the stroke is occurring. Emergency IV medications are used to break up clots and restore blood flow to blocked vessels. The gold standard treatment is called tissue plasminogen activator (tPA), or alteplase. It works by dissolving the blood clot that is causing the stroke. The sooner a patient receives it, the better, as there is a critical window of just a few hours where you can restore blood flow and not experience as much brain damage.

For more severe strokes, doctors now use intraarterial techniques like mechanical thrombectomy, where doctors go into the blood vessel with a catheter and pull out the blood clot. They can also deliver tPA directly into the brain where the stroke is happening. These advancements have saved thousands of lives. (See page 46 for more information about these and other innovative stroke products.)

HOW STROKE CERTIFICATIONS MAKE A DIFFERENCE

The more practice a hospital stroke team has, the more likely patients are to have good outcomes. That's why The

Joint Commission, AHA and ASA teamed up to implement four advanced stroke certifications:

- Comprehensive Stroke Center (CSC) certification, for hospitals with specific abilities to receive and treat the most complex stroke cases
- Thrombectomy-Capable Stroke Center (TSC) certification, designed for hospitals providing endovascular procedures and post-procedural care
- Primary Stroke Center (PSC) certification, for hospitals providing the critical elements to achieve long-term success in improving stroke outcomes
- Acute Stroke Ready Hospital (ASRH) certification, for hospitals or emergency centers with a dedicated stroke-focused program

Dr. White treats patients at several different hospitals in the San Diego area. "If a person is having a stroke, then it's best to be taken to a facility with a Comprehensive Stroke Center certification," he says. But if you don't know, he recommends going to the nearest hospital. "Then you have the possibility of being transferred to a CSC that does meet the requirements of certification," he adds.

STANDARDIZED APPROACH TO STROKE FOR BETTER OUTCOMES

It is important and beneficial for hospitals to have a standard, consistent approach to stroke care. "I once heard that if something gets measured, it can be changed," says Dr. White. When hospitals began measuring door-to-balloon time in heart attack patients, that metric was able to improve. With strokes, hospital teams measure door-to-imaging and door-to-reperfusion time. "These sorts of metrics have been improving because we're tracking them. Keeping in mind the concept of 'time is brain' and the BE FAST acronym, the sooner you recognize a stroke and can treat it, then the better the outcomes."

"With stroke patients, there is a standardized approach to treatment, so having that awareness gets the patient that treatment sooner," adds Werthman. "It gets everybody on the same page so that it becomes muscle memory." Reducing variation improves clinical outcomes and creates a way to measure the effectiveness for future improvements.

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HOW THE PANDEMIC AFFECTED STROKE TREATMENT

In the early months of the pandemic, people were told to stay home to reduce the spread of COVID-19. Hospitals halted elective procedures and used telemedicine in ways they never had before to avoid physical contact. Patients largely stopped coming to the hospital altogether, even for life-threatening emergencies like heart attacks and strokes, which concerned medical professionals.

"One of the fallouts early on in the pandemic was that we told people not to go to the hospital. So they didn't go to the hospital, even for symptoms of stroke and heart attack, and as a result, procedures to treat these conditions decreased," says Bush. The Joint Commission reacted by temporarily reducing its volume eligibility requirements for the advanced TSC and CSC certification programs.

The volume standard demonstrates a certain proficiency with stroke patient care. "If I'm going to have surgery, one of my first questions to the surgeon would be, 'How many of these procedures have you done?'" says Bush. "Because I don't want to be the first."

That philosophy applies to certification. If a hospital is not treating a sufficient number of stroke patients, then it becomes a question of competency and the ability to evaluate that competency. Now that patients feel safer and volumes are returning to pre-pandemic levels, The Joint Commission has returned to original eligibility requirements.

As hospitals look toward the future, pursuing stroke certification is a smart strategy. "The public feels better knowing there are independent agencies making sure that quality is maintained," says Dr. White. Taking this important step makes the community aware of which hospitals prioritize stroke care and make an investment in the staff and equipment needed to perform these lifesaving, subspecialized interventions. **HT**

SEE PAGE 46 for more information about innovative stroke products on contract with HealthTrust. To learn more about stroke certification requirements, visit jointcommission.org/accreditation-and-certification

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1. Pegues DA, et al. *Impact of Ultraviolet Germicidal Irradiation for No-Touch Terminal Room Disinfection on Clostridium difficile Infection Incidence Among Hematology-Oncology Patients*. Infect Control Hosp Epidemiol. 2017 Jan;38(1):39-44.
2. Pavia M, et. al. *The effect of ultraviolet-C technology on viral infection incidence in a pediatric long-term care facility*. Am J Infect Control. 2018 Jun;46(6):720-722
3. Based on independent laboratory testing. For a copy of the laboratory results, please contact uv@uvdi.com.

FUELING CHANGE

HealthTrust offers Energy-as-a-Service to reduce energy costs

HEALTHCARE FACILITIES ACROSS THE COUNTRY face an emerging need to reduce their energy consumption from both an expense management and a sustainability standpoint. To meet this need, HealthTrust has entered into a national agreement with Bernhard ProStar (BPS) to provide Energy-as-a-Service (EaaS) solutions for HealthTrust members.

WHAT IS EaaS?

EaaS provides an alternative to the typical customer-funded or financed project. "In the EaaS model, healthcare providers partner with us to manage their complete energy infrastructure needs," says **Caleb Haynes**, VP of Business Development for BPS. "BPS offers HealthTrust members a comprehensive choice of services, including engineering design, construction, operations and maintenance, and financing that will reduce energy consumption and their carbon footprint while providing unique financial and operational benefits."

HOW WILL EaaS HELP MEMBERS?

Rising costs, tighter margins and competing needs for capital continue to prevent many healthcare providers from proactively addressing deferred maintenance, energy infrastructure upgrades, large-scale renovations or new construction projects. By shifting these capital needs to an operational expense, BPS EaaS solutions provide clients with efficient and resilient infrastructure coupled with the long-term guaranteed benefits of budget certainty and risk transfer. Whether an organization's goals include enhancing patient delivery to the local community or sustaining environmental resources, the EaaS program can be tailored to guarantee results and allow the provider to focus resources on core healthcare operations.

THE PROGRAM IMPACT

"EaaS is a truly custom solution developed to create impactful value to each organization," explains Haynes. BPS strives to meets clients' key objectives in all aspects of the program with brand-neutral delivery. "The solution is attractive for all providers because it delivers alternative, off-balance sheet capital that doesn't compete with the capital investments needed for hospital operations," says Haynes. "BPS raises the capital required for the project and can also raise excess capital that the provider can reinvest back into their core business." While potential savings vary by facility, BPS customers typically realize utility savings of 30%-40% each year.

HOW THE PROGRAM WORKS

"We begin by engaging with a healthcare organization in a risk-free due diligence process to identify key objectives, infrastructure needs and operational savings potential," says Haynes. "BPS will then develop a unique scope of work, including infrastructure renewal and optimization services that aim to reduce energy usage and demand (gas, electric and water) and provide the greatest financial benefit to the facility." Typically, within 60 to 90 days of the due diligence period, BPS will deliver a comprehensive first offer to the health system's leadership that aligns with key objectives for each facility.

"We are excited about the future of this program and the additional opportunities the BPS partnership will bring to the HealthTrust membership," says **Allen Wright**, SVP of Commercial Products Strategic Sourcing for HealthTrust. "BPS can also partner with the HealthTrust Energy team for a collaborative approach that addresses both the supply and demand aspects of utilities. While BPS focuses on demand, the HealthTrust Energy team looks at

the supply side and how a facility purchases its utilities, how it hedges risk and manages the utilities. We look forward to seeing the impact of these complementary services for our membership," says Wright.

MEMBER SPOTLIGHT

Louisiana Children's Medical Center (LCMC) recently entered into a 15-year agreement to provide EaaS solutions at seven of its regional facilities. It transfers the risk of operations and maintenance of LCMC Health's central utility system to BPS and allows for state-of-the-art infrastructure upgrades. This 15-year EaaS agreement has a projected life-cycle cost savings of $96 million. HealthTrust awarded LCMC with its 2021 Member Award for sustainability for this project. Read about it on *The Source* website at **bit.ly/2021HTMemberAwards**

Another Louisiana-based health system entered a 20-year agreement with BPS to implement an energy asset concession that provides capital renewal, deferred maintenance, energy improvements, and ongoing operations and maintenance of the hospital's energy infrastructure. The scope of the project spanned 1.4 million square feet of the organization's main campus, and the organization exceeded its $2.1 million energy savings guarantee. **HT**

Determine the potential savings & sustainability impact an EaaS solution could have on your organization. Email BPS VP of Business Development Caleb Haynes at chaynes@bernhard.com

EaaS SUSTAINABILITY BENEFITS

EaaS offers the following advantages:

- Operational efficiency
- Greenhouse gas reduction
- Carbon emission decrease
- Utility supply management

A WINNING STRATEGY

BMC invests in high-performance teams for surgical specialties

WHEN BOSTON MEDICAL CENTER (BMC) RECEIVED A GRANT IN 2019 for its implementation of a high-performance team (HPT) in its vascular surgery service line, the 514-bed academic medical center planned on using the grant to kickstart an expansion of HPTs to all its surgical specialties. The coronavirus pandemic disrupted those plans, but it didn't put a stop to them. Now, the race is back on.

A RUNNING START

Several years ago, in its continuous effort toward quality improvement, BMC leadership decided to focus on the surgery department. BMC leaders recognized that having highly specialized, dedicated teams for specific service lines would result in improved OR outcomes, so they piloted an HPT in vascular surgery, says **Pamela Rosenkranz**, MEd, BSN, RN, Senior Clinical Quality & Patient Safety Director of Surgery at BMC and Assistant Professor of Surgery at Boston University.

The vascular surgery HPT pilot was a huge success. Surgical site infections went down, a checklist for the surgeons that standardizes surgical prep procedures was developed, and efficiencies were created. One included the

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creation of a vascular surgery cart that had all the necessary materials, which reduced the number of times team members left the OR to retrieve supplies.

The vascular surgery HPT used simulation lab training to work through new processes and met every other week. Those regular meetings included time for social interaction, which transformed the team dynamic, as team members spent more time getting to know and trust each other. "It wasn't just the surgeon who had a voice; everybody in that room had a voice because, at that meeting, they were on the same level," Rosenkranz explains.

With the success of the vascular surgery HPT, the goal became to create HPTs for every surgical specialty. However, as a safety-net hospital, BMC didn't have many extra resources to put toward the development of HPTs for every service line. But that changed when BMC received a grant that gave the team not only resources but the incentive to keep moving forward, Rosenkranz explains.

With a goal of creating an additional six surgical HPTs, leadership started the team development incrementally. The plan was to launch the first three immediately and add the remaining three in March 2020, but complications arose.

HITTING SOME HURDLES

The coronavirus shutdown in March 2020 halted all elective surgeries and derailed further progress on the development of the HPTs. The kickoff meeting was postponed, and the monthly in-person team meetings went virtual.

Other challenges got in the way. The new HPTs were combined specialties because there wasn't enough staff to have dedicated teams for each one. Among the challenges they faced was being able to identify which staff members had the right skill set for a particular team and then scheduling those people when their teams were in the OR, says **Ingrid Rush**, Clinical Quality Improvement and Patient Safety Specialist.

Rush recognized the need for a way to easily identify available staffing resources for more efficient and effective daily team member assignments. "We created

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an enhanced staffing grid in the electronic health record that displays all the staff's shifts, teams and skills, which is used to make daily assignments for the OR schedule," she says.

In a follow-up project, HealthTrust engineers are assisting nurse schedulers in anticipating staffing needs with a dashboard, launching soon. "This is being done in hopes that in the future, staff will voluntarily assign themselves on the day that their team is working," Rush explains.

LONG-TERM WINS

One of the most thrilling benefits of using HPTs in the surgery department has been seeing a crisis debriefing tool developed by one team picked up by other teams, say Rush and Rosenkranz. Rush's favorite example of this is a debriefing process created by the trauma/acute care/pediatrics HPT for when the team faces an emotionally devastating case.

During this process, the team meets to talk about what happened. A social worker with a background in crisis management and a team member with a dog who participates in BMC's Healing Pups program are on hand to help everyone work through the difficult experience. Other teams, such as surgical oncology, have begun adopting the trauma/acute care/pediatric team's process, says Rush. "It's been a really good project," Rush adds. "We're just trying to establish mechanisms to keep it sustainable."

There's more to be excited about. In the fall of 2021, the launch event that had to be postponed in March 2020 finally took place for all six new HPTs, and the teams are back to monthly in-person meetings, says Rosenkranz.

BMC is using surgical outcomes data to measure how the HPTs are doing, but, at this point, the teams are too new for enough information to have accrued to provide usable data, Rosenkranz says. Still, they've learned a lot, in particular, that HPTs are a continuous process. "It's not like you start this and it's done; it remains a work in progress," she says. "All these processes with data and outcomes, and offering continuing education during the monthly in-person meetings, is to create a culture of safety. That's the overall goal. That's what these teams will do." **HT**

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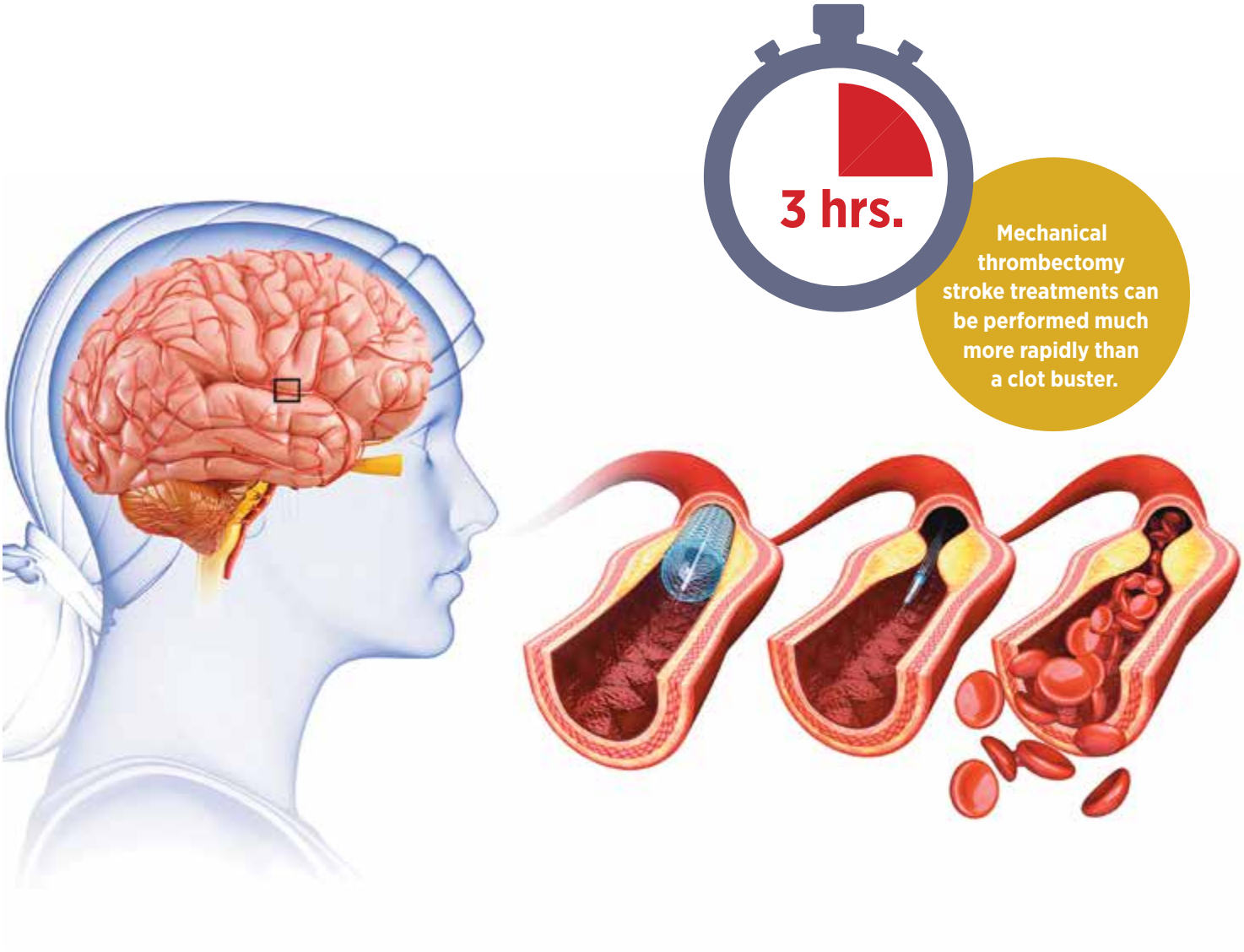

BRAINSTORMING solutions

As stroke treatments evolve, HealthTrust expands its product portfolio

TO KEEP UP WITH RECENT ADVANCEMENTS IN NEUROVASCULAR CARE, HealthTrust has expanded its category of products to treat neurovascular conditions. These include devices used for acute ischemic stroke and hemorrhagic stroke, as well as neurovascular access devices and accessories.

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THE USE OF MECHANICAL THROMBECTOMY

Stroke treatment technology has improved significantly over the last few years. Perhaps the most noteworthy development is with mechanical thrombectomy techniques and approaches for acute ischemic stroke, the most common type of stroke.

For years, physicians have been relying on tissue plasminogen activator (tPA), a thrombolytic drug that acts to dissolve a blood clot in the brain. While this treatment can be lifesaving, its effectiveness is limited because it must be administered within a three-hour window, and stroke patients aren't always able to get to the hospital in time.

"tPA is still the treatment, but advanced healthcare centers are doing thrombectomy, which actually extracts the clot by snaring it with a stent or suctioning it out," explains **Dan Ingram**, AVP of Custom Contracting for Trinity Health. This treatment is performed much more rapidly than a clot buster. And because the mantra for stroke treatment is "time is brain," the faster the treatment, the more positive the outcome.

Mechanical thrombectomy, used primarily for large-vessel occlusion stroke, has also proven to be quite effective. Interventional physicians use revascularization devices such as stent retrievers, aspiration catheters and pumps to remove a clot from a patient with impressive speed and precision.

While not every stroke can be treated with mechanical thrombectomy, acute ischemic strokes with large-vessel occlusion are treated with this procedure, and studies have demonstrated high success rates. "The number needed to treat for stroke is very low, at 2.6. If you treat almost three stroke patients with mechanical thrombectomy, at least one individual will benefit, which is a really impressive number," says **Karen Bush**, MSN, FNP, BC, NCRP, Director of Clinical Research and Education for Clinical Services at HealthTrust.

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In 2018, Trinity Health's Saint Joseph Mercy Health System in Michigan was the first hospital in the nation to receive certification from The Joint Commission as a Thrombectomy-Capable Comprehensive Stroke Center. "The Joint Commission is helping to advance stroke care and ensure hospitals are capable," says Ingram.

QUALITY IMPROVEMENTS TO DEVICES & APPROACHES

The major device suppliers continue to innovate and offer new products with smaller catheters and other advancements that allow them to reach smaller vessels in the brain to remove a clot. Mechanical thrombectomy procedures using aspiration catheters, stent retrievers or a combination of the two with or without a balloon guide catheter have been developed in an attempt to improve patient outcomes.

The goal is to improve blood flow to the brain as quickly as possible, resulting in improved neurologic function for the patient.

Low first-pass rates are preferred, which means the physician is successful at retrieving the clot on the first attempt. "This causes less trauma to the vessel and is faster and better for the patient," explains Bush.

In addition, more interventional physicians are considering use of a radial artery access approach, which means going in through the wrist rather than the groin. This shift was made years ago in interventional cardiology and is now used routinely.

"Interventional neurology has seen increased interest in this alternative access approach for the same reasons it is used in interventional cardiology. Reasons include reduced complication rates, including bleeding; reduced hospital length of stay; and improved patient satisfaction with the procedure," says Bush. More research is needed, but early studies show stroke patients appear to respond well to the radial technique.

In the treatment of ruptured and unruptured aneurysms, products and approaches have also evolved. Physicians can use a tiny coil to fill an aneurysm, blocking flow and preventing rupture. A balloon assist technique and intracranial stents can be used as adjuncts to the procedure. There are also flow diversion devices that reduce the risk of aneurysm rupture by routing flow back on the normal vessel path and away from the aneurysm. Flow diverters have been widely adopted in the treatment of unruptured intracranial aneurysms.

CONTRACTS TO ACCOMMODATE PHYSICIAN PREFERENCES

Physician preference and training is a strong factor in the selection of devices in this category. Engaging physicians who perform these procedures in your organization is key in your value analysis process.

Such is the case at Trinity Health, a healthcare network that spans across 22 states from coast to coast, says Ingram. At the local hospital level, there are value analysis teams that approve products for stroke teams to use. **HT**

STROKE PRODUCT DEVICES

HealthTrust's stroke product category includes minimally invasive devices used in the treatment of thrombus and emboli, ruptured and unruptured aneurysms, and arterial/venous malformations in the neurovasculature (cerebrovasculature).

- **Acute ischemic stroke devices**: Revascularization devices such as stent retrievers, aspiration catheters, pumps and related supplies
- **Hemorrhagic stroke devices**: Embolization coils, flow diverters, intrasaccular devices, liquid embolics and neurovascular stents
- **Neurovascular access devices & accessories**: Balloon guide catheters, guide catheters, microcatheters, occlusion balloons, neurovascular guidewires and intracranial support catheters

PRODUCTS ON CONTRACT

Visit the Member Portal to learn more about the neurovascular devices and accessories in the newly expanded HealthTrust portfolio:

- Stryker Neurovascular, contract #73770
- Penumbra Inc., contract #72614
- Johnson & Johnson Health Care System, contract #73772
- Asahi Intecc USA Inc., contract #75248
- Microvention Inc., contract #63749
- Balt USA LLC, contract #75112

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1. Tiscar-Gonzalez V, Rodriguez MJM, Rabadan Sainz C, et al. Clinical and economic impact of wound care using a polyurethane foam multi-layer dressing versus standard dressings on delayed healing ulcers. Adv Skin Wound Care. 2021;34(1):23–30

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[1]PDI Prevantics Device Swab Clinical Compendium: https://pdihc.com/resource/prevantics-device-swab-clinical-compendium/