The Journal of
Healthcare CONTRACTING
Providing Insight, Understanding and Community
October 2012 | Vol.9 No.5

The Path We're On

Eliminating healthcare-acquired infections

The case for Unique Device Identification

Progress in vendor credentialing

MINIMIZE EXPOSURE.

SemperCare® Tender Touch™ Nitrile provides protection from on-the-job risks along with excellent tactile sensitivity and a comfortable fit. And because it's Sempermed, it well surpasses ASTM standards for better consistency and performance every time.

THIS IS SEMPERMED

For your free box of Tender Touch™ gloves, *email us at Hospital_Gloves@SempermedUSA.com or call 800.749.3650. For more information, visit SempermedUSA.com/JHC*

Sempermed®
We are people protection.®

GLOVE the PLANET™
Learn how eco-friendly practices minimize our global impact at www.GlovethePlanet.com

Follow us on Twitter SempermedUSA.com/Blog Connect on LinkedIn

13900 49th Street North • Clearwater, Florida 33762 Phone: 800.366.9545 / 727.787.7250 Fax: 800.763.5491

The Journal of Healthcare CONTRACTING

The Journal of Healthcare Contracting
is published bi-monthly
by mdsi
1735 N. Brown Rd. Ste. 140
Lawrenceville, GA 30043-8153
Phone: 770/263-5262
FAX: 770/236-8023
e-mail: info@jhconline.com
www.jhconline.com

The Journal of Healthcare Contracting (ISSN 1548-4165) is published bi-monthly by Medical Distribution Solutions Inc., 1735 N. Brown Rd. Ste. 140, Lawrenceville, GA 30043-8153. Subscriptions: $48 per year. If you would like to subscribe or notify us of address changes, please contact us at the above numbers or address.

POSTMASTER: Send address changes to Medical Distribution Solutions Inc., 1735 N. Brown Rd. Ste. 140, Lawrenceville, GA 30043-8153.

CONTENTS »»» OCTOBER 2012

"Our goals were to provide clear interpretation of regulatory and accrediting body requirements, and provide guidance to hospitals regarding a standard practice for vendor credentialing."

– Kathy Wallace, director of performance improvement

pg 24

John Pritchard

Supply Chain Complexities

The last few years I have travelled the nation speaking at events, seminars and national sales meetings about the complicated U.S. Healthcare Supply Chain. As our nation worked its way out of the financial meltdown in 2008 – and braced itself for reform – suppliers, providers and communities saw great pressure and strain on the supply chains of our nation's hospitals and IDNs.

Since 2008 we have seen supply chain leaders take drastic action to ensure their systems stay solvent and persevere through these historic economic and political challenges. They worked tirelessly to reduce spending, drive standardization and educate and influence clinicians trying to moderate utilization.

The influence these supply chain leaders demonstrated during these difficult times and the results they delivered have made them a key component of the leadership team in IDNs from coast to coast. They've worked tirelessly to position the supply chain as a strategic piece inside the IDN – not just an operational cost center.

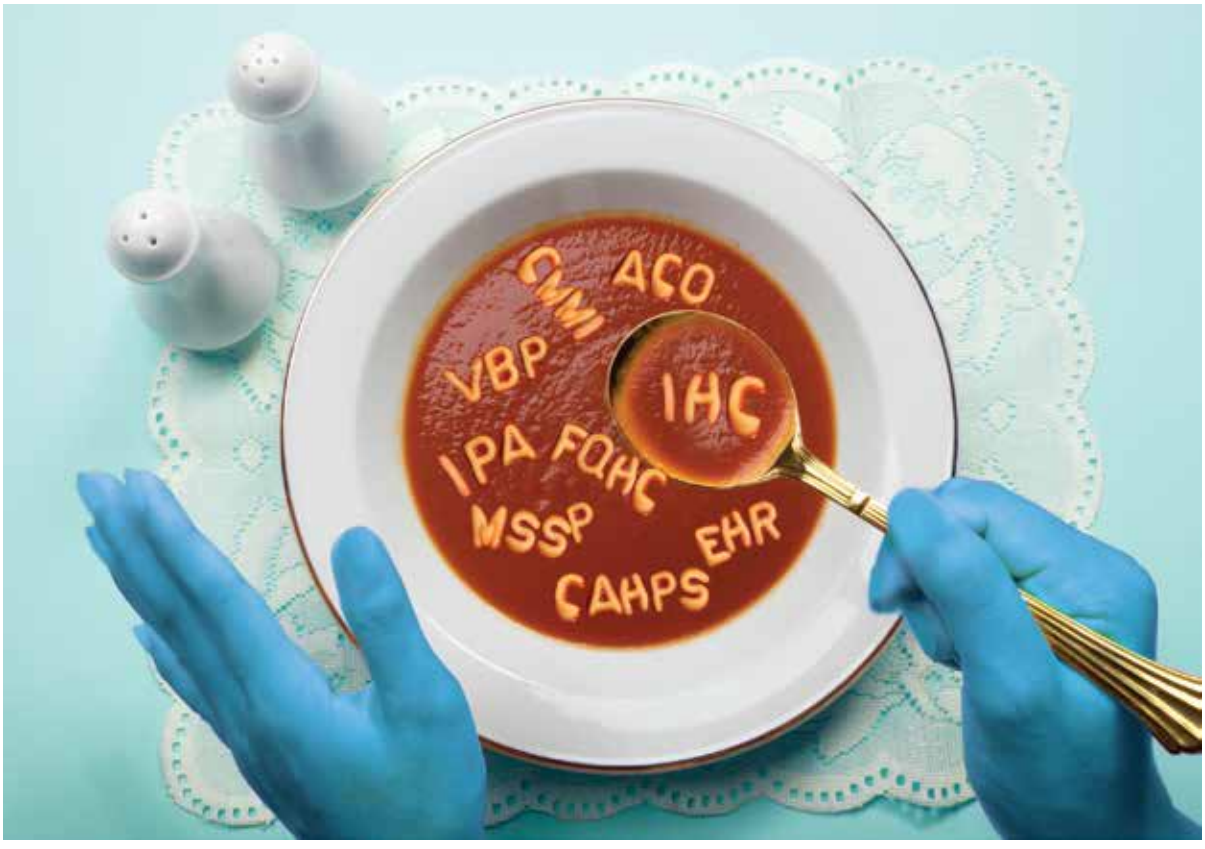
As I write this, we are about 50 days from the presidential election, and just three months from 2013, when reimbursement reform really starts to commence. Regardless of who wins the election, I think we will continue to see our supply chain evolve into more complex systems than in the recent past.

I expect major IDNs to continue to organize into aggregation groups and leverage their GPO contracts, enjoy the benefits of participation in Regional Purchasing Coalitions, engage in direct contracting – and even start their own GPO!

We are seeing it already. Just in the last few months, multiple large multi-state IDNs have announced the formation of wholly owned GPOs. Pretty interesting to think a supply chain leader can be a shareholder of a national GPO, stakeholder in a RPC, orchestrate direct contracts and own a GPO.

Thanks for reading this issue of the *Journal of Healthcare Contracting*.

Looking for Shared Savings in the Alphabet Soup?



Electronic Health Record

Accountable Care Organization

Independent Practice Associations

Value Based Purchasing

Medicare Shared Savings Programs

Innovative Healthcare Corporation

Federally Qualified Health Centers

Center for Medicare & Medicaid Innovation

Consumer Assessment of Healthcare Providers & Systems

For High Value Medical Gloves, One Choice Stands Out.

For over twenty years, IHC has offered a menu of high quality gloves, exceptional value and professional support.

IHC. Get A Taste for REAL Shared Savings.

INNOVATIVE HEALTHCARE CORPORATION

Product Solutions You Trust

www.ihcsolutions.com

For Samples: Contact the best Customer Service in the business at 800-272-1533

Data-driven, evidence-based

Durral Gilbert, Premier's new president of supply chain services, believes that good supply chain decisions rest on good data and collaboration

In July, the Premier healthcare alliance pro-moted Durral Gilbert to president of supply chain services. As such, he oversees Premier's core supply chain business, which includes sourcing, contract management and operations, and business analytics, as well as businesses and partnerships that comprise its emerging supply chain efforts.

Durral Gilbert

Prior to serving as the president of supply chain services, Gilbert was senior vice president of supply chain emerging services. In that position, he worked with his team to lead the development of Premier's pharmacy offerings for providers, while identifying overall supply chain and clinical improvement opportunities. He has also led the design of Premier's semiannual Economic Outlook publication.

Gilbert recently responded to questions posed by the *Journal of Healthcare Contracting*.

Journal of Healthcare Contracting: In the announcement of your promotion, a couple of references were made to work you have done integrating practice patterns, clinical efficacy and resource utilization. Can you expand on your efforts in this area?

Durral Gilbert: Premier maintains the nation's largest clinical, financial and outcomes database, with information on one in every four patient discharges, 2.5 million real-time clinical transactions a day, and close to $43 billion in annual purchasing data. We also offer quality, safety, labor and supply chain technology apps, which are connected on one technology platform. With this integrated data and technology, our members can review utilization, supply and practice patterns, and identify and target waste. Ultimately, this means they're making streamlined decisions based on a combination of quality, safety and cost information.

For a supply chain executive, this helps inform purchasing decisions based on a combination of price and quality, and decisions are

The Welch Allyn Connex® Electronic Vitals Documentation (EVD) System wirelessly sends accurate vitals from the bedside to your EMR—to enhance clinical decision making, improve patient safety, and minimize risk.

When staff can't access accurate vitals, it costs you and your patients dearly. Studies show that in a typical 200-bed hospital, 10,000 vitals documentation errors can occur each year. This inefficiency compromises clinical decision making, putting patient safety and your facility at risk. Plus, manual documentation of vitals needlessly consumes 8,000 staff hours annually, adding up to nearly $250,000 in lost productivity.*

The Connex EVD System is an end-to-end electronic vitals documentation system designed specifically for general-care environments by Welch Allyn, the frontline care experts, which:

- Virtually eliminates transcription errors
- Is customizable to your optimal workflow
- Features automatic patient ID and data-privacy functions
- Is scalable to meet your needs today and tomorrow

Welch Allyn Connex EVD helps you get the most out of your EMR—to help care for your patients and your bottom line.

Learn more about the Welch Allyn Connex Electronic Vitals Documentation System at www.welchallyn.com/connex.

Welch Allyn®
Advancing Frontline Care™

 *Calculations based on these sources; sample calculations available upon request. 1. Computers, Informatics, Nursing: September/October 2009, Volume 27, Issue 5, pages 318-323, Connected Care: Reducing Errors Through Automated Vital Signs Data Upload, Smith, Laura B. MSN, RN; et al. 2. Automated Vital Sign Documentation for Medical Surgical Units: Saving Time and Increasing Accuracy: Fact or Fairytale?, Meg Meccariello, RN MS; Jennifer Johnstone, RN MS, Presented at The Nursing Management Congress 2008 Las Vegas, NV. 3. Vital signs measurement frequency estimates from "Lippincott's Textbook for Nursing Assistants: A Humanistic Approach to Caregiving," Pamela J. Carter, 2007, page 292. 4. Hospital beds (most recent) by country estimates from NationMaster.com, www.nationmaster.com/graph/hea_hos_bed-health-hospital-beds. 5. Population, Source: U.S. Census Bureau, Population Division.

supported by tens of thousands of outcomes. He or she can then interact with peers nationwide to get feedback on products being considered for contracts. Moreover, they're alerted when new contracts are launched in order to immediately and easily obtain best pricing.

Presbyterian Healthcare Services is saving nearly $2 million a year – without affecting clinical outcomes – through more efficient use of an anticoagulant for cardiac valve patients. In another example, Banner Health in Arizona is saving $1.6 million a year through more efficient use of an abdominal adhesion barrier in C-sections, with no discernible difference in patient outcomes.

In both of these cases, the health systems accessed our comparative database, which is considered credible by physicians since it's severity adjusted, and shows the performance of top-tier hospitals. These are perfect examples of what we call data-driven, evidence-based decision-making.

The supply chain is ever expanding, integrating non-traditional supply chain data. We're working alongside our members in cohorts focusing on resource utilization and comparative effectiveness – areas that are and will continue to be a major focus for the alliance. We're focusing not on just the price, but using clinical data to understand variation across four core areas: supply variation, and pharmacy, lab and procedural utilization.

JHC: Last year, Premier field employees were able to help members save more than $4.2 billion through improved efficiencies. Can you elaborate on who these field employees are? What are your expectations of them? How do they work with members?

Gilbert: Our field specialists are a team of experts, clinically and technically trained, who advise Premier members about efficient and effective supply spend and process improvement strategies. They also specialize in helping members improve quality and reduce costs via our performance improvement collaboratives and technologies. They are incented to safely reduce costs, and their principal means of doing so is driving contract penetration, which creates value for both members and suppliers.

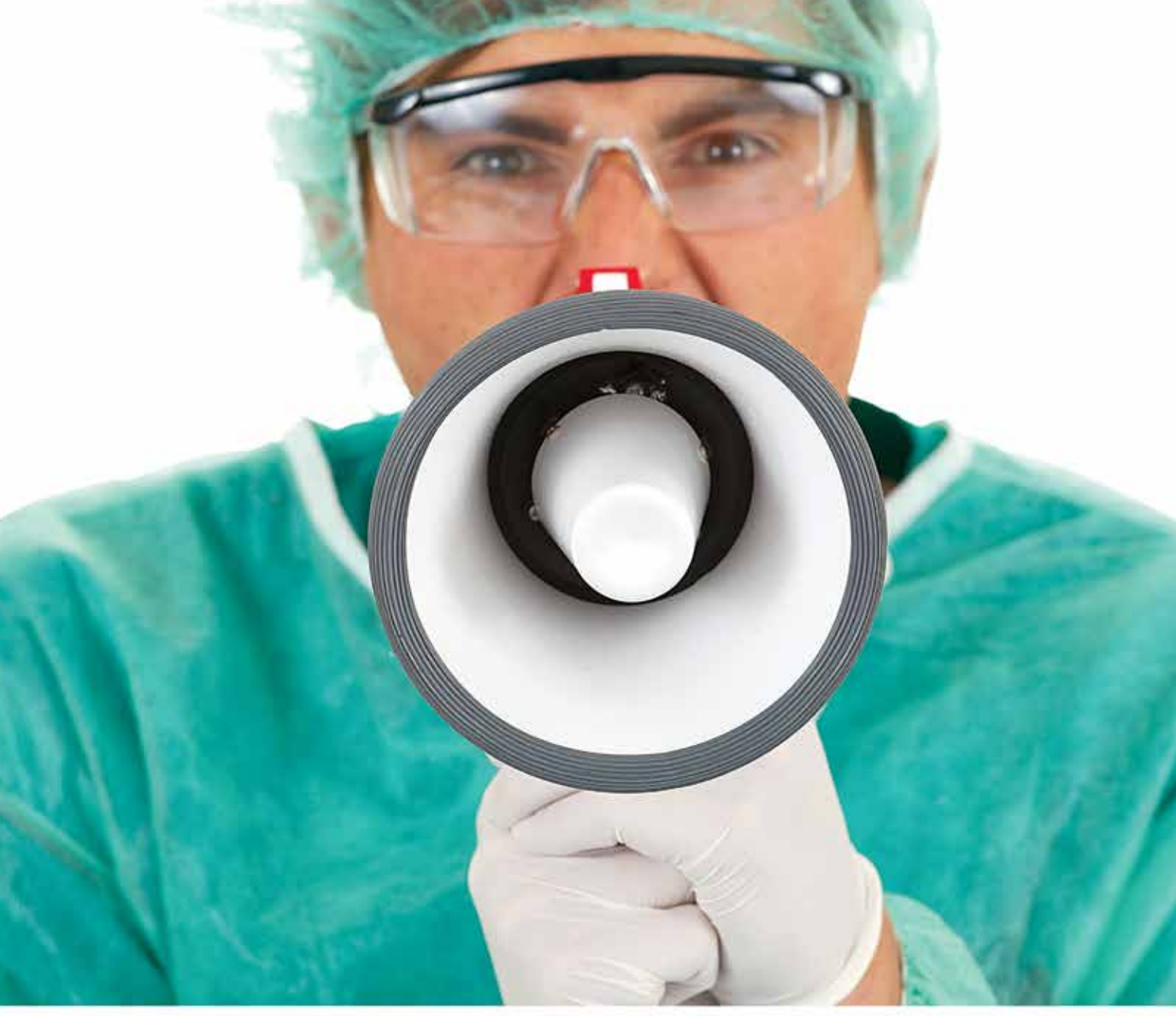
These experts are based across the nation to collaborate with members and scale solutions that disrupt and change healthcare's future. They share with each other what their top performing hospitals are doing and expand those pockets of excellence across the alliance to operationalize meaningful change.

Because reform magnifies the need for integrated, actionable information on clinical and supply chain data, we have also connected our supply chain, quality, safety and labor offerings. We're able to intertwine these traditionally disparate areas through our integrated performance platform, PremierConnect.

JHC: One of your goals, as you stated in July, is to "further the alliance's vision of transforming healthcare through innovation and partnership with our member organizations." Can you describe what you'd like that innovation and partnership to look like?

Gilbert: Health systems today need an integrated look into utilization, quality, safety, costs and efficiency. And they need to connect care across all of their care sites – hospitals, physician offices, outpatient clinics and more. We're assisting them in supporting new care delivery models and improving population health by integrating health information from hospitals, other healthcare sites and payors.

Because reform magnifies the need for integrated, actionable information on clinical and supply chain data, we have also connected our supply chain, quality, safety and labor offerings. We're able to intertwine these traditionally



I WANT A REAL BOVIE®!

Bovie®

Bovie Medical Corporation • 5115 Ulmerton Road • Clearwater, FL 33760
Ph 1-800-537-2790 • Fax 1-727-347-9144
sales@boviemed.com • www.boviemed.com

disparate areas through our integrated performance platform, PremierConnect.

We also focus on collaboration among our members, so good ideas can be shared and replicated across our membership. We have learned that working together, with established measures, data transparency and best practice sharing, accelerates improvement to degrees not seen in single-system efforts.

Specific to purchasing, it's quantifiable value they cannot get on their own. Last year our members validated a record savings of more than $1.45 billion (a number that is audited by a third party firm) by collaborating to improve performance, integrating and comparing data, and using innovative purchasing practices. This is on top of the $2.75 billion in savings that was realized by more aggressive product pricing and increased revenues.

As we all know, health reform has expanded the purchasing dialogue well beyond traditional pricing and into care delivery. Our members are working to close the gap between cost and quality, or the cost of supplies and services required to provide optimal care.

JHC: Which provisions of healthcare reform will have the greatest impact on your members? What role, if any, will supply chain/materials executives play? Will Premier be able to help your members address these challenges?

Gilbert: As a part of our bi-annual Economic Outlook survey, we recently polled 600+ member executives regarding what overall trend – not specific to reform only – will have the biggest influence on them over the next year or so. Reimbursement and all of its uncertainties was cited by 43 percent of respondents, with 75 percent of respondents listing reimbursement cuts among the top three trends impacting their organizations.

Frank Fernandez, assistant vice president of supply chain services, Baptist Health South Florida, Miami – a 30+ year supply chain veteran – summed it up well when he told us that he'd "never experienced such cost pressures before." Reimbursement cuts are clearly driving these pressures.

Health information technology requirements and new care delivery, such as accountable care organizations, were the other two areas most cited by respondents.

As we all know, health reform has expanded the purchasing dialogue well beyond traditional pricing and into care delivery. Our members are working to close the gap between cost and quality, or the cost of supplies and services required to provide optimal care. As such, purchasing executives are finding themselves interacting more and more with the C-suite.

Likewise, as utilization becomes a target in health reform, clinical users must become more proficient in value analysis to maintain cost efficiency while supply chain managers must strive to better understand clinical protocols to maintain quality. Data is the fundamental tool required to marry quality of care goals with cost-cutting strategies.

JHC: How is the QUEST program affecting your members' supply chain teams, if at all?

Gilbert: Preliminary four-year results suggest participants saved $6.9 billion. A significant portion of these savings are through more appropriate utilization of drugs, tests and other resources.

QUEST participants played a key role in the development of our efficiency dashboard, which identifies categories of potential savings opportunities in hospitals. Specific to the supply chain, we found annual savings opportunities of more than $4.8 million through more appropriate lab testing, diagnostic imaging, blood utilization and purchase order automation.

Our QUEST Comparative Effectiveness & Innovation Program (QCEIP) generates objective results to inform providers and patients about safe, cost-effective treatments for certain clinical conditions. Suppliers volunteer to participate in the program, which evaluates products and clinical interventions in real-world settings at our hospitals. It also helps the healthcare community better understand patient outcomes associated with the use of certain products, and helps manufacturers understand better how their products are working in the real world. **JHC**

Your Full-Line IV Therapy Supplier

Streamlining the ordering process and improving supply chain efficiency can lead to less hassle and reduced SKUs. With B. Braun, one vendor means one solution.

Call your B. Braun representative today or visit our website for product information and additional resources.

1-800-227-2862
www.bbraunusa.com

B|BRAUN
SHARING EXPERTISE

12-3334_JHC_7/12_KE

On the Horizon

FAH prepares for March meeting

The Federation of American Hospitals' annual Public Policy Conference and Business Exposition has been *the* place for national account executives to network with group purchasing executives since the early 1980s, says Dennis Daar, managing partner of Medical Strategies International, LLC and the 2013-2014 chair of the FAH's Exposition Advisory Committee. And the upcoming conference, to be held next March in Washington, D.C., will be no exception.

Over the years, the meeting has grown from a supplier-booth trade show to its current format featuring service centers manned by representatives of GPOs, IDNs and the U.S. Department of Veterans Affairs, explains Daar. This evolution began in the early 1990s, when the FAH Exposition Advisory Committee decided to invite representatives from all GPOs to participate on the committee, and to eliminate supplier booths and promotional items in order to offer parity to all healthcare supplier companies in attendance. The result was a reverse trade show.

The decision to use service centers with private meeting rooms ensures that the GPO meeting is open to all companies, and the format helps curtail the expense of shipping products and associated trade show costs, says Doug Weigel, director of corporate accounts for Spacelabs Healthcare and immediate past chair of the FAH Exposition Committee.

"Being in D.C. affords us the flexibility to bring in the most relevant healthcare speakers," points out FAH President and CEO Chip Kahn. "Also, attendees are accustomed to bringing their senior management to meet with both the GPO executives and their Congressional representatives on the Hill during the meeting."

Why attend?

There are several reasons for attending the Federation conference, says Weigel. "First, there is the networking with over 225 executives from 35 GPOs, IDNs and the VA. Also, the educational workshops and plenary sessions highlight the leadership of our industry sharing useful information. This information is then used in the development of our strategic direction. In addition, best practices are shared by suppliers and providers during workshop sessions."

"The conference offers an opportunity to understand the latest

regarding industry trends and issues in healthcare, networking with hospital executives and peers, and the chance to gain knowledge through a myriad of educational sessions," adds Todd Ebert, president and CEO, Amerinet. It also offers a valuable opportunity to connect with current and potential supplier partners, he says.

The FAH conference "is a great opportunity for suppliers to spend quality time with the respective GPOs, to identify further areas of collaboration, and to drive value for our mutual customers," says Ed Jones, president of HealthTrust Purchasing Group and a long-time FAH Exposition Advisory Committee member. "In addition, we can identify new supplier opportunities … and establish next steps with current and potential suppliers, which creates momentum toward specific initiatives once the meeting concludes."

"From a supplier's point of view, it would take me a good two months of traveling and more than $12,000 in related travel costs for the networking and contacts made over the three days of the FAH meeting," says Weigel.

"GPO and IDN executives easily can conduct more than 100 short, to-the-point meetings at the FAH's annual meeting," adds Daar. "The reverse business exposition, private business meeting time, and networking opportunities provide a mutually beneficial opportunity to make new contacts, move a relationship/project to the next level and to hear useful information."

Healthcare reform

"I think some of the key highlights for me in 2013 will revolve around hearing from Capitol Hill regarding healthcare reform, particularly if there are any changes relative to the presidency or control of either the House or the Senate," says Jones. Speaker presentations will give those in attendance an opportunity to better understand the macro environment of healthcare, the changes underway, future trends, and how GPOs and suppliers can assist providers navigating through a very challenging time in the history of healthcare, he adds.

The FAH's 2013 Public Policy Conference and Business Exposition will take place March 3-5, 2013, at the Marriott Wardman Park Hotel in Washington, D.C. For more information, call Bonnie Moneypenny at (501) 661-9555 or go to www.fah.org. **JHC**

"The reverse business exposition, private business meeting time, and networking opportunities provide a mutually beneficial opportunity to make new contacts, move a relationship/project to the next level and to hear useful information."

– Dennis Daar, managing partner of Medical Strategies International, LLC

GET COMFORTABLE

COMPRESSION THERAPY CONCEPTS
www.CTCDVT.com | 800-993-9013

IN PREVENTING DVT

Solid Start, Positive Results

For one regional purchasing coalition, a strong foundation helps ensure success.

Due to careful planning and a solid framework, in less than two years, the Central Atlantic Health Network (CAHN) has forged a strong connection among its 39 hospital members (11 IDNs) and anticipates $8 million in savings by the end of 2012. When the regional purchasing coalition began operation Feb. 1, 2011, its goal was "to approach the supplier community as one entity in order to create an incremental economic advantage and to generate additional value through other quality, cost and efficiency opportunities." Guided by a board of directors and formal by-laws and operating documents, CAHN has grown from an $800 million supply chain operation to a $1.2 billion supply chain spend operation. Indeed, its executives' foresight to form an LLC early on has provided a clear set of parameters within which the coalition can move forward.

In a recent interview with the *Journal of Healthcare Contracting*, Preston Comeaux, III, vice president, financial support services/supply chain management, Vidant Health, and Tom Lawton, managing director, materials department, Centra Health, spoke about the coalition's goals and direction.

The Journal of Healthcare Contracting: Are you open to new members joining?

Preston Comeaux and Tom Lawton: Yes, we are. However, any new CAHN member must be a VHA member and must receive approval from 100 percent of the present CAHN membership.

"We are engaged in organization-wide strategic planning. Our process includes a well-thought-out contracting plan and a success strategy for physician-preference devices, products and materials."

JHC: What steps are CAHN's leaders taking to ensure the coalition will flourish in years to come?

Comeaux and Lawton: We are engaged in organization-wide strategic planning. Our process includes a well-thought-out contracting plan and a success strategy for physician-preference devices, products and materials. We believe that our future opportunities lie in pharmacy, capital equipment and service areas.

JHC: What goals does the coalition hope to accomplish in its first five years?

Comeaux and Lawton: In our first year of operations, members saved approximately $4 million, and we anticipate savings of $8 million in the 2012 calendar year. Planning for 2013 is underway, with a focus on physician preference, and we expect to significantly exceed our 2012 savings. Calendar 2014 and 2015 will result in a continued, accelerated savings growth pattern.

JHC: What advantages will CAHN be able to offer its members in the upcoming years?

Why Rely on Henry Schein...

We are the global experts in alternate care supply chain.

In fact, Henry Schein serves more health care practitioners with products and services than any other company worldwide.

We deliver supply chain business solutions through:

- Contract compliance
- Product standardization
- Custom data analytics and benchmark reporting
- Inventory management, automated ordering, and electronic receiving
- Technology integration through EDI, punch-out, and e-commerce

Let us demonstrate what we can do for you!

HENRY SCHEIN® MEDICAL

Rely on Us

To rely on us call 1-866-530-3547 or visit www.henryschein.com/whyrelyonus to learn more.

Comeaux and Lawton: Our members will experience the opportunity to be part of the best supply network in the nation, with market presence fully recognized by the supplier community and a track record of success. We will venture into areas such as service contracts, insurance and employee benefits. And, we will constantly churn what we have developed and continue to reap rewards from our relentless pursuit of best prices offered to a supply chain network.

JHC: How will being part of a regional purchasing coalition enable your members to leverage their buying power?
Comeaux and Lawton: Regional purchasing coalitions add leverage to buying power in tangible and intangible ways. From a tangible perspective, they provide access to tier maximization, particularly within the GPO contract portfolio. A recent trend in GPO contracting is the nationally negotiated network tiers. Being in a network, you have access to those tiers. Additionally, members gain specific knowledge from product evaluations. When several members are going through evaluations, one is able to better validate or invalidate objections by comparing notes. From an intangible perspective, it comes down to building strong professional relationships with those from your industry. The networking [opportunity] in CAHN strengthens our skills and knowledge, [as well as] our ability to impact our organizations.

JHC: Is this something your members should become better and smarter at over the years?
Comeaux and Lawton: Absolutely. And quite frankly, we have to. With the decline in reimbursement, uncertainties of healthcare reform and constant pressures on reducing cost, supply chain leaders must improve with every lesson learned. Working in a network has its challenges and is best positioned for success when everyone is on the same page.

JHC: Can you explain the process whereby your supply chain executives meet and make their decisions?
Comeaux and Lawton: The network's operating committee has a formal process for identifying, obtaining consensus and executing initiatives. Opportunities and potential projects come from network leadership, members, VHA and the VHA region, and are presented for consideration. Based on the size of spend and potential savings, the operations committee allocates resources to further investigate an opportunity. A formal member voting process and Robert's Rules of Order are utilized for decision-making. The operations committee is supported by its board of directors, which approves the contract plan as well as sets the overall strategy of the network. The operations committee meets face-to-face monthly in a central geographic location and utilizes teleconference as needed. The network is supported with dedicated leadership, sourcing and analytics through a consulting agreement with VHA.

When several members are going through evaluations, one is able to better validate or invalidate objections by comparing notes. From an intangible perspective, it comes down to building strong professional relationships with those from your industry.

JHC: How will you co-exist with your GPO?
Comeaux and Lawton: As an LLC, CAHN has the ability to go off GPO contract when the value from the contracted suppliers is not satisfactory or practical for the membership, or when a relevant contract does not exist. VHA and Novation are fully supportive and provide the resources to work with non-GPO suppliers.

JHC: How will you ensure that the interests of each of your facilities are considered and that each facility's needs are met?
Comeaux and Lawton: Our contract plan is mutually established with each member, with one vote. Although there is a possibility that not every member will be able to participate in every initiative, the goal is to find opportunities relevant to all organizations. The network goal is to ensure that no project negatively affects price points as a result of our decisions.

JHC: How difficult does it appear to be to get buy-in from each of your facility's physicians and staff when it comes to purchasing off the coalition's contracts?
Comeaux and Lawton: Buy-in typically has not been difficult to obtain. In instances where this has been a challenge, the vendor community has worked with us to establish provisions beneficial to all parties. With regard to staying on contract, historically there have been very few instances of product request running contrary to the networks' contract portfolio. However, as we contract more and more on clinical and physician preference items, this issue will come up.

JHC: If you could change one thing about the way your purchasing coalition works, what would that be?
Comeaux and Lawton: Speed. There are so many factors impacting our ability to get things done quickly, it is difficult to narrow it down to a single item. Bottom line, as we continue to develop pristine data, build collaboration with suppliers to achieve results faster, and align CAHN goals with our organizational goals – yet work within competing priorities back at our individual shops – we will get things done more quickly.

Buy-in typically has not been difficult to obtain. In instances where this has been a challenge, the vendor community has worked with us to establish provisions beneficial to all parties.

JHC: How do you envision your purchasing coalition in five years or so?
Comeaux and Lawton: If you asked each member, you might get a few different elements, but I suspect we would all hope to have:

- A physician committee coordinating our internal physicians around Network projects.
- Mature sub-committees focusing on standardization and utilization of product and clinical practices.
- A deep contract portfolio consisting of commodity, clinical preference and physician preference items. **JHC**

Designs on the Future

A varied career in healthcare and hospital supply chain prepared one executive for a focused strategy for building a new facility and establishing operations.

Mike Switzer knows how to make things happen. Whether he's designing and building distri-bution facilities or installing new computer systems, he knows how to look at the big picture – and bring together the parts to create a unique product. Largely, he credits his varied work experiences with preparing him for his current role as vice president of supply chain, North Mississippi Health Services, Inc. (NMHS), Tupelo, Miss. Prior to joining NMHS in 2006, he worked for several organizations, including:

- Huntsville Hospital, as well as worked with other members of Health Group of Alabama.
- HCA (HealthTrust, Columbia, Columbia/HCA).
- Summa Health System.
- Deaconess Hospital (Cleveland, Ohio).
- A hospital-shared engineering service and was co-owner of a biomedical engineering company.

Mike Switzer

"My past work experiences prepared me in some unique ways," says Switzer. "My engineering work gave me the ability to look at all of the processes individually, and to make them come together as a functioning system. The last 23 years have all been in multi-hospital roles, where I have had opportunities to redesign and open new distribution facilities, design and build facilities from the ground up, [and] upgrade and install new computer systems." And, he has learned some valuable lessons along the way, such as the following, he notes:

- There is not a cookie cutter answer to every supply chain need.
- Do not settle for less. Stick to your guns and get the systems and automation you need.
- Listen to your people. They come up with a lot of great ideas.
- If you can't measure it, you can't fix it.
- Communicate, communicate, communicate.

Today, Switzer has a number of responsibilities at NMHS, an IDN comprised of six hospitals, four nursing homes, a surgery center and 38 clinics, and a med/surg and pharmacy spend of $1.3 million. His oversight includes:

- Purchasing.
- Supply Processing and Distribution (Logistics).
- Central Sterile Processing.
- Laundry, Couriers, Print Shop.
- Contracting.

Challenges, today and tomorrow

Perhaps one of the most challenging and rewarding projects Switzer has worked on over the past year or two has been to design, build and bring into operation a facility to provide central sterile processing and case cart assembly services for the IDN. "[We] designed the building from scratch, using the three-zone concept: decontamination (dirty), prep/pack (clean) and sterile," he explains. "There is actually a fourth zone in the concept, which is a common (support) area.

This has been a very challenging project, as we have had to bring together multiple software vendors and develop interfaces to allow the seamless flow of information to trigger processes," he continues. "This has resulted in eliminating manual processes wherever possible. However, it has not been without its challenges. The biggest challenge is ongoing, [as] we are still waiting on the FDA to

SutureExpress®

“Let me be direct!”

Brian Forsythe
President & CEO

Don't be fooled by manufacturers who sell you on direct purchases – they are only telling you part of the story. Buying direct typically means hidden costs, slower delivery and less flexibility. Compare that to transparent savings, overnight shipping and best-in-class service at Suture Express, and it's easy to see where the real value is.

We guarantee the **industry's best fill rates**, **next-day delivery** and **no hidden fees**. Get the whole story: for better savings and service, don't buy direct. Get everything you need from Suture Express.

Call 855-4-SUTURE (855-478-8873) or visit us at www.sutureexpress.com to make the switch today.

approve a new type of robot to automate some of our manual processes."

Looking ahead, Switzer has plans to build an automated, LEED-certified laundry, with a sterilization plant and a clean room for pack assembly. "We will get away from using disposable surgeon's gowns, surgical towels, back table covers and mayo stand covers," he says. "We have a laundry [facility] that was designed back in the 1980s, but we have outgrown it." And, newer is better, he points out. "The new laundry [facility] will take advantage of many new technologies to save electricity, water and gas," he says. "We are planning to build this plant to not only handle our laundry, but to be able to sell our services to other facilities outside of our system."

"We worked with [Owens & Minor] on many different concepts to make things better for both of us. First, we looked at how they made deliveries to all of our facilities, [and] decided to have all deliveries [sent] to our logistics center."

– Mike Switzer

Besides working on a new laundry facility, Switzer looks forward to continuing to expand the role of the central sterile processing department. "We are currently doing the sterilization for over half of our facilities," he explains, noting that the plan is to bring all of the IDN's facilities online. "We plan to sell this service to some of the smaller hospitals in our region. which may have 20- to 30-year-old sterilization equipment and can't afford an upgrade," he adds.

Working with suppliers

When choosing a supplier, Switzer and his team look for one that demonstrates the ability "to help – not hinder us and our group purchasing organization – in moving forward," he says. "MedAssets has been key in helping us find these great relationships.

"Too many companies have one way of doing business, and you have to fit into their mold," he continues. "The best companies for us are those that are nimble and flexible enough to embrace change and look into different ways of doing business. We have embraced LEAN and look for partners with a similar outlook."

At the top of Switzer's list of prime suppliers is Owens & Minor. "When we opened our logistics center, its business plummeted because we were getting many items direct," he says. "We worked with [Owens & Minor] on many different concepts to make things better for both of us. First, we looked at how they made deliveries to all of our facilities, [and] decided to have all deliveries [sent] to our logistics center. We then could cross-dock these items and deliver them to our facilities on our trucks with our deliveries. This cut Owens & Minor's cost, allowing them to pass on the savings.

"Another [more time-consuming] item we worked on was the ability to use pallets as a unit of measure," Switzer continues. "We have several items of which we use large quantities, but not large enough to go direct. We worked with Owens & Minor to set up standards for these items so that when we order a pallet of an item, we always get the same number of cases on a pallet, [rather than] split several pallets. This may sound like a trivial item, but it makes a huge difference in the ability to receive and put away goods in a timely manner. Owens & Minor had to make system changes to allow them to do this, [rather than simply] go to multiple locations in their warehouse and spread [a delivery] among multiple pallets."

On the horizon

Of the various changes supply chain executives anticipate in healthcare in years to come, Switzer believes one of the biggest will revolve around contracting. "No longer will we be looking at squeezing pennies out of every item we buy on an individual basis," he predicts. "To be successful, we will have to insert ourselves into the entire chain of the money flow. We will have to work directly with insurers, vendors and manufacturers to negotiate prices we can all live with, while looking at where we can implement LEAN methods to cut our overhead."

It will be imperative for supply chain executives to get involved, he adds. Otherwise, "we'll end up on the outside, looking at direct contracts between the insurers and the manufacturers." **JHC**

transform

ACHIEVE SUSTAINABLE PERFORMANCE IMPROVEMENT

"We've realized over $71.7 million in supply chain cost reductions through a proven, data-driven, clinician-engaged process across 10 health systems. Our results have exceeded the savings guarantee from MedAssets, and we continue to make informed decisions to achieve quality patient care at the best price.

— Geoff Brenner, president and chief executive officer, Texas Purchasing Coalition

MedAssets

medassets.com 888.883.6332

MedAssets on:

Are we all on the same page yet?

Suppliers, hospitals and vendor credentialing companies appear to be moving in step with each other…with a few exceptions

"Pragmatic and optimistic" is how Bruce Mairose describes the recent Vendor Credentialing Summit in Alexandria, Va. "I believe each of the constituencies have a desire to do the right thing for the patients," says Mairose, vice chair, supply chain operations, Mayo Clinic. "There is consensus on the need for national standards as well. I believe there is a recognition of what expectations should be guided by national standards.

"The challenge for everyone is coalescing not only peer groups, but internal stakeholders within their respective organizations, around common interpretation of the requirements and guidelines that are driving [healthcare industry representative] credentialing."

Since vendor credentialing first reared its ugly (or beneficent, depending on one's point of view) head six or seven years ago, supply chain executives and their vendors have hardly seen eye to eye on the issue. But recent work by the hospital associations of Indiana and Minnesota, and Mayo Clinic, as well as the recent Summit, point to what looks like a new day. (See related article.) This new attitude may become formalized with the anticipated launch of an industrywide group focused on vendor credentialing – the Coalition for Best Practices in HCIR Requirements (where "HCIR" stands for "healthcare industry representative").

"The challenge for everyone is coalescing not only peer groups, but internal stakeholders within their respective organizations, around common interpretation of the requirements and guidelines that are driving [healthcare industry representative] credentialing."

– Bruce Mairose, vice chair, supply chain operations, Mayo Clinic

"People feel there's hope," says Rhett Suhre, chair of the Advanced Medical Technology (AdvaMed) working group on HCIR credentialing and director, HCIR credentialing, Abbott. "At the first Summit, there was confusion, misunderstanding and frustration. At the second Summit, the attendees discussed what requirements were the most appropriate. At this year's Summit, we discussed the work that had been done to arrive at a draft best practices document, and spent the majority of the meeting sharing best practices and working toward how to best meet the requirements.

"Everybody understands why this is needed in the industry," says Suhre. "It's all about improving patient care. If we can all understand that, we can work together on how we can best do it."

A change in mood

"The tenor and tone of Summit has changed," says Doug Cones, director, sales operations, Cardinal Health, who has attended all three Summits held since 2010. At the most recent event, there was less finger-pointing, and more working together to try to figure out the best way to meet everyone's needs. "People are listening to

all sides to make sure this process is efficient for everyone. We want to make sure there is awareness across the three constituencies – hospitals, vendors and the vendor credentialing companies – that the primary focus is patient safety, privacy, and making sure reps are adequately trained. These are things everybody gets and can agree on.

"The big change is, our reps get it and know it's part of the process," he continues.

"Overall, there's an acceptance that credentialing is here to stay," says Shawn Walker, CEO, Bay State Anesthesia, North Andover, Mass., and past president of IMDA, the specialty distributor association. This is especially true among the largest suppliers, who have devoted the resources necessary to comply with providers' requests, she points out. But the smaller and more independent the supplier, the more it tends to resist credentialing, says Walker. This is due in part to the fact that credentialing directly impacts these organizations' pocketbooks.

One also has to consider the "genetics" of many small companies, she says. "[Credentialing] chafes against the personalities of the types of organizations they are. They're independent, in many cases, because they don't want to be told what to do. And they don't like paperwork. So I would say it continues to be a struggle, especially at the independent rep level."

Disparate requirements

Sponsored by a number of manufacturers, distributors and supply-chain-related organizations, including the Health Industry Distributors Association, the Summit was the third annual such event.

"People realize credentialing is going to be there," says Kevin Connor, president and CEO, VeriREP and a key figure in organizing the first Summit, held two years ago in Niagara Falls. "The question is, 'How can we make it as seamless and inexpensive and efficient as possible?"

Vendors still experience angst due to the fact that hospitals in the same metropolitan area might be contracted with different vendor credentialing companies, requiring reps to jump through multiple hoops, he says. "The expense of credentialing wasn't the concern [of suppliers at the Summit] as much as the disparate requirements. We heard more complaints about, 'This company makes me do this, this one makes me do that.' I said that the fabric needs to remain the same throughout the industry, but everyone can embroider their competitive advantage on it."

But over time, as vendor credentialing companies became more embedded in the supply chain, they began approaching hospitals with suggestions on what they considered to be important information to capture in the credentialing process, and what they considered to be irrelevant.

Connor likens the early days of credentialing to the dot-com boom of the early and mid-1990s. Back then, a growing number of start-up companies were all but forcing vendors to use their pipeline to allow hospitals to send supply orders. Connor recalls the upheaval caused by the crazy things the dot-coms were trying to force vendors to do.

Similarly, five or six years ago, multiple credentialing companies arose, so that in a busy metro area, a rep could have four or five different subscriptions. "It was an expensive proposition," he says. "Hospitals would tell the vendor credentialing company what they wanted, and the vendor credentialing company would do it." Things got a little crazy, he says.

But over time, as vendor credentialing companies became more embedded in the supply chain, they began

approaching hospitals with suggestions on what they considered to be important information to capture in the credentialing process, and what they considered to be irrelevant. Naturally, hospitals could – and often did – decline to take their advice.

"We have to be competitive and support our customers' requirements," says Connor, whose company chose to focus on regional markets. "But if we can help them manage expectations, that's great.

"The question was brought up at the Summit: Are the hospitals driving the requirements, or are the vendor credentialing companies offering solutions to problems they don't have?" says Connor. "As time goes on, the core elements of what needs to be done will surface, and I think they're already starting to."

"There were misperceptions about what hospitals were required to do, whether they were referring to The Joint Commission, OSHA or CDC," he says. "And that was another thing we did at the Summit – provide clarity on what is and what is not required." In fact, the Joint Commission's "Frequently Asked Question," published in April 2012, was a topic of discussion. The FAQ answered the question, "What are The Joint Commission's expectations regarding non-licensed, non-employee individuals in health care organizations, including health care industry representatives?" (*See related article.*)

Best practices

Vendor credentialing companies are committed to bringing order to the credentialing process, according to those who attended the Summit.

"There were misperceptions about what hospitals were required to do, whether they were referring to The Joint Commission, OSHA or CDC. And that was another thing we did at the Summit – provide clarity on what is and what is not required."

– Rhett Suhre, chair of the Advanced Medical Technology (AdvaMed) working group on HCIR credentialing and director, HCIR credentialing, Abbott

Alignment is needed

"From the vendor/supplier side, we have to figure out the best, most efficient way, to ensure that our representatives are able to meet the requirements of our customers," says Suhre, who is on the steering committee of the Coalition. "From the provider side, I think they understand they need to align their requirements on the things that are the most important. There are certain documents reps aren't authorized to sign, so it's better if they are able to get those documents to the authorized person in the company. Credentialing provides that mechanism.

In a panel discussion, representatives from VeriREP, IntelliCentrics, Vendormate and Vendor Credentialing Service stated that aligning on a set of requirements or best practices made sense, says Suhre. "They stated that they have, in fact, been moving toward that for the last year or so. Time will tell if they're promoting alignment to best practices in their discussions with their customers."

One idea floated at the Summit was that, once the industry agrees on vendor credentialing "best practices" criteria, vendor credentialing companies offer their customers a

SutureExpress.

Brian Forsythe
President & CEO

"Complete orders tomorrow. I promise."

Ask around. With more than 7,000 suture, endomechanical and surgical products in stock, we fill and ship orders faster than anyone. Even items that others consider "non-core" are on our shelves. That's how we can guarantee an industry-best 99% fill rate to our committed customers. We promise no substitutions, no minimum orders and no hidden charges – just reliable, next-day delivery for one low shipping fee.

Say goodbye to back orders, hassles and headaches, and get all the closure you need at Suture Express. We've been putting customers first since 1998. **Call 877-790-1873 or visit www.sutureexpress.com to make the switch today.**

SUTURE EXPRESS
FILL RATE GUARANTEE
COMPLETE SELECTION

Switch today! Call now to learn how you can enjoy our unbeatable 99% fill rate guarantee.

877-790-1873 | www.sutureexpress.com

"best practices option," says Suhre. The system would be good for vendors, as it would move the industry toward standard requirements. But it would also help hospitals that are new to credentialing, and who have yet to put a process in place, he suggests. "They could see that the industry is coalescing around this set of requirements, and if they opt for this package, they will get up to speed rapidly."

In fact, organizers of the Coalition for Best Practices in HCIR Requirements have circulated a draft of recommended best practices for vendor credentialing. "It's an iterative process that began at last year's Summit," says Suhre. Borrowing from concepts proposed by the Indiana Hospital Association as well as Mairose, the committee put together the document and sent it to various organizations for vetting, including the American Hospital Association, American College of Surgeons, Association of periOperative Registered Nurses and the American College of Cardiology, among others.

"Our goal is to have a final document that we will ask people to endorse," says Suhre. But the recommended best practices will be a "living document," that is, subject to modification as circumstances dictate, he emphasizes. For example, if a disease becomes more prevalent, such that the CDC recommends that healthcare workers be vaccinated against it, the Coalition would review that and perhaps incorporate new recommendations into the best practices document. Discussions on such changes would be held throughout the year, with a final vote at the annual Summit.

There would be certain expectations of those who endorsed the final document, says Suhre. "If you were a supplier, you would do everything you need to do to ensure your representatives meet the recommendations. As a provider, you would be asked to align yourself with the best practices. And if you were a professional organization, such as the American College of Surgeons, you would advocate among your peer group that they follow the best practices recommendations."

Ultimately, the Coalition hopes to have its own website, or central repository, to house information on ongoing developments related to vendor credentialing. In the meantime, it will rely on the websites of other organizations, such as AdvaMed and the Healthcare Industry Supply Chain Institute, to store and disseminate pertinent information.

Ultimately, the Coalition hopes to have its own website, or central repository, to house information on ongoing developments related to vendor credentialing. In the meantime, it will rely on the websites of other organizations, such as AdvaMed and the Healthcare Industry Supply Chain Institute, to store and disseminate pertinent information.

"The Coalition is committed to open and ongoing dialogue between industry and healthcare providers to facilitate safe and confidential patient care by ensuring continuing access to advances in medical technology," said Ashley Palmer,

director government affairs, HIDA, in presenting the Coalition concept at the Summit. Its mission is to:

- Streamline the healthcare industry representative credentialing process for all stakeholders…
- while meeting the common goals of patient safety and confidentiality…
- through the development of industry recommendations and best practices.

It will produce educational materials and industry recommendations, said Palmer.

"The idea [behind the Coalition] is to streamline the credentialing process, reinforcing that we believe in patient safety and confidentiality and that we are committed to continue building a bridge between vendors and the supply chain through dialogue and collaboration, and ensure continuing access to medical technology," says Walker, who has been part of the discussions in forming the Coalition. "We want to give people a place where they can participate, spread the word that the industry now has an umbrella we can all sit under." What's more, the Coalition would give those involved in vendor credentialing broad recognition, "so, hopefully, we can more efficiently bring about change and standardization."

The Coalition will put more definition around, and focus on, credentialing, adds Cones, who is on its steering committee. "It will allow us to continue with the common discussion, bring more hospitals to the table, help [providers] understand our perspective, and help [vendors] understand theirs."

"My hope is that this Coalition will be seen as a multidisciplinary group that has maintained a focus on the needs and challenges of their respective constituencies, while…assuring a safe and healthy work environment within the patient care setting," says Mairose. "Also, that the group has developed standards that are consistent with the intent and spirit of collaboration and patient safety, which brings the conversation out of the extremes to the middle ground."

Shared benefits

The Coalition can lead to tangible benefits for all supply chain players, large and small, adds Suhre. One example is the development and dissemination of training modules on, for example, fire safety. "One of our goals is to take a training module that we all agree is appropriate, and make it available to everyone in the industry," he says. "We keep costs down and we're consistent, so that every rep calling on hospitals is receiving the same training.

"I want to make sure people understand, we're past the 'talking about it' stage as an industry and are actively working on mutually agreeable solutions," says Suhre. As new requirements crop up, or if compliance to a particular set of requirements is low, the industry now has a forum – with the Summits and, soon, the Coalition – to get together and figure out how to proceed in an efficient and appropriate manner.

"We're really trying to work collaboratively to solve this," he says. "We want to figure out what makes sense. If people understand that, we can begin to have that discussion." **JHC**

"My hope is that this Coalition will be seen as a multi-disciplinary group that has maintained a focus on the needs and challenges of their respective constituencies, while…assuring a safe and healthy work environment within the patient care setting."

– Bruce Mairose

Change the conversation™
from constraints to choices

You work hard to provide quality, affordable healthcare. But in the midst of a shifting healthcare landscape, it seems as if large suppliers with short-term motivations are working against you.

You need a supplier that can offer a full breadth of products and a business model that works with you, not against you. **Cook Medical fills that need as a large medical device manufacturer with the unique, customer-focused culture of a privately held company.**

Cook Medical—Giving you the choices you need without compromising your objectives.

www.cookmedical.com

COOK® MEDICAL

Attention turns back to credentialing

Recent work on vendor credentialing by the Indiana Hospital Association, The Joint Commission and Mayo Clinic indicate that the issue is on the radar of suppliers and providers, and that both are willing to get their hands dirty and address it.

"The amount of time, effort and cost that is being dedicated toward [healthcare industry representative] credentialing is significantly more than what people were experiencing in 2009," notes Terry Chang, M.D., director, legal and medical affairs, Advanced Medical Technology Association, or AdvaMed. "That has resulted in a renewed focus on reaching a mutually agreeable solution," that is, one that works for providers and vendors.

Recently, AdvaMed put together some numbers on what vendor credentialing costs the industry. Based on the number of hospitals in the country (approximately 5,754, per the American Hospital Association), the number of credentialed sales reps (an estimated 350,000), and the estimated time that suppliers and providers spend on credentialing (an estimated 240 hours per hospital per campus per year, and 40 hours per year by or on behalf of the average sales rep), the cost to the industry probably exceeds $800 million, says Chang, who has worked on behalf of AdvaMed on the vendor credentialing issue for a number of years. And that cost is being borne by both the buy and sell side of the supply chain.

The manner in which vendor credentialing is currently being carried out presents other risks.

More than cost

But cost isn't the only issue, says Chang. The manner in which vendor credentialing is currently being carried out presents other risks. Given the absence of definitive guidance from oversight or regulatory bodies, providers may have naturally tacked on additional requirements in an effort to cover their bases, he says. "But diverse and often duplicative, and sometimes inappropriate, requirements can create risks for patient safety instead of improving it. And some of these required elements for [healthcare industry representatives] present a confusing message." For example, is it necessary – or desirable – to insist that sales reps be trained on emergency evacuations of the hospital? "This is something you probably wouldn't want the [healthcare industry rep] to be directly involved in," says Chang. Rather, reps should perhaps play a supporting role at the direction of the institution.

Chang is encouraged by recent developments surrounding vendor credentialing, including The Joint Commission's recent clarification of the issue, and he applauds the work of the Indiana Hospital Association, which drew up recommended standards for credentialing late last year. "The IHA standards are a great example of collaboration," he says. "Through a series of meetings, all requirements were discussed and categorized as applicable or not applicable to each 'level' of [healthcare industry rep]. Enough detail was discussed so that the vendors know how to meet these requirements.

"One of the biggest advances is that it was recognized that if this requirement was met once, it should be sufficient for all healthcare organizations. Vendors also appreciated that the extensive work that they already do to ensure that their representatives are meeting these requirements is being recognized and accepted in an attestation letter.

"We're excited about continued dialogue and collaboration with all stakeholders, to work toward a joint solution," says Chang. In Indiana, hospital CEOs recognized that "in addition to the toll [vendor credentialing] takes on their own organizations, it involves a pool of resources that isn't infinite. Eventually, it will affect overall cost of care."

Amerinet®

COST REDUCTION

"The Amerinet Keystone Alliance saved more than a quarter million dollars last year on reference lab fees for esoteric testing alone—but membership is about so much more than great prices. Networking and regular meetings are an ongoing and invaluable resource that has enhanced operational excellence and quality-of-care across the region."

John Romano
Manager, Laboratory Services
Wayne Memorial Hospital

Listen. Create. Deliver.

As a leading national healthcare solutions organization, Amerinet collaborates with acute and non-acute care providers to listen, create and deliver unique solutions through performance improvement resources, guidance and ongoing support. With better product standardization and utilization, new financial tools beyond contracting and alliances that help lower costs, raise revenue and champion quality, Amerinet enriches healthcare delivery for its members and the communities they serve.

Amerinet. Reducing healthcare costs. Improving healthcare quality.
877.711.5700 | **www.amerinet-gpo.com/create8.aspx**

Suppliers optimistic about vendor credentialing

Work in Indiana and Minnesota, as well as The Joint Commission, are cause for hope

There may be a hint of light at the end of the tunnel for vendors wrestling with expensive and duplicative vendor credentialing standards, says Shawn Walker, CEO, Bay State Anesthesia, North Andover, Mass., and past president of IMDA, the specialty distributors association. Speaking at this summer's annual meeting of IMDA, Walker cited not only the work of the Indiana Hospital Association, but a recent clarification about credentialing from The Joint Commission, ongoing work by AdvaMed, a proposed set of credentialing standards from a major IDN, and work completed earlier this year by the Minnesota Hospital Association, as reason for optimism.

Several years ago, supplier organizations, including AdvaMed, a trade association for medical products manufacturers, worked with provider groups to try to iron out industry standards.

Suppliers' dilemma

The problem for suppliers is many-faceted, according to those with whom the *Journal of Healthcare Contracting* spoke. For one, the cost to vendors of getting their reps credentialed grows along with the number of facilities they call on and the number of vendor credentialing firms with which they have to deal. Second, the requirements of credentialing may vary from hospital to hospital. And third, the criteria for credentialing have multiplied, which presents implications for patient safety.

"The more hospitals ask you to read and sign off on, the less likely the rep is to remember it all," said Walker. "That can present repercussions." What's more, there have been reports of service personnel being denied access to certain areas of the hospital because they lacked credentials.

Several years ago, supplier organizations, including AdvaMed, a trade association for medical products manufacturers, worked with provider groups to try to iron out industry standards, says Walker. But the economic downturn and then healthcare reform forced the issue to the back burner. "But it's starting to be addressed now," she adds. (*See related article.*)

Indiana Hospital Association

Late last year, the Indiana Hospital Association drew up a set of recommended vendor-credentialing guidelines for its members in an effort to gain statewide consistency in their credentialing requirements. (The guidelines may be viewed on IHA's website at http://www.ihaconnect.org/about/moreinformation/unlockeddocs/d97363.aspx.)

"Representatives of medical device manufacturers approached the IHA with concerns about inconsistency in the policies and practices hospitals require of them," explains Kathy Wallace, director of performance improvement. Some examples: repeat PPD (tuberculosis skin) tests, duplicative training in life safety code issues and repeat criminal background checks.

"The companies sought a solution whereby they can comply with the necessary medical tests, background checks and training required by the various regulatory bodies, but to do so in a manner in which the requirements will not have to be unnecessarily repeated, and their personal medical and background information will be safely held," she says. Vendors initially sought a legislative solution to address the situation. "While the IHA opposed the legislation, we understood their concerns and initiated meetings with them to find a mutually beneficial solution."

So last year, the IHA assembled a task force consisting of eight hospital CEOs from across the state, representing various sizes of institutions. "Our goals were to provide clear interpretation of regulatory and accrediting body requirements, and provide guidance to hospitals regarding a standard practice for vendor credentialing," says Wallace. What followed was a series of meetings involving the CEOs, vendor representatives, supply chain executives and risk managers. "At each step along the way, we received input and tweaked our original recommendations." Consensus was reached, and the Indiana Hospital Association board passed a resolution encouraging facilities to adopt standard guidelines.

"We found common ground much sooner than we both thought might happen," says Wallace, referring to vendors and hospital representatives. "I think it relates back to our agreement to work as partners and understand each other's needs."

No universal passport

The task force did discuss vendors' desire for a "universal passport," that is, one set of standards and one pass that could gain them entrance into any hospital. "We understood that requiring individual [sales reps] to undergo multiple tests and/or complete extremely similar requirements for every hospital across the nation just increases the cost of supplies," says Wallace. "That being said, every organization will have some individual requirements that must be clearly understood and acknowledged by [sales reps] in order to maintain the safety of the patients. This might include something as simple as understanding the emergency codes and exit routes. Maintaining the safety of the patient and those within our facilities is our first concern."

"Our goals were to provide clear interpretation of regulatory and accrediting body requirements, and provide guidance to hospitals regarding a standard practice for vendor credentialing."

– Kathy Wallace, director of performance improvement, IHA

The guidelines address the following areas:

- Employment verification.
- Liability insurance.
- Criminal background check.
- Immunization.
- Training in bloodborne pathogens and OR protocol (for reps in sterile areas).
- HIPAA training.
- Training in an applicable code of ethics.
- Product training/competency.
- Fire safety training.
- Training in product complaints and medical device reporting requirements.

The association concluded that the following may be omitted from recommended requirements:

- Confidentiality declaration.
- Conflicts-of-interest documentation.
- False claims.
- Gift disclosure form.
- Non-exclusion documentation (OIG).
- Office of Medicaid Inspector General (OMIG).
- Business associates agreement.
- Substance abuse testing.
- Electrical safety training.
- National patient safety goals.
- Professional certification/state licensure.
- Tissue/bone rep FDA registration/approval.

"Overall, the reaction from members has been very positive," says Wallace. The hospital association has committed to meet jointly with the vendor community on a regular basis to review concerns from both sides. Supply chain executives will be included in those discussions.

Minnesota

While the Indiana Hospital Association was at work on credentialing, so too was the Minnesota Hospital Association. And while the association didn't issue a ringing endorsement for vendor credentialing standards, its "Vendor Credentialing Report," published in January, offers hope to vendors willing to read between the lines.

The report had been mandated in 2010 by the state legislature, which called for the hospital association, in conjunction with the Minnesota Credentialing Collaborative, to make recommendations by January 2012 "on the development of standard accreditation methods for vendor services provided within hospitals and clinics." According to the report's authors, "This legislation was in response to a legislator's constituent concern that the vendor credentialing process was overly burdensome and that each hospital had its own unique and different set of requirements."

As part of its research, the hospital association surveyed its members about credentialing. Of the 84 that responded, 68 percent (primarily larger facilities) reported having a vendor accreditation process in place. Of that 68 percent, 73 percent said they used a national vendor accreditation company, and 26 percent said they had an internally developed process.

Healthcare isn't alone

The report points out that the healthcare industry is not alone in requiring vendors to be credentialed. "Food processing manufacturers, oil refineries and banking all require a very high level of security and scrutiny before a vendor representative may attempt to sell a product or service," according to the authors. "[I]t is the hospital administration's responsibility to manage access to the hospital campus so that everyone is safe and care processes are not disrupted." Vendor credentialing helps hospitals achieve that goal.

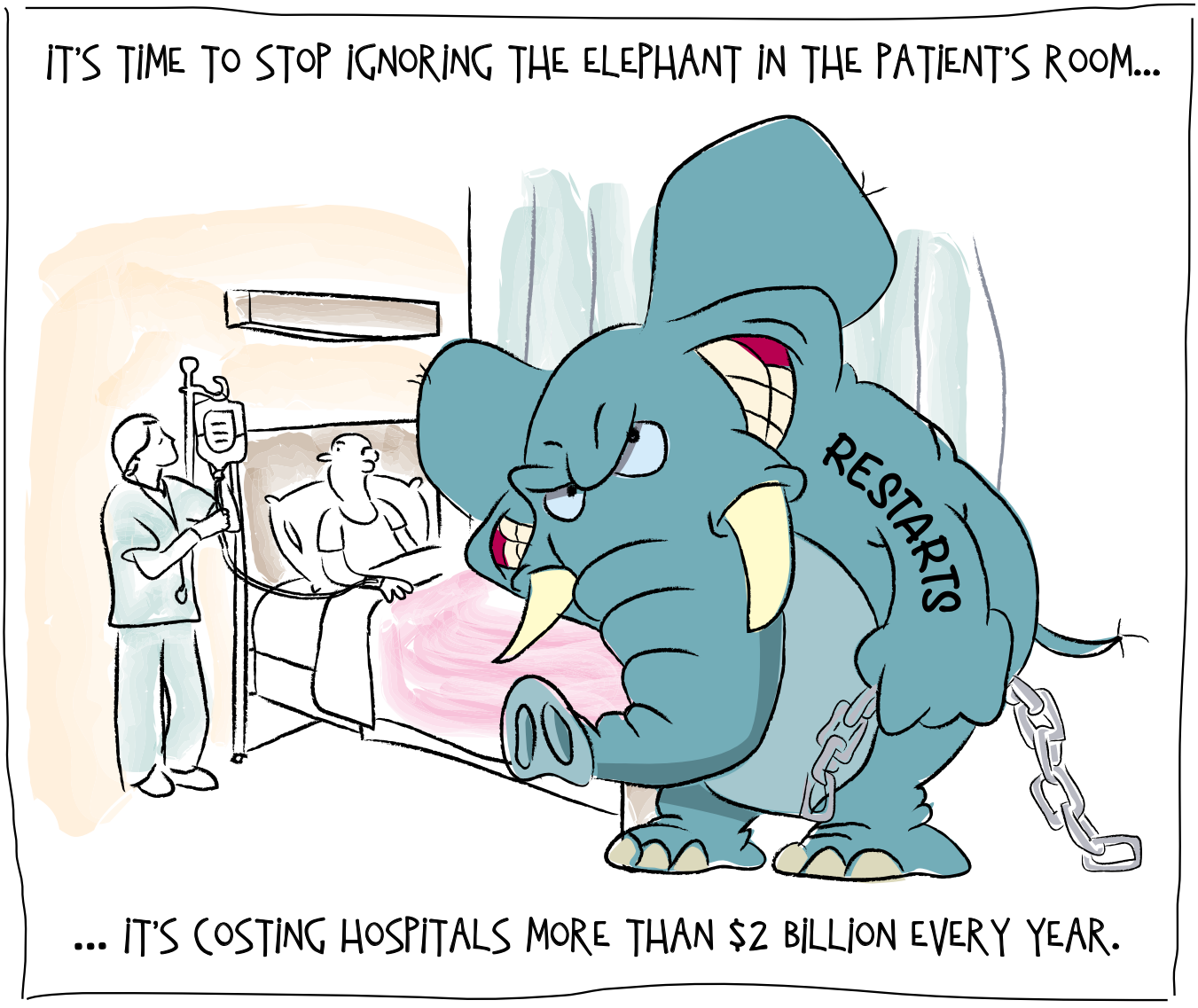
"Credentialing is also a step in managing the supply chain and therefore managing costs for the hospital."

The report points out that the healthcare industry is not alone in requiring vendors to be credentialed.

"There is a need to manage vendor credentialing, communication, and facility access," says Jim Van Drasek, system director materials management, HealthEast Care System, Saint Paul, Minn., and a member of the work group that helped produce the document. "This is increasingly important as we drive product and contract standardization and corporate value analysis program selection processes to ensure that those decisions are not undermined.

"The vendor management companies can provide an effective service to assist with this. However, it is the organization personnel that must ensure that we have compliance. Staff must identify vendors that are not complying and do not follow our organization's procedures. They need to take action and communicate situations to Materials Management so that appropriate action can be taken."

In its report, the Minnesota association encourages hospitals and healthcare systems to post their vendor requirements on their websites. But it is its second recommendation that signals openness to the concept of standardization. "[T]he current work being done at the national



The cost of unscheduled PIV restarts can no longer be ignored!

Unscheduled peripheral IV restarts cost hospitals over two billion dollars every year! Some experts peg it at double that amount. Facts to consider:

- 90% of all patients receive a PIV during their hospital stay
- There are an estimated 128 million unscheduled restarts per year
- Inserting and troubleshooting a peripheral IV averages $23 in nursing labor costs
- US hospitals spend an average of $2,800 per bed on unscheduled restarts
- IV complications are one of the top causes for patient/hospital lawsuits
- IV restarts are one of the main reasons for patient dissatisfaction

Most unscheduled restarts are preventable.

CENTURION
MEDICAL PRODUCTS
www.sorbaviewshield.com

Data on file at Centurion Medical Products.

level to develop common standards should continue," conclude the report's authors. "This work by AdvaMed, providers and others in the health care industry has Minnesota participation and should be encouraged to continue. This national effort could provide a model which would facilitate vendor credentialing standards across state lines."

The Joint Commission

Another big development in recent months was The Joint Commission's decision to publish a "Frequently Asked Question" about credentialing on its website this spring. (See http://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQChapterId=66&StandardsFAQId=410.) Several years ago, The Joint Commission had declined to draw up guidelines for vendor credentialing. Meanwhile, some hospitals were under the impression that the organization required them to have a credentialing system in place.

"The problem is, the demonstration of competency is never made by a disinterested third party, only by the party giving the training, that is, the company itself."

– Robert Wise, M.D.

In the FAQ, The Joint Commission states that it does not require credentialing of sales reps (or "health care industry representatives," which is the term it uses for sales reps.). But it makes clear that its primary concern is the competence of sales reps calling on hospitals, particularly those who have an impact on patient care, or who offer training and guidance on the use of medical devices.

Much of the credentialing being done today on behalf of hospitals and hospital systems addresses such things as adherence to infection control protocols, criminal background, etc., explains Robert Wise, M.D., medical advisor to the Division of Healthcare Quality Evaluation at The Joint Commission. "While these are important issues to anybody coming into a hospital, these areas do not help determine if the rep is qualified to train and advise clinicians on products and procedures."

To that end, Wise and others at The Joint Commission held discussions with industry associations, including AdvaMed, about how vendors establish the competency of their reps in the field. "As we looked deeper, we verified that the people being sent [into hospitals] are in fact undergoing some type of internal training process," says Wise. "The problem is, the demonstration of competency is never made by a disinterested third party, only by the party giving the training, that is, the company itself." Nor at this time did it seem that any independent certification of competency was forthcoming. Given that, hospitals will continue to have difficulty making an independent judgment of the competency of the reps who call on them, he says.

In the FAQ, The Joint Commission cites minimum standards healthcare organizations should address for what it refers to as "non-licensed, non-employee individuals," including sales reps:

- Ensure that patient rights are respected, including communication, dignity, personal privacy and privacy of health information.
- Obtain informed consent in accordance with organization policy.
- Implement infection control precautions.
- Implement patient safety program.

"Accredited health care organizations may choose to apply other Joint Commission standards and/or more stringent requirements for these individuals as they see fit," says the FAQ.

Mayo Clinic

While these developments were unfolding, Mayo Clinic was at work drawing up suggested standardized requirements for the credentialing of healthcare industry reps, in hopes that other providers would consider adopting them as well. "We have always taken supplier credentialing very seriously," says Bruce Mairose, vice chair, supply chain operations, who crafted the guidelines.

More than 10 years ago, the Rochester, Minn.-based IDN worked with pharmaceutical representatives on a similar program. "When supplier credentialing came along for the larger segment of the industry, it was a natural extension of what we needed to do, to ensure we were creating a safe and healthy environment for ourselves and our patients."

SERIOUS SERVICE

- National Sales Support
- Global Manufacturing
- Marketing Support for Product Standardization
- Knowledgeable Staff
- Dedicated Management





STRONG BRANDS

DUKAL CORPORATION · Caliber · DUKAL Basic Care · DUKAL Spa Reflections · DUKAL Suave · Dawn Mist · RESIST-A-BAND · Wavelength

PASSION. PARTNERSHIP. POSSIBILITIES

DUKAL Corporation • Ronkonkoma, NY 11779 • 631-656-3800 • www.dukal.com

Mairose got involved in the credentialing issue in order to simplify the process within Mayo Clinic, and to try to control credentialing-associated costs for providers and suppliers. "Keep in mind, Mayo Clinic operates across eight states," he says. "Some are taking it upon themselves to regulate or set up their own rules; others already have unique requirements in place, which can be very complicated for Mayo. It's important for us to manage a single program," that is, one that can be applied in all of Mayo's 130-plus legal entities.

Mayo faces some internal vendor-credentialing-related challenges as well. The infection control department, for example, has slightly different expectations of vendor credentialing than, say, risk management. "My thought was, if we can refine the interpretation of the requirements across our own organization, and [tap into] resources across the industry – such as the American College of Surgeons, The Joint Commission, and the Centers for Disease Control and Prevention – we'd be a lot further along," says Mairose.

Based on the work of the Indiana Hospital Association, Mayo's recommended guidelines spell out what the IDN expects of its suppliers in terms of immunizations, training, background checks, etc. In addition, it offers a clear "escalation process" should vendors fail to meet these expectations. "It's only fair that we make sure suppliers are aware of our expectations," says Mairose.

The exercise of drawing up recommended guidelines was an education in itself, says Mairose. "We found we were making some of the same errors that many in the industry do." For example, Mayo, like other IDNs, has at times included clauses in vendor-credentialing agreements that are more appropriately handled in contracts, such as provisions regarding price increases.

Although suppliers may dream of a so-called "universal passport," which would give them access to any and all healthcare organizations, "there will always be interpretation," says Mairose. That said, industry guidelines can reduce some of the extreme positions that hospitals and IDNs have taken to manage their risk. In the process, vendor-credentialing costs for the entire industry – providers and suppliers – may be reduced.

Safe and healthy environment

"In terms of the cost to the supplier, I think it's important our supply partners understand that we're trying to create a safe and healthy environment for our patients," says Mairose. "We're not asking our vendors to do anything that we don't require our employees to understand, know and do."

The suggested standardized requirements for healthcare industry representative credentialing recognizes three classes of sales reps, each with its own set of credentialing requirements:

- **Level 1 reps:** that is, those who do not have access to clinical areas, do not provide technical assistance, do not operate equipment, do not enter patient care areas, and do not provide assistance or consult with patient care staff or clinicians. In general, Level 1 reps are not required to provide any credentials or documentation, though they would be required to wear a name tag and be accompanied by a credentialed representative.

- **Level II reps:** Those reps with access to the patient care environment excluding sterile or restricted areas. They serve primarily in a technical support role or product and service sales role. They may work in patient care areas where other visitors may be present, or they may provide assistance to or consult with patient care staff.

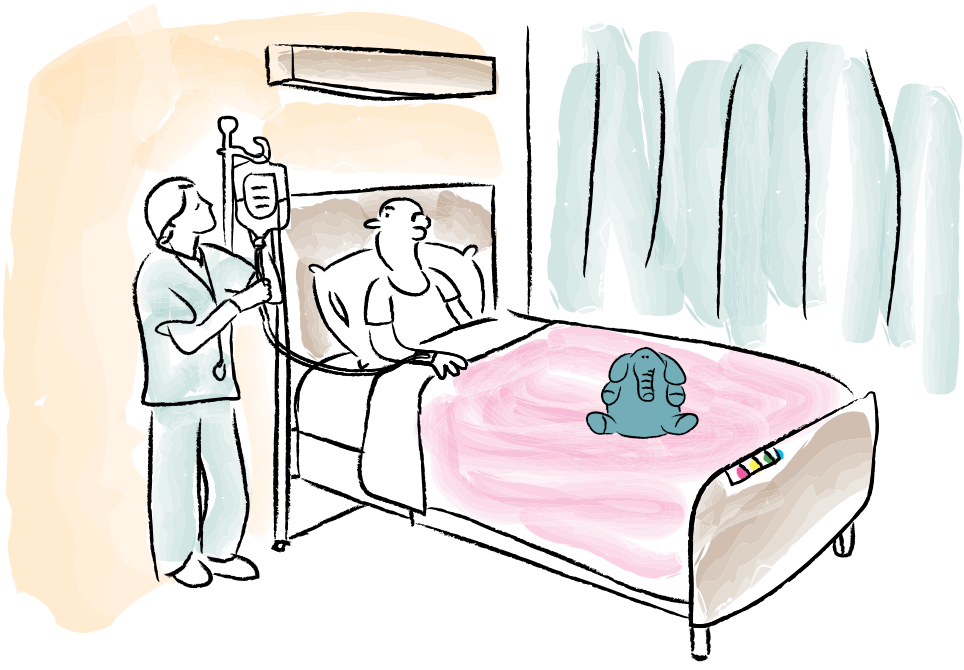
- **Level III reps:** These reps have access to the patient care environment, including sterile or restricted areas. They serve primarily in a clinical support or product sales/service role while attending or observing patient procedures.

Some provisions of the suggested standardized guidelines, for Level II and III reps, include:

- **Proof of liability insurance.** The guidelines call for reps or their employer or principal to provide proof of general liability insurance coverage in the form of either a certificate of insurance or a memorandum, or other written documents confirming the existence of insurance coverage through either a third-party insurer or a self-insurance program.

- **Proof of criminal background check.** Privacy concerns dictate that these records should be handled and maintained by the employer, says Mairose. Recommended is a letter from the employer attesting that background verification was performed for each representative upon

UNSCHEDULED PIV RESTARTS COST HOSPITALS AN AVERAGE OF $2,800 PER BED PER YEAR.



PROPER CATHETER SECUREMENT IS THE KEY TO SHRINKING THESE COSTS... AND THE ELEPHANT IN THE ROOM.

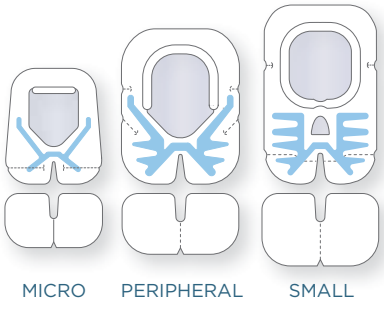
Most unscheduled restarts are preventable.

Studies show that most unscheduled restarts are caused by catheter movement or dislodgement due to inadequate catheter securement.

- SorbaView® SHIELD is the only securement product clinically **proven to reduce unscheduled restarts by as much as 90%**[1]
- SHIELD's patented design combines the best securement dressing available with a built-in manufactured stabilization device
- SHIELD's superior performance and ease of application:
  - Creates a consistent standard of securement for every PIV
  - Improves nursing efficiency and patient safety
  - Improves quality of care and patient comfort
  - Reduces complications and costs
- According to a study published in the *Journal of Infusion Nursing*, "The material and labor cost savings associated with longer dwell times, fewer restarts, and fewer complications have been shown to offset the added cost of [a] stabilization device."[2]

The evidence is overwhelming. Proper catheter securement saves money and improves quality of care.

It's time to break from the herd and use SorbaView SHIELD on all your PIVs.



CENTURION
MEDICAL PRODUCTS
www.sorbaviewshield.com

Data on file at Centurion Medical Products.

[1] Flippo, P, Lee, J (2011). Clinical Evaluation of the SorbaView SHIELD Securement Device Used on Peripheral Intravenous Catheters in the Acute Care Setting. *Journal of the Association for Vascular Access*, 16(2), 2011, 95.

[2] Bausone-Gazda D, Lefaiver CA, Walters SA (2010). A randomized controlled trial to compare the complications of 2 peripheral intravenous catheter-stabilization systems. *Journal of Infusion Nursing*, 2010, Nov-Dec; 33(6):371-84

Centurion® SorbaView® SHIELD U.S. Patent Nos. 6,841,715; 7,294,752 and 8,053,624

hire and that action would be taken subsequently, if warranted. The scope of the background check should be provided as an attachment. If the rep's employer does not perform the background check that meets the standard, a background check conducted by a recognized third party, such as a vendor credentialing company, would be acceptable.

- **Recommended training credentials include:** bloodborne pathogen training, HIPAA training, and product training/competency verifications. In addition, the Level II or III rep should have a letter from the employer verifying that the rep has been trained on policies and procedures consistent with a nationally recognized code of ethics.

- **Level II reps** would provide proof of tuberculosis testing and immunization against influenza, while Level III reps would provide proof of those as well as immunization against MMR, varicella or chickenpox, tetanus/TDaP, and hepatitis B, or declination.

The following would be excluded from credentialing of general healthcare industry reps, per the recommended guidelines:

- Written acceptance of a confidentiality declaration, conflict-of-interest documentation, or false claims (all of which are contained in the code of conduct, on which reps are trained, or which are better suited for contract terms).

- U.S. Department of Health & Human Services Office of the Inspector General (OIG) non-exclusion documentation (applicable to individuals and entities currently excluded from participation in Medicare, Medicaid and all other federal healthcare programs.) Rationale for this exclusion: This is better suited for a contract term; an attestation by the representative does not eliminate the requirement for the healthcare provider to comply with these regulations. Mayo does its own checks on an ongoing basis.

- Business associate agreement, unless the rep or employer meets the definition of a business associate. Rationale: A rep is not authorized to sign a business associate agreement on behalf of his or her employer.

- Substance abuse testing. Only the National Institute of Drug Abuse five-panel drug screen should be required and only at the time of hire, unless prohibited by law, recommends Mairose. If there is cause for additional drug screening, the rep's employer is required to follow its drug screening process.

- Electrical safety training. Rationale for exclusion: Reps are not employees of the healthcare organizations upon which they call, and some liability would exist if they were to act.

- Fire safety training. Though general awareness of fire safety is recommended, reps should not be required to train on each healthcare organization's fire safety protocol, per the recommended guidelines. Rather, they should follow the instructions of the staff.

- National Patient Safety Goals. Rationale for exclusion: These are intended for healthcare professionals, not for sales reps. (On another note, while important to the organization, Mayo does not require representatives to read its strategic plan, says Mairose.)

- Professional certification/state licensure. Rationale for exclusion: This is only relevant for those practicing medicine, and/or it is covered in the definition of "contracted clinical healthcare industry representative," says Mairose.

- Tissue/bone rep FDA registration/approval. Rationale: This is appropriate for very specific reps only.

- Business- or contract-related terms. These should be negotiated at the time of the business agreement.

"The real inherent value of the recommendations is in creating a critical mass within the industry to implement them," says Mairose. **JHC**

THE BUSINESS OF HEALTHCARE TRANSFORMED℠

Transform your processes and systems with proven best practices.

Parallon's Supply Chain Solutions has successfully transformed over 170 facilities with its shared services platform, resulting in over $1 billion in documented savings. With more than 10 years of progressive experience, the strength of Parallon is our people, processes and proven results.

As fellow operators, we have daily accountability to deliver—hundreds of hospitals are counting on us. No other consultant can say that.

Contact us at 615.807.8000 or business.solutions@parallon.net
and take your operations to the next level.

PARALLON
BUSINESS SOLUTIONS℠

HealthTrust Purchasing Group • Supply Chain Solutions • Business Performance Group • Workforce Management Solutions

Catheter-associated urinary tract infections

Education, product and teamwork help Mercy Medical Center reduce CAUTIs

Editor's Note: *In the United States, 75 percent of all healthcare-acquired infections are either urinary tract infections, surgical site infections, bloodstream infections or pneumonia, according to The Joint Commission. Experts believe that many of these infections are largely preventable when evidence-based practices are followed consistently over time. Recently a joint "call to action" to move toward the elimination of healthcare-acquired infections was set forth by a number of organizations, including the Centers for Disease Control and Prevention, the Association for Professionals in Infection Control and Epidemiology, the Society for Healthcare Epidemiology of America, and the Infectious Diseases Society of America. Understanding and tackling healthcare-acquired infections is a complex process. Although contracting executives won't be clinical experts on the topic, they can play an important role in the fight against infections. In Part 1 of a multipart series on infection control topics, the* Journal of Healthcare Contracting *focuses on central-line-associated bloodstream infections.*

Striving for a 50 percent reduction in catheter-associated urinary tract infections is not an unrealistic goal, says Rich Lyon, BA, MA, JD, RN, CIC, infection control coordinator for Mercy Medical Center in Canton, Ohio. But for Lyon and the team at Mercy, it's only the beginning.

"We've nearly reached that goal [of 50 percent reduction], and have set our targets on 'zero tolerance,'" says Lyon. In the meantime, he and the Mercy team are watching with pride the steady downward curve of the incidence of CAUTIs in their facility.

A catheter-associated urinary tract infection is caused by germs that enter the urinary system through a catheter that has been inserted into the bladder to drain urine, according to Partnership for Patients, a public-private entity created in April 2011 by the Department of Health and Human Services in an attempt to make hospital care safer and less costly. These

infections affect the bladder, and may also affect the kidneys. Urinary catheters are used in almost all hospital patients receiving major surgery and in many other situations. In recent years, up to 560,000 healthcare-associated urinary tract infections have occurred annually, 40 percent of which are preventable, according to Partnership for Patients.

"Patient safety concern alone is a good enough reason to establish protocols to reduce the incidence of CAUTIs, but now there is definitely a financial incentive as well," says Michelle Christiansen, MS, PA, clinical resource team, urology, Medline Industries Inc. "CAUTI can have a significant impact on a health system's bottom line and, given the frequency of these infections, costs add up quickly.

"Research shows that CAUTI increases hospital costs and length of stay," continues Christiansen, whose company offers the ERASE CAUTI

program, which encompasses education, a new tray design, and implementation process. "Research also shows that these infections can, in some cases, be deadly."

CAUTIs are patient-safety indicators and are publicly reported, says Christiansen. What's more, as of 2008, these preventable infections are no longer reimbursable by the Centers for Medicare & Medicaid Services, as a result of the Medicare Modernization Act of 2003 and the Deficit Reduction Act of 2005. "Hospitals and patient care providers are under more pressure than ever to prevent CAUTIs, and their rates need to be trending towards zero," she says.

CAUTI reduction program

Mercy's efforts to eradicate catheter-associated urinary tract infections began in late fall 2011, explains Lyon. "We were dissatisfied with our own performance compared with the [National Healthcare Safety Network] measures," he says. (The NHSN is a Centers for Disease Control and Prevention reporting program, which allows healthcare facilities to electronically share information regarding the safety of patient and healthcare personnel.)

The hospital established a CAUTI reduction team, which included infection control, nursing and urology. Step 1 was to review where Mercy stood with UTI events during the previous 12-month period, says Lyon. Step 2 was to talk with Mercy's prime vendor, Medline Industries, about potential solutions, including the company's one-layer Foley catheter kit.

Older kits stack their components, so that the nurse must take them out, stack them somewhere on the sterile field, and retrieve them as needed, explains Lyon. "That's inconvenient for the nurse, and nurses have so much more to do now than they did in the past." In contrast, Medline's kit is in one layer, so nurses don't have to stack or unstack anything.

Choosing a catheter wasn't difficult, he says. "We wanted to go latex-free, which we had prior to this. And we wanted silver-coated catheters because of their antimicrobial action." Medline offered both, and Mercy proceeded to trial the kit in three patient care units.

After a successful trial, the new product (and mandatory training program) was rolled out to the rest of the hospital. A baseline of CAUTI occurrence data had already been collected prior to the changes, so patient care managers and directors could see their performance on a unit-by-unit basis.

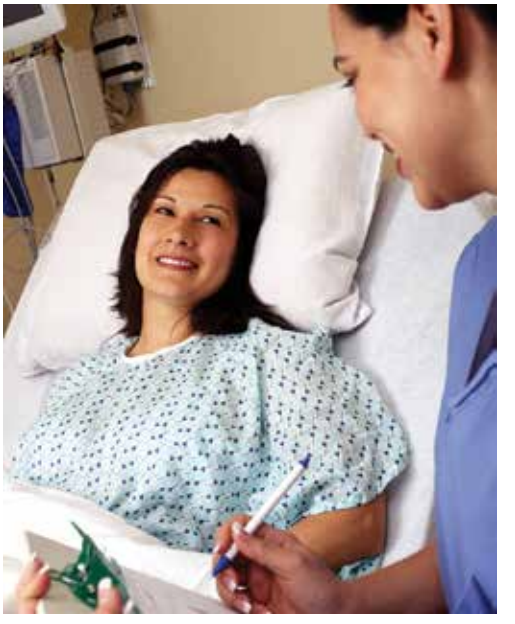
Training

Lyon was especially attracted to the ERASE CAUTI online training program. All staff involved in inserting Foley catheters or in Foley catheter care were instructed to view the online training modules and take tests on the material presented. They were able to access the modules via terminals at the hospital (including those in the medical library) and on their home computers.

> **"Hospitals and patient care providers are under more pressure than ever to prevent CAUTIs, and their rates need to be trending towards zero."**
>
> **– Michelle Christiansen, MS, PA, clinical resource team, urology, Medline Industries Inc.**

After three or four days, each additional day that a Foley catheter is in, the risk of infection increases by 5 to 8 percent, says Lyon, citing studies. So Mercy stressed education on insertion technique, particularly in the emergency department and the OR. In the ICU, where many catheter-associated urinary tract infections occur, the emphasis was on post-insertion catheter care. That means cleaning of the insertion site at least daily, and more if the patient's condition necessitates it; and discontinuing catheterization as soon as possible.

"With any major change in products, you will often encounter misgivings or resistance by the end-user staff," says Lyon. "It is crucial that they be provided adequate product change rationale and support training to help ease the transition." In fact, when asked to identify the single most important factor in Mercy's success in reducing CAUTIs, he answers, "Education, education, education, reinforcement and continual performance feedback to the nursing staff and physicians."



used, how it must be cared for, and that it needs to be removed as soon as circumstances will allow," he says. The ERASE CAUTI kits include a patient education card which explains, in English and Spanish, why the Foley has been used and if it's still needed.

"This education card encourages a patient to become an advocate in their own care," says Christiansen. The card reviews information such as, "What is a urinary catheter?" and "What you should know about your catheter." It also reviews ways the patient can reduce the risk of acquiring a catheter-associated urinary tract infection, including washing their hands and asking their doctor daily if the catheter is still clinically needed. "If the catheter can be removed from the patient when it is no longer needed, their risk of getting an infection is dramatically decreased.

"One of the biggest misconceptions regarding catheterization is that nothing can be done to prevent CAUTI, because the colonization of bacteria is inevitable," she says. "Going up against that mindset is quite the obstacle."

But with training, teamwork and the right products, hospitals and patients can overcome it. **JHC**

"Studies have shown that often physicians don't know a Foley has been placed in a patient, or that its use has been continued beyond necessity."

– Rich Lyon, BA, MA, JD, RN, CIC, infection control coordinator for Mercy Medical Center

Physicians and patients

Nurses and OR techs aren't the only ones involved in Mercy's CAUTI reduction program. Physicians and patients are part of the program as well.

"Studies have shown that often physicians don't know a Foley has been placed in a patient, or that its use has been continued beyond necessity," says Lyon. That's why, after 48 hours of catheterization, Mercy places a reorder sheet, which reminds the doctor that a catheter's additional usage time must be ordered.

Patients themselves can play a role in reducing catheter-associated urinary tract infections, he continues. "It is important that the patient understand why the Foley is being

You Shouldn't Have To Pay More to Get What You Really Want.

ICU Medical provides you with a complete line of clinically-proven and customizable products that can cost you less than other companies' stock offerings. Why pay more to get less?

You want products and solutions that fit the way you work. ICU Medical delivers. We have a complete line of some of the world's safest, most reliable medical devices and systems for infusion therapy, oncology, and critical care applications that are fully customizable to fit your specific clinical needs. You can choose from needlefree vascular access devices and sets, closed preparation and delivery systems for hazardous drugs, advanced sensor catheters, hemodynamic monitoring systems, and closed blood sampling systems—all delivered just the way you want them, just when you need them.

Infusion Therapy

Oncology

Critical Care

Save time, save money, reduce SKUs, and streamline your inventory levels. Contact us today to find out how.

icumedical
human connections

800.824.7890 | www.icumed.com

New CAUTI patient safety goal

The Joint Commission's newest National Patient Safety Goal addresses catheter-associated urinary tract infections

The Joint Commission established its National Patient Safety Goals (NPSGs) in 2002 to help accredited organizations address specific areas of concern in regard to patient safety. The first set of NPSGs was effective Jan. 1, 2003.

The organization approved one new National Patient Safety Goal (07.06.01) for 2012, addressing catheter-associated urinary tract infection for the hospital and critical access hospital accreditation programs.

The NPSG calls on providers to implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections, and refers providers to guidelines established by the Society for Healthcare Epidemiology of America and the Centers for Disease Control and Prevention. Following is from the goal.

Elements of performance for NPSG.07.06.01

1. During 2012, providers should plan for the full implementation of the NPSG by Jan. 1, 2013, says The Joint Commission. Planning may include a number of different activities, such as assigning responsibility for implementation activities, creating time lines, identifying resources, and pilot testing.

2. Insert indwelling urinary catheters according to established evidence-based guidelines that address the following:
- Limiting use and duration to situations necessary for patient care.
- Using aseptic techniques for site preparation, equipment and supplies.

3. Manage indwelling urinary catheters according to established evidence-based guidelines that address the following:
- Securing catheters for unobstructed urine flow and drainage.
- Maintaining the sterility of the urine collection system.
- Replacing the urine collection system when required.
- Collecting urine samples.

4. Measure and monitor catheter-associated urinary tract infection prevention processes and outcomes in high-volume areas by doing the following:
- Selecting measures using evidence-based guidelines or best practices.
- Monitoring compliance with evidence-based guidelines or best practices.
- Evaluating the effectiveness of prevention efforts.

Note: Surveillance may be targeted to areas with a high volume of patients using in-dwelling catheters. High-volume areas are identified through the hospital's risk assessment as required in IC.01.03.01, EP 2.

A panel of patient safety experts advise The Joint Commission on the development and updating of NPSGs. This panel, called the Patient Safety Advisory Group, is composed of nurses, physicians, pharmacists, risk managers, clinical engineers and other professionals who have hands-on experience in addressing patient safety issues in a wide variety of health care settings.

Source: The Joint Commission, http://www.jointcommission.org/assets/1/6/NPSG_Chapter_Jan2012_HAP.pdf

Average annual cost

$23,999[1]

Polymer stents
repeated changes required

$13,605

Resonance Metallic
Ureteral Stent

Cost savings with Resonance

$10,394[1]

1. López-Huertas HL, Polcari AJ, Acosta-Miranda A, et al. Metallic ureteral stents: a cost-effective method of managing benign upper tract obstruction. *J Endourol.* 2010;24(3):483-485.

Change less. Save more.

The Resonance® Metallic Ureteral Stent's optimized compressive and radial strengths allow the stent to remain indwelling for up to 12 months, providing continuous renal drainage. The longer indwelling time also minimizes the need for multiple stent placements and the complications associated with frequent stent exchange.[1]

Cook Medical—Pioneering urological products for a physician to use and a patient to trust.

www.cookmedical.com

COOK MEDICAL

Resonance®

METALLIC URETERAL STENT

AORTIC INTERVENTION | CRITICAL CARE | ENDOSCOPY | INTERVENTIONAL RADIOLOGY | LEAD MANAGEMENT | PERIPHERAL INTERVENTION | SURGERY | UROLOGY | WOMEN'S HEALTH

On the CUSP

The Centers for Disease Control and Prevention estimates that roughly 2 million healthcare-associated infections occur each year in U.S. hospitals. These infections are said to result in approximately $40 billion in excess healthcare costs and as many as 99,000 deaths.

In 2009, the Department of Health and Human Services launched the HHS Action Plan to Prevent Healthcare-Associated Infections. As part of this plan, the Agency for Healthcare Research and Quality increased support for and scope of a project funded in 2008 to reduce central line-associated bloodstream infections, and funded a second initiative to reduce catheter-associated urinary tract infections. Both of these projects, "On the CUSP: Stop BSI" and "On the CUSP: Stop CAUTI," apply the Comprehensive Unit-based Safety Program (CUSP) to improve the culture of patient safety and implement evidence-based best practices to reduce the risk of infections.

The national "On the CUSP: Stop CAUTI" effort began in 2009 with support from the Agency for Healthcare Research and Quality. Its goal was to reduce mean rates of catheter-associated urinary tract infections in participating clinical units by 25 percent.

On the CUSP: Stop CAUTI

In 2007, the Michigan Health and Hospital Association Keystone Center for Patient Safety & Quality implemented a project to reduce CAUTI, the most common of all healthcare-associated infections, in 163 inpatient units in 71 Michigan hospitals. The project implemented two separate bundles, one of which emphasized the timely removal of nonessential catheters and the proper care of necessary catheters, while the second bundle addressed the insertion of catheters, that is, appropriate indications and proper insertion technique. Participating hospitals achieved a reduction in indwelling catheters from 19 percent to 14 percent between January 2007 and December 2010, resulting in an estimated 26 percent reduction of patients with urinary catheters and a 30 percent improvement in appropriate catheter use.

The national "On the CUSP: Stop CAUTI" effort began in 2009 with support from the Agency for Healthcare Research and Quality. Its goal was to reduce mean rates of catheter-associated urinary tract infections in participating clinical units by 25 percent. "Stop CAUTI" looks to the work of the MHA Keystone Center as a model and uses the CUSP framework developed at Johns Hopkins to address culture change. Since the nationwide launch in late 2010 of "On the CUSP: Stop CAUTI," more than 20 states have joined the initiative.

The Partnership for Patients, a public-private partnership led by the Department of Health and Human Services, has identified CLABSI and CAUTI as two of ten hospital-acquired conditions to be reduced by 40 percent by 2013. The 26 Hospital Engagement Networks (HENs), established by the Partnership for Patients and supported by the Centers for Medicare & Medicaid Services, will lead learning collaboratives and provide technical assistance for hospitals, and will develop mechanisms for monitoring hospitals' progress toward providing safer care for their patients.

Source: National Implementation of the Comprehensive Unit-based Safety Program to Eliminate Healthcare-Associated Infections, www.onthecuspstophai.org.

Medtronic

Looking for more?

At every stage of care, Medtronic provides comprehensive heart failure management solutions for high quality patient outcomes, while reducing costs and variation in care.

medtronicCVG.com

Cardiac and Vascular Group at Medtronic | Breadth. Value. Unimagined Opportunity.

Numbers Don't Tell All

Reports that hospital systems are losing as much as $100,000 annually on every physician they employ may be exaggerated. Nevertheless, hospital executives can and should take steps to help maintain the profitability and efficiency of the practices they acquire.

Reports on huge losses sustained by hospitals related to physician practices may not be as alarming as they look, says Peggy Naas, M.D. MBA, vice president, physician strategies, VHA, speaking with the *Journal of Healthcare Contracting*. Even practices that were profitable prior to the acquisition can look like money-losers, depending on how the bookkeeping is done. (Of course, physician practice management professionals should ensure that practices are run efficiently, she adds.)

Peggy Naas

"There has to be a clear understanding of the value of the practice, and what is an appropriate competitive salary, so the health system is not overpaying [for the practice]."

– Peggy Naas, M.D. MBA, vice president, physician strategies, VHA

If hospital or IDN administrators consider only the revenues the physician realizes from seeing patients, they may believe that a physician is losing money, says Naas. In other words, on paper, at least, the expenses associated with employing that physician may exceed patient revenues. Those expenses include salary, malpractice insurance, employee benefits, and all the other services offered for the convenience and care of patients, such as CT and Doppler services. Meanwhile, revenues from ancillary services provided in the office, such as imaging, may no longer be "credited" to the practice, but instead, to the hospitals' radiology department. As reimbursement for physicians' services flattens or even falls, the numbers look even worse.

What's more, a physician practice may incur additional expenses simply by becoming part of the hospital system, including costs associated with unionized employees, increased liability coverage, or more support staff in the office.

"But the physician is doing other things besides, literally, seeing patient after patient," Naas points out. Today, physicians coordinate care, teach and counsel patients, supervise nurse practitioners, and develop team-based-care systems. Payers and hospital systems are increasingly recognizing the value of these activities, and will continue to do so as accountable care organizations and pay-for-performance systems mature, says Naas. IDN boards of directors must do the same.

"Obviously, there are significant benefits to bringing physicians into a collaborative relationship with a health system," says Naas. But caution is a must.

"There has to be a clear understanding of the value of the practice, and what is an appropriate competitive salary, so the health system is not overpaying [for the practice]. And there has to be a clear understanding of the IDN's strategy to employ physicians, and a way to identify which ones bring value."

Willingness and skill

IDNs have a number of options with which to build collaborative relationships with physicians, points out Naas. Employment is one. Clinical integration and co-management are two more. "Each is very appropriate, depending on the market and the skill sets of the health system and the physician."

Employment. "Any IDN can employ a physician," says Naas. "But to create a sustainable [solution] that delivers on the potential of a well-coordinated, single, employed group in an integrated system requires leadership skills on the part of physicians and administrators."

Co-management. This approach can work provided two conditions are met, says Naas. "You need physicians who are willing to contractually take responsibility for management of the service line or department, and that takes physicians with the appropriate skill set and willingness." Administrative leaders, in turn, must have the willingness and skill set to partner with physicians."

Clinical integration. In this model, the cadre of physicians – who may or may not be employed by the hospital or IDN – work together to deliver efficient and high-quality care, and are recognized for doing so by payers and employers, says Naas. Again, two ingredients are needed – willingness to set up these kinds of structures, and solid leadership skills, on the part of both physicians and administrators.

Up to the challenge

IDNs and physicians are up to the challenge in a way they weren't a couple of decades ago, during the last wave of physician-practice acquisition by hospital systems, says Naas.

"[In the 1990s], there was enthusiasm, even exuberance, that exceeded common sense," she says. (That said, not all those experiments ended in disaster.) "But people learn, health systems learn, just as we do in our private lives. And circumstances are different today. Health systems have many more models [of physician collaboration] from which to choose. We have a better sense of the kind of leadership that is required. We know what good employment structures look like, because they are modeled across the country for us."

Today's administrators have better data to measure and benchmark such indicators as physician productivity, the overall value of a practice and quality of care, she adds. "So this is a different environment, and people understand what they're trying to achieve by employing physicians."

There's another big difference today, says Naas. "Physicians coming out of training are expecting a more team-oriented, group experience than the physicians in mid-career who ended up being employed by health systems [in the 1990s]. We're dealing with a different physician cadre, so expectations are different."

Today's IDN executives have the knowledge and ability to select the right physician leadership and administrative leadership to make collaborative relationships work. "One does not lead these groups like one leads a department in the hospital," she points out. Today's IDNs also know that newly employed physicians must be given a cohesive vision or strategy.

"It's challenging," she says. But with the right strategy, leadership, physicians, and salary or compensation structure; and with continual monitoring of compensation, quality and value that the physician practice brings the community, physician employment and other collaborative models can be a winning strategy. **JHC**

"But people learn, health systems learn, just as we do in our private lives. And circumstances are different today. Health systems have many more models [of physician collaboration] from which to choose."

Changing of the Guard for HealthTrust

Founder Jim Fitzgerald honored; successor Ed Jones welcomed.

Networking, collaboration and education attracted more than 3,500 HealthTrust members, leaders and supplier partners to the GPO's annual conference this summer, in Las Vegas.

The event, whose theme was "Positioned to Win," featured 65 education and information sessions with programming targeted to supply chain leadership, healthcare executives, pharmacists and a variety of clinicians.

Ed Jones, CEO

Two hundred and twenty HealthTrust member facilities and/or IDNs hosted meetings before or after the conference. Many of HealthTrust advisory boards met as well, including two new boards: the Facilities & Infrastructure Advisory Board, which provides member feedback on contracts dealing with facility infrastructure, design, construction and energy management; and the Physician Advisory Committee, with representatives in cardiovascular, orthopedics, spine/neurosurgery, general surgery, internal medicine/hospitalist and infectious disease.

Changing of the guard

Jim Fitzgerald was honored for his leadership as the retiring founder and president/CEO of HealthTrust. Fitzgerald officially stepped down as the organization's first and only CEO on May 31. "I'm most proud of the fact that HealthTrust established the right culture, where its members and partners know we are going to make decisions in the best interest of healthcare providers," he said. "We have a strong program of ethics and compliance that is based on integrity and the absence of conflicts of interest. And, internally, we've created a culture where colleagues feel they have an environment to grow and accomplish their goals with a team passionate about what we do."

Fitzgerald oversaw the formation of HealthTrust in 1999, and its financial and operational functions, and he managed the contracting for clinical supplies, pharmaceuticals and capital equipment, totaling approximately $20 billion annually. He is a member of the Federation of American Hospitals and serves as a board member of the Tennessee Minority Supplier Development Council.

Fitzgerald's successor as president and CEO, Ed Jones, presented his vision for the

Jones and Fitzgerald

organization at a general session during the conference. Jones previously held the position of chief operating officer, with responsibility for strategic sourcing, clinical operations, custom contracting, supplier diversity, global sourcing and regional operations. In addition to his new position as president and CEO of HealthTrust, Jones will also serve as president of Parallon Supply Chain Solutions. Founded in May 2011, Parallon offers outsourced revenue-cycle and other business processes, workforce management, supply chain services and group purchasing.

"Supply chain is more important than ever in this environment, where providers will continue to be paid less," said Jones, in response to questions from the *Journal of Healthcare Contracting*. "Increasingly, they will need our help on much more than supply expenses. HealthTrust is uniquely positioned to help with total cost solutions that make us more than a traditional GPO." Jones pointed to HealthTrust's and Parallon's service offerings in the following areas as examples:

- **SourceTrust**, a custom contracting program for medical devices. HealthTrust aids members with clinical support and a review of new technology.
- **SpendTrust**, which provides pharmacy and purchasing analytics with cross-reference databases, price auditing and benchmarking. It is designed to offer hospitals a view of their spending across facilities and multiple IT systems.
- **EnergyTrust**, which provides utility bill pay services as well as discounted utility costs in states with deregulated energy markets.
- **AdvantageTrust**, designed to offer physician offices and clinics, long-term-care and home-health facilities the same pricing and contracts as large member hospitals.
- **Business Performance Group**, designed to provide revenue cycle services, from patient registration to billing, collections, denial management, etc.
- **Supply Chain Solutions**, which provides consulting and outsourced supply chain services, including clinical resource management, value analysis, inventory utilization and product standardization, pharmacy order entry, operating room optimization, purchasing, accounts payable and distribution.
- **Workforce Management Solutions**, designed to offer assistance with healthcare staffing management, including contingent staffing, recruiting and enhanced productivity and scheduling technology.
- **Technology Solutions**, extending a proven healthcare technology platform focused on increasing top line revenue.

Continuing education

The HealthTrust conference featured continuing education in a variety of disciplines, including:

- "Clinical integration and the evolution of accountable care organizations," with Albert Tomchaney; Gunter Wessels, Ph.D.; and Bill Woodson.

- "Medication safety issues," featuring Michael R. Cohen, president of The Institute for Safe Medication Practices; Michelle Mandrack; and Allen Vaida, PharmD.

General session keynotes addressed the economy, healthcare reform and the impact of the 2012 elections. Speakers were:

- Stephen Moore, chief economist, *The Wall Street Journal.*
- Michael Leavitt, former governor of Utah and chairman of Leavitt Partners, who addressed the implications of healthcare reform.

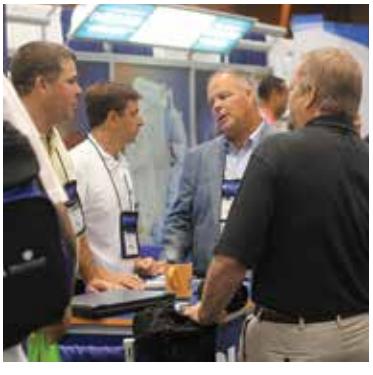
Other speakers included:

- Jay Arthur, author of books and articles about Lean Six Sigma.
- Robert Burns, Ph.D., Wharton Center for Health Management and Economics, on supply chain management and its relationship with the C-suite.
- Leadership and professional development experts Dale Smith Thomas; Tina Thomas, Ph.D.; and Susan Williams, Ph.D.

HealthTrust members and the GPO's subject matter experts shared best practices and lessons learned in implementing HealthTrust offerings in the areas of purchased services, medical devices, capital equipment, value analysis, pharmacy analytics and effective workforce management through productivity and benchmarking. SourceTrust medical device subject matter experts offered insights on technology and innovations in the areas of osteobiologics, orthopedics and interventional cardiology, as well as strategies for effectively engaging and collaborating with physicians in hospital medical device initiatives.

Vendors on display

The Exhibit Hall was open several times throughout the Conference for members to meet one-on-one with almost 300 vendors. Included among vendor attendees were those representing minority, women and/or veteran owned businesses as well as those offering members sustainably solutions through Environmentally Preferred Purchasing.



HealthTrust honored its Top 10 Vendors as chosen by the membership. Members vote and select the "best in class" based on key criteria, which include product and service quality, on-time delivery, billing accuracy and customer service. Input is also collected from the GPO's contracting teams and management. This year's Top Ten Vendors are:

- Alcon Laboratories, Inc.
- Boston Scientific.
- CDW Healthcare.
- CR Bard.
- Johnson & Johnson.
- Kerma.
- Medline.
- Owens & Minor.
- Stryker.
- Trinity Sterile.

Member awards

Outstanding Member Awards went to Mark Weaver, director of contracting and procurement in supply chain services, Hospital Sisters Health System, Springfield, Ill; and Karl Blomback, vice president of materials management and budget, Hackensack (N.J.) University Medical Center.

Other award-winners were:

- Operational Excellence Award: Matt Mayer, corporate vice president for material resources, Franciscan Alliance, Mishawaka, Ind.
- Clinical Excellence Award: Lynne Farkas, RN, clinical manager of value analysis, Trinity Health, Novi, Mich.
- Social Stewardship Team Award: Working Green/Living Green Team, KentuckyOne Health, representing facilities in Berea, London and Lexington, Ky. Team members are Greg Gerard, president, Saint Joseph Berea (chairman of the initiative); Terry Crist, executive chef, Saint Joseph London; Amanda Goldman, director nutritional services at two of the facilities; and Pedro Green, chef at Saint Joseph Hospital.

Looking ahead

Jones sees challenges and opportunities for HealthTrust and its members in the future.

"As an industry, health care does not have a uniform numbering system to allow providers better access to data," he said. "So, in the area of spend analytics, the biggest challenge for supply chain leaders is a lack of good data and information to base decisions on.

"HealthTrust has now built that capability with a platform that will dramatically improve information and reporting as well as offer great insights as to how providers can take costs out of their systems beyond the contract pricing HealthTrust provides. This platform will offer a tremendous benefit to HealthTrust members going forward." **JHC**

resource optimization

...more than just saving money

X-GEN Pharmaceuticals, Inc. improves health care by offering affordable generic pharmaceuticals to hospitals and other healthcare facilities around the world. It is our goal to provide healthcare providers that serve our communities with high-quality treatment options at low cost.

In addition to supporting the bottom line, X-GEN product purchases can help facilities reach their diversity goals while strengthening the industry's supply chain through investment in a competitive marketplace. Facilities across the nation have active supplier diversity goals and often struggle to include pharmacy purchases into their program. As a certified Women Owned Business Enterprise, X-GEN products qualify as diverse supplier purchases. Our line of acute care injectables do more than just save your facility money, they are an investment in the future of the healthcare industry.

X-GEN PHARMACEUTICALS INC

www.x-gen.us | 866-390-4411

Certified WBENC Women's Business Enterprise

By Brian Stepien

Supply Chain Road Trip

Driving logistics beyond the boundaries of healthcare

No childhood event provides a more vivid picture than a family vacation, aka road trip. These memories are certainly not all warm and fuzzy; squeezing all of us in a station wagon and rambling far from home was often both exhilarating and perilous. This is the brief story of a modern day road trip, one our hospital's "supply chain family" recently undertook.

A substantial financial opportunity exists within our very infrastructure, within our daily inventory workflow; it just takes a little journey to get the most out of it.

Our destination? Far beyond the relatively safe boundaries in which we regularly travel, to the Technology Plains of the Private Sector. We wanted to travel far to bring back an automated inventory management solution enhanced with RFID technology, one that provides a lightning fast ROI and a true perpetual inventory platform – a system that significantly affects the bottom line while giving clinicians valuable time to concentrate on direct patient care.

Our destination

Why did we choose this particular spot on the map? Think back to the lessons Dad was always trying to teach us. It seems like every trip I can remember had an educational component, perhaps a piece of history and a few lessons along the way about "good value."

The value component on our trip at Northwestern was obvious: Every hospital system or IDN that we talk to is concerned about reducing cost. We all spend time, energy and resources trying to beat up our suppliers for deeper and deeper savings. The sourcing and contracting side is definitely where we spend the lion's share of our collective efforts, but this avenue is far from an endless opportunity to achieve our budgetary targets. A substantial financial opportunity exists within our very infrastructure, within our daily inventory workflow; it just takes a little journey to get the most out of it. The souvenir we wanted to bring back from this vacation was a technology solution for supply distribution, one that would bring a strong ROI by reducing waste and optimizing revenue.

As we headed out on our jaunt, we knew we would run into a lot of road hazards before we even got down the street. Hospitals and IDNs are trying to drastically reduce costs. The specter of healthcare reform has everyone scrambling to prepare themselves to survive reimbursements at a Medicare/Medicaid level. This means that every stone is being turned to shave expense. Supply chain is a key component in this equation, because reducing costs on "stuff" is far more attractive than reducing staff. Across the pond, healthcare costs are lower and patient outcomes are as good if not better than those in the United States. Life expectancy is significantly higher in countries where the cost of treatment per capita is a fraction of our own. Supply chain is not the entire solution to this financial crisis, but we certainly are being relied on to make a major contribution to the overall cost-cutting effort.

man-hours. During our recent trip, we talked to all of the usual healthcare suspects and found one or all of the above to be true.

What is critical when looking for a technology solution is buy-in from all of the siblings mentioned previously. That means deciding on a system that is intuitive and user-friendly, one that requires very little infrastructure and doesn't negatively affect clinical workflow. Oh yeah, there are lots of departments competing for very few capital dollars, so make sure it's cheap as well. A strong ROI will get your brother in finance strapped into his car seat very quickly.

Build the solution together. In our case, we had nurses at the table every step of the way. They chose everything from how to pick patients to badge swipes, and when it came time to roll out the new model, they were proud to say that it was their solution! Get physicians – especially surgeons – into the discussion, too. Once they are actively promoting these tools, others will quickly follow.

Hospitals and IDNs are trying to drastically reduce costs. The specter of healthcare reform has everyone scrambling to prepare themselves to survive reimbursements at a Medicare/Medicaid level. This means that every stone is being turned to shave expense.

Getting the kids in the car

When we were kids, we used to fight to get the best seat in the car. A window seat was the very best you could hope for. Our trip at Northwestern, if successful, would need to promote some serious family harmony. The sibling group would include brothers and sisters from nursing, supply chain, IT, finance, and senior leadership. We could simply have attempted to travel locally, and visit plenty of healthcare vendors that supply inventory technology – cabinets, handheld devices, tools that weigh the product, etc. The problem is, these solutions tend to be expensive, reliant on multiple disciplines following a strict workflow, inflexible, or too dependent on IT

Travelling on the cheap

Dad was a very practical, frugal kind of guy. Chances are your senior leadership is as well. This is where that "good value" piece comes in. When I was a kid, we never stayed at the Ritz; it was camping out in tents or a roadside motel that advertised that they would "leave the light on for you." And in the end, that was exactly what we needed.

This journey was no different. Choosing our technology solution was like packing chicken salad sandwiches instead of eating at the diner when you rolled into town. Ask yourselves a few quick questions when setting the budget for such an adventure:

- How much are we being quoted for hardware or infrastructure?
- What are the installation and ongoing maintenance costs?
- Are there customizable tools to easily validate expected results?
- What are we solving to? Are we getting every feature we need for a good price?

At our hospital, we found the perfect technology solution by partnering with folks from the automotive and retail world. These industries have had RFID technology for decades, but in hospitals, it is still in its infancy. We found a company that basically asked our clinicians what their workflow was, so they could customize a solution to match existing practice. No change in workflow equals no resistance from staff.

RFID solutions within healthcare often rely on expensive cabinetry. These devices are effective, but very costly, especially when you are looking at a solution that will capture the entire high-dollar inventory throughout your institution. We were able to implement things like automated kiosks and portals built into doorframes. We used old shelving and even bookcases, and turned them into "smart shelves" by simply adding a couple of well-placed readers and antennae. The results were dramatic.

The mechanics: How it runs

No sojourn is ever successful without a well-oiled machine to keep you moving. In a nutshell, the solution that we partnered to build works like this:

- Inventory comes into the facility and is tagged with a label that includes several key pieces of information. The tag has a small RFID chip embedded in it, which stores a product's lot, serial number, price, and expiration. The tags are applied by an inventory technician with a completely wireless, mobile receiving station.
- The inventory is placed in a room, on a shelf, or in a cabinet that electronically inventories it on a constant basis.
- When inventory is removed from one of these spaces, we know one or more of the following – when it left, who took it, how many they took, and what case it was used in. Any product used for a procedure is automatically replenished, completing a fully perpetual inventory.
- Every 24 hours, the supplies that were billed are compared to the inventory that was decremented. Any delta is captured immediately and added to our patient billing. Built-in alerts and safeguards track product that is close to expiration so it can be used or returned to the vendor.

Serving Your Oncology Needs

Our Generics Lineup Just Expanded—Again.

At Pfizer Injectables, we're dedicated to delivering customer-focused solutions that can help drive your business. One measure of our commitment is an expanding oncology portfolio and a growing selection of oncology products in CYTOSAFE® plastic vials. Backed by our heritage of commitment to quality and reliable manufacturing, we stand ready to leverage the proven resources of Pfizer and execute with the high level of service that today's generics marketplace demands.

Pfizer Injectables also offers products in other key therapeutic areas, including:

- Anesthetics
- Anticoagulants
- Anti-infectives
- Anti-inflammatories
- Hemostatics

To learn about our full range of solutions for your business, contact us today.

For Ordering Information, call **800.533.4535**.

For Pfizer Medical Information, call **800.438.1985** or visit **www.pfizermedicalinformation.com**.

For more information, visit **www.pfizerinjectables.com**.

Pfizer Injectables | Solutions Are Our Business.™

All of this results in a very smooth-running process that keeps all sides happy. The bottom line is better than ever, and other than adding some technology, it was all accomplished within our own four walls.

Postcards and souvenirs

We have just about completed our journey at this point. Our hospital family is safe within our four walls, but this adventure changed our outlook forever. When we started down the driveway, supply chain controlled less than 50 percent of our total medical/surgical supplies inventory. We now manage over 99 percent of the hospital spend.

We have automated and centralized inventory for departments with very high-cost supplies, such as surgical services, GI, cath lab, interventional radiology, mammography and pathology. Over a two-year period we have achieved each of the following:

- Produced a documented hard-dollar ROI in less than six months.
- Reduced our on-hand inventory by over $8 million.
- Taken a baseline of over $600,000 per year in expired product down to a small fraction of what it used to be.
- Captured over $4 million (cost) of supply charges that would have been missed in the old decentralized model.
- Made product availability better than ever; and our process for product recall – should one occur – calls for little more than a touch of a button.
- Given many productive hours back to nursing for direct patient care.

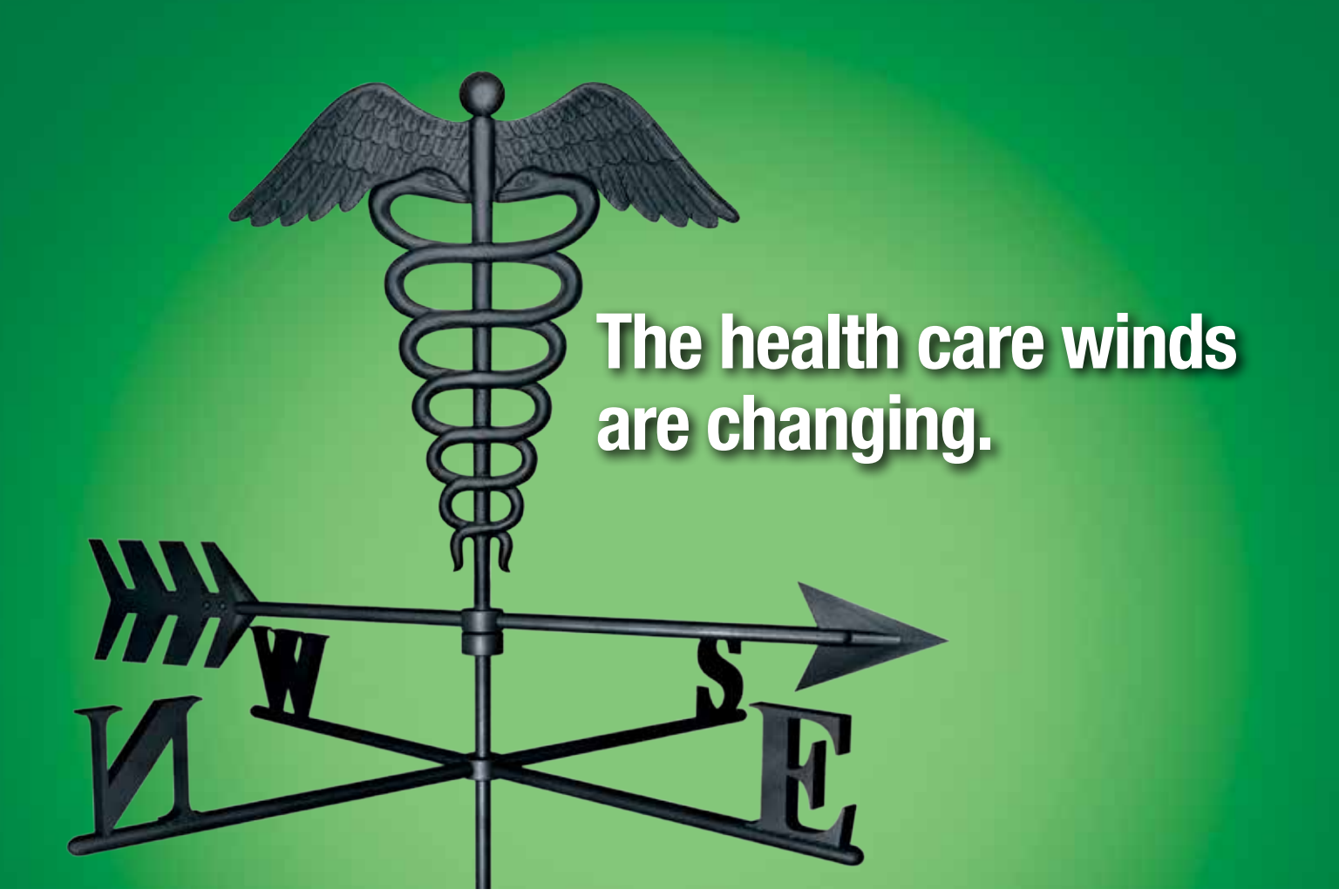
Once a platform like this is in place, the only limit to where you go next is your imagination.

Dreaming the next trip

Once you get the travel bug, you will never be happy simply staying at home. Once a platform like this is in place, the only limit to where you go next is your imagination. We plan to use this technology to track patient movement, product utilization in packs and kits in central sterile, and patient specimens and pharmaceuticals. We are working with our distributor and various OEMs to eventually create cradle-to-grave tracking of medical and surgical supplies.

The sky is the limit. Happy travels. **JHC**

Brian Stepien is director, supply chain distribution and logistics, Northwestern Memorial HealthCare, Chicago.



Get pointed in the right direction.

Changes in the health care system are creating serious challenges for you. You have more options than you may realize. As one of the world's largest medical device manufacturers, **Terumo can help**.

In addition to the high-quality products…

- Hypodermics with T-SHARP™ Technology, 10% sharper on average than the market leader*
- IV Catheters with SURFLASH® Technology to help deliver first-stick success
- CAPIJECT® and SURSHIELD® blood collection products that allow safe and easy sampling in the office
- ELEMANO® Blood Pressure Monitors with PrecisePulse™ Technology to help speed patient triage

…we offer powerful support to help you face changing times:

- **Streamlining your contracting efficiencies with Terumo-wide partnerships** via our expanded Corporate Accounts team
- **Helping your physician practices comply with OSHA requirements** with new products and innovative programs
- **Providing experienced clinical educators** and a nationwide sales organization
- **Identifying practice efficiencies** through our proprietary *Storeroom Checkup* program

Connect with our Corporate Accounts department at www.terumotmp.com/contactus and enter "JHC" in the promotional code box.

Get more than you pay for.

*Reference: Data on file. Terumo Medical Products, August 2009.

TERUMO®

TERUMO MEDICAL PRODUCTS

By Curtis Rooney

Unique Device Identification: A unique opportunity

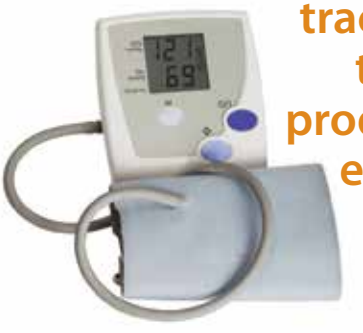
The Healthcare Supply Chain Association (HSCA) recently wrote to the U.S. Office of Management and Budget (OMB) to express its support for the guidelines to implement the regulations establishing a unique device identification ("UDI") system for medical devices. Responding to OMB's request for comments, HSCA highlighted the direct benefits to patient safety of adopting a UDI system, and pointed out that the proposed system would help products move more efficiently and reduce costs across the supply chain.

In its comments, HSCA stated that "a UDI system, properly aligned with the GS1 standards so widely recognized worldwide, will not only achieve the numerous health benefits sought by the FDA in its proposal and its preliminary regulatory impact analysis, but will also yield huge savings to the healthcare system that will far outweigh any costs incurred by manufacturers, suppliers, or providers."

Product tracking is vital

As products pass among manufacturers, distributors, suppliers, and healthcare providers, a UDI system would make tracking those products easier. Product tracking helps ensure that the right products are delivered to the right purchaser at the right time. Efficient tracking can also help prevent products from being lost or misplaced along the supply chain, and would protect against counterfeit devices that pose significant patient safety concerns. Clearly, effective tracking is vitally important for ensuring accurate, efficient product recalls.

As products pass among manufacturers, distributors, suppliers, and healthcare providers, a UDI system would make tracking those products easier.



Without standards, various actors along the supply chain often develop their own system for identifying products and recording data, resulting in numerous proprietary "standards" that healthcare suppliers and providers must manage. Numerous standards lead to inefficiencies and inaccurate data, which lead to unnecessary costs. A 1996 study, Efficient Healthcare Consumer Response, estimated that $11 billion is wasted in the healthcare supply chain each year as a result of inefficiencies and errors attributable to the absence or under-utilization of data standards. Global standards promote simplicity, consistency, and accuracy in supply chain communications.

GS1

The GS1 system is one of the most widely used supply chain standards in the world. GS1 standards have been used in a wide variety of industries in the United States and globally for over 35 years. Recently, a number of hospitals, healthcare suppliers, and healthcare-related organizations have begun moving toward adopting the GS1 system of standards to help improve supply chain efficiency and patient safety. In fact,

many of our current business partners (e.g., Johnson & Johnson, Cardinal Health, 3M, McKesson) have already started using these standards. Presently, the U.S. healthcare industry is working toward implementing the full range of GS1 standards by Dec. 31, 2012. We believe that the GS1 system represents an excellent model for how the UDI system will work upon implementation.

The GS1 system employs a series of Identification Numbers to identify physical things, such as trade items, assets, logistic units, and locations; as well as logical things, such as corporations or service relationships between provider and patient. These GS1 Identification Numbers include Global Location Numbers ("GLN") and Global Trade Item Numbers ("GTIN"), which are published to the GS1 Global Data Synchronization Network ("GDSN"). Every Identification Number, whether GLN or GTIN, provides a link between the object and the information pertaining to it.

Summary of HSCA's comments on proposed rule

HSCA's primary goal is to improve patient safety through a UDI system. Our comments on this Proposed Rule related to the Paperwork Reduction Act of 1995 focus on the following areas of particular interest to the healthcare supply chain:

- The OMB and FDA should incorporate into the cost-benefit analysis the value of the benefits of the UDI system to patients, providers, and the overall healthcare supply chain.

- The OMB and FDA should exclude costs already incurred by labelers as they prepare to comply with the market's demand for GS1 compliance by 2012 when determining the burdens imposed on labelers by the proposed UDI system.

- The FDA should shorten the proposed seven-year phase-in to three years, because it does not lessen the burden imposed on labelers by the rule. We believe OMB will determine that the seven-year phase-in period may in fact increase the burden while also unduly delaying the benefits to patient safety.

- The FDA should eliminate the proposed labeling exceptions to ensure that all devices in the United States healthcare supply chain are labeled with UDIs that are published in the Global Unique Device Identification Database, or GUDID. We believe the OMB will determine that the benefits to patient safety provided by UDI labeling outweigh the nominal additional burdens on labelers.

We believe OMB will determine that the seven-year phase-in period may in fact increase the burden while also unduly delaying the benefits to patient safety.

HSCA believes that an effective UDI system has the potential to facilitate the identification of device compatibility problems, ensure that the correct device is used with the correct patient, and improve methods for recording device-related patient information in the patient's electronic health record, including relevant device-related allergies. Furthermore, device tracking in the UDI system will facilitate comparative effectiveness research by helping to compare devices in the supply chain. Similarly, healthcare providers will benefit from the more accurate, efficient inventory management capabilities provided by the UDI system as well as improved invoice accuracy and reduced ordering mistakes.

The appropriate implementation of the UDI system is a unique opportunity for the healthcare supply chain to move forward. **JHC**

Curtis Rooney is president of the Healthcare Supply Chain Association, www.supplychainassociation.org.

By Robert Betz, Ph.D.

Narrowbanding

How upcoming FCC regulation affects healthcare providers

Nikola Tesla developed the idea for the radio in 1893. It wasn't until 1901, that Guglielmo Marconi sent the first radio signal, thus creating the radio. The 20th century witnessed the explosive use of radio and, as an emerging industry; its use in health care was no exception. Today, wireless radio communications technology in hospitals is the standard. According to the Federal Communications Commission (FCC), two-way radio use in hospitals, as well as other industries, are about to be impacted by regulations effective Jan. 1, 2013. My suspicion is that many hospitals are not focusing on this important regulatory deadline and will be facing substantial monetary penalties for non-compliance.

Background

On Jan. 1, 2013, the FCC will require anyone using two-way radios with 25 kilohertz (kHz) efficiency technology to now instead use 12.5 kHz narrowband units in order to communicate. This will affect public safety communication systems, emergency communications, and more specifically hospital communication systems.

The purpose of mandatory "narrowbanding" is to promote more efficient use of the very-high frequency (VHF) and ultra-high frequency (UHF) land mobile bands. Over the years, these bands, in particular the 150-512 MHz band, have been crowded, and there is not enough room on the spectrum to expand or make new communication systems. In order to make more room, licensees must purchase equipment that operates on narrower bandwidths. This allows for new channels to be created and less overlap between them. Through narrowbanding, licensees can achieve greater interference protection, as well as enhanced opportunities for interoperability and system upgrades to advanced technologies (which wear out over time).

The conversation around narrowbanding (which some techies initially called "refarming") began over 20 years ago.

Users who do not make the switch by Jan. 1, 2013, face the loss of their communication capabilities. The FCC already moved forward in implementing its plan. On Jan. 1, 2011, the FCC stopped granting applications for new voice operations or applications that use 25 kHz channels, so that only narrowband authorizations will be granted. The FCC also now prohibits the manufacture or importation of new equipment that operates on 25 kHz channels. This will reduce the availability of new equipment for legacy radio systems and will affect how hospitals and others maintain and upgrade older systems. The failure to implement the new FCC narrowband standards will not only violate FCC rules but also cause harmful interference to adjacent narrowband channels, because 25 kHz channels will be competing with overlapping 12.5 kHz channels.

The financial consequences for non-compliance are steep. Penalties for non-compliance may include license revocation, and/or monetary forfeitures of up to $16,000 for each such violation or each day of a continuing violation, and up to $112,500 for any single act or failure to act.

According to Fish & Richardson P.C., an international law firm specializing in intellectual property and technology, the FCC's process of dealing with violations has "become more formal and the costs of non-compliance have skyrocketed," which puts further strains on organizations that have been putting off compliance.

A little history

The conversation around narrowbanding (which some techies initially called "refarming") began over 20 years ago. The FCC released a Notice of Inquiry (NOI) on July 2, 1991 in order to promote efficiency in the frequency bands under 512 MHz. To address the NOI, PR Docket No. 92-235 proposed a

hisci

Healthcare Industry
Supply Chain Institute

"As a new small business owner, I'm continually looking to build relationships with others in the industry. I joined HISCI because it provides me equal access to GPO trading partners through their network of supply chain professionals, while offering me the tools and education I need to grow."

To join, contact Meredith Young, HISCI's executive director | 202.367.1185 | info@hisci-net.org | www.hisci-net.org

number of measures to achieve this. Among the measures was the suggestion of reducing channel spacing to 6.25 kHz.

The Telecommunications Act of 1996, which amended the Communications Act of 1934, added Section 337 to U.S. law, which determined allocation and assignment of new public safety services licenses and commercial licenses, which gave the FCC the authority to carry out the mandate requiring spectrum efficient technology.

On Feb. 12, 2003, the FCC, in its Second Report and Order, adopted an order promoting spectrum efficient technologies on certain Part 90 frequencies, which imposed the deadlines for migration to 12.5 kHz technology for private land mobile radio services (PLMRS) systems operating in the 150-174 MHz and 421-512 MHz bands. The deadlines were Jan. 1, 2013 for non-public safety systems and Jan. 1, 2018 for public safety systems, however in December 2004, the date for public safety systems and others was revised to January 2013, the current deadline. Since then, certain counties, municipalities, companies, and organizations across the U.S. have requested waivers to extend the deadline for compliance.

Right now, there appears to be no agency or organization that believes that the FCC will push back its initiative, seeing as most organizations have had about 10 years to plan for and implement the changes.

What hospital associations and public safety communication organizations are saying

Surprisingly, neither the American Society for Healthcare Engineering of the American Hospital Association (AHA), nor the Federation of American Hospitals, or other hospital groups, appears to have formally commented on the upcoming FCC regulation on the narrowband mandate. However, based on a statement made by the AHA before the FCC's Joint Advisory Committee on Communications Capabilities of Emergency Medical and Public Health Care Facilities, the AHA is open to new methods of effective interoperability.

On a daily basis, hospitals deal with multiple communication and data systems that are incompatible and/or too complex, and thus may look favorably on the goal of interoperability that can be achieved through the narrowband mandate. However, the AHA cautions that "financial support almost certainly will be needed to enable first responders and hospitals to replace existing communications systems with interoperable, advanced technology, especially in rural and remote areas of the nation."

Who is supporting the mandate

The Association of Public-Safety Communications Officials (APCO) is fully supportive of the conversion to 12.5 kHz efficiency, encouraging all public safety licensees to make the conversion before the deadline, and urges Congress to "authorize the use of existing federal grant programs such as the State Homeland Security Program (SHSP), the Urban Area Security Initiative Grant Program (UASI), the Metropolitan Medical Response System (MMRS), Emergency Management Performance Grants (EMPG), the Regional Catastrophic Preparedness Grant Program (RCPGP), the Community Oriented Policing Services (COPS) Technology, Department of Justice's State, Local, and Tribal Terrorism Prevention Training and Technical Assistance National Initiative Program, or the Justice Assistance Grant (JAG) Program to expedite the migration of wideband equipment to narrowband equipment." APCO also responded to the accusation that the upcoming FCC regulation is an unfunded mandate: "The dates are extended enough to ensure most agencies have fully amortized the value of their current equipment by the time the mandates kick in." However, budgetary problems may hamper efforts to fully comply, as was claimed in a case with the City of South Lake Tahoe.

The National Public Safety Telecommunications Council (NPSTC) is similarly supportive of the measure to replace 25 kHz efficiency technology and begin operating on channel bandwidths of 12.5 kHz or less, and is actively assisting in the transition by providing information and advising state and local agencies.

Every government agency that has a stake in emergency response is pushing for the implementation of this policy,

especially the Department of Homeland Security, with its long list of literature related to the transition and guides to implementation.

In regards to how hospitals are specifically affected by the narrowband mandate, a letter written by Lee Burns, the Acting Director of the Bureau of Emergency Medical Services (EMS) to Hospital Chief Executive Officers in New York warns that because "radio equipment configured for wideband operation is incapable of communicating with equipment configured for narrowband operation on the same frequencies, it is imperative that the conversion of EMS-to-hospital radio systems to comply with this mandate be coordinated between the two, within each regional EMS system." Burns also points out that "since the base station radio equipment used by hospitals typically has a much longer service life than the mobile and portable equipment used in the field, it is likely that many hospital radios pre-date the anticipation of this conversion, and therefore lack the capability of being re-configured to comply with it." The cost may be greater for hospitals that have older radios due to the necessity for a complete replacement of radio equipment that is out of date.

Right now, there appears to be no agency or organization that believes that the FCC will push back its initiative, seeing as most organizations have had about 10 years to plan for and implement the changes. Yet many hospitals seem unaware of the pending deadline. This FCC regulation will inevitably be implemented, and for those that are not granted waivers by 2013 will either have to comply or face the operational consequences and substantial financial penalties.

Who is opposing the mandate

Opposition to these regulations does exist. It comes primarily from counties and municipalities struggling to come up with funds in order to implement the policy change. Seen in the rejected request for a waiver, the City of South Lake Tahoe "states that in 2010 its vendor informed it that narrowbanding its infrastructure would cost $800,000 and upgrading the infrastructure from analog to digital to compensate for coverage loss, could increase the cost to $1.5 million" and that "due to the economic downturn it is currently operating with an annual budget deficit of $4.7 million that precludes it from funding the narrowband transition." The FCC did not find that Lake Tahoe presented sufficient evidence to conclude that a waiver was necessary. In addition to not finding its circumstances unique or unusual, the FCC stated that "Lake Tahoe provides no description of its prior efforts (if any) to obtain the necessary funding, or the results of such efforts. Finally, Lake Tahoe also provides no explanation for the proposed delay until July 2014 – a year and a half after the narrowbanding deadline – before it plans to undertake a budgetary analysis to determine its funding needs."

Extensions and grants for conversion

By contrast, the FCC has, for example, granted the State of Oregon a 10-month extension, the University of Iowa Hospitals and Clinics a 12-month extension, and the County of Hawaii's 21-month extension.

In an effort to assist states and counties with the cost of implementation, multiple grants are available for narrowbanding projects. The Public Safety Interoperable Communications grant program awarded $968,385,000 to fund interoperable communications projects in the 56 States and Territories.

Additionally, many FEMA Preparedness grants, including the SAFECOM program for Emergency Communication grants, which announced more than $1.3 billion in grant money for FY 2012, present states and counties with opportunities for additional federal funding. Of course, this does not mean that every state, county, and municipality in need of funding receives any. It appears that in most cases those that do receive federal funds only receive a certain percentage of the necessary funds to complete implementation.

In 1934, Nikola Tesla said "Radio power will revolutionize the world!" He was right. He also once said "Money does not represent such a value as men have placed upon it." Hospitals and other organizations facing the enormous financial penalties for non-compliance with the FCC narrowbanding first-of-the-year deadline, are about to find out if Tesla was right on this observation as well. **JHC**

Note: *The author wishes to specifically thank Matthew Morris, 2012 Graduate, Columbian College of Arts and Sciences, George Washington University, for his research contributions to this article.*

Robert Betz, Ph.D., is President of Robert Betz Associates, Inc. (RBA), a well-established federal health policy consulting firm located in the Washington, D.C. area. Additionally, Dr. Betz is an adjunct professor teaching at The George Washington University where he specializes in political science and health policy. For more information about RBA, visit www.robertbetz.com.

Robert T. Yokl, Chief Value Strategist, Strategic Value Analysis® in Healthcare

Cost Controls

Why you must have methods to monitor and control every penny you report as saved

(In our rush to save money for our healthcare organi-zations, we often overlook one critical success factor in supply chain management – having "cost controls" on the millions of dollars of purchases that flow through the supply chain department annually. It's not enough for supply chain managers to just save money to be successful, it is even more important for them to control their gains or they will lose those gains as quickly as they have achieved them. That's the paradox of "only" paying attention to the uppermost end of your savings funnel and not the bottommost end!

What we have observed over the last six years with our value analysis analytics practice is that a savings isn't a savings until it is confirmed, verified and certified through observation, benchmarking or predetermined measurement, that it is hitting our client's financial statement.

From an accounting point of view, cost controls are methods used by supply chain managers to ensure that the savings being reported is actually reflected in their healthcare organization's financial statement. Those methods could include observations, benchmarks and predetermined measurements. For example, one of our clients reported to their senior management that they saved $162,932 on cardiovascular stents. However, when we tracked this savings over a three-month period with our value analysis analytics we discovered that only $62,943 (annualized) hit our client's financial statement. There were various reasons why this happened, but the point I want to make is that without having cost controls in place this client would have erroneously reported this savings as a fact to their senior management. Naturally, this client adjusted their savings report to reflect the slippage in their original savings estimate on these cardiovascular stents.

I remember another client whose CFO wanted to know where the savings were on the I.V. set contract his supply chain manager told him would save tens-of-thousands of dollars for his system, since the CFO was seeing an increase, not decrease in this category of purchase. After some investigation, this supply chain manager uncovered that his hospitals were buying the highest priced feature rich I.V. sets, now that they thought they had the best price on I.V. sets in their region. This supply chain manager could have saved himself a lot of grief and embarrassment if he would have established benchmarks (before and after the changeover) and then measured the cost impact of his new I.V. set contract.

What we have observed over the last six years with our value analysis analytics practice is that a savings isn't a savings until it is confirmed, verified and certified through observation, benchmarking or predetermined measurement, that it is hitting our client's financial statement. We now recommend our clients report projected savings and then certified savings separately to their senior management. This way there is no confusion or doubt on what is actually saved by supply chain management in any given period. That's why you need methods to monitor and control every penny that you report as saved, so that your healthcare organization's financial statement is always as accurate as possible. Remember: your credibility is at stake, so make sure the savings you are reporting to your senior management is not an illusion, misrepresentation or wishful thinking. It is negligent and irresponsible to do otherwise! **JHC**

Robert T. Yokl is president and chief value strategist of Strategic Value Analysis® In Healthcare, which is the acknowledged healthcare authority in value analysis and utilization management. Yokl has nearly 38 years of experience as a healthcare materials manager and supply chain consultant, and also is the co-creator of the new Utilizer® Dashboard that moves beyond price for even deeper and broader utilization savings. For more information, visit www.strategicva.com. For questions or comments, e-mail Yokl at bobpres@strategicva.com.

Subscribe to JHC for year-round coverage

JHC publishes year-round
6 printed and 6 digital.

To ensure you are receiving every issue
please email us at **info@jhconline.com**
or visit our website at **www.jhconline.com.**

Ochsner Health System shuffles executives

Warner Thomas, former COO of Ochsner Health System (New Orleans, LA), was installed as the system's new president and CEO on September 1, 2012. Thomas replaces Dr. Patrick Quinlan, who was selected as CEO of Ochsner Clinic Foundation and Ochsner International Services and executive director of the Center for Community Wellness and Health Policy. Michael Hulefeld was named EVP and COO of Ochsner. He formerly was CEO of Ochsner Medical Center New Orleans (New Orleans, LA) and New Orleans Region. Rob Wolterman, CEO of Ochsner's New Orleans Community Hospitals, was name as CEO of Ochsner Medical Center.

Tenet Healthcare names Cancelmi as CFO

Tenet Healthcare Corp (Dallas, TX) appointed Daniel J. Cancelmi as CFO. Previously, Cancelmi served as the principal accounting officer of Tenet since 2007. Cancelmi reports to Trevor Fetter, Tenet's president and CEO. He has held several finance positions involving increasingly broader responsibility for hospital financial operations, company-wide accounting practices and policies, SEC financial reporting and governmental reimbursement from Medicare and Medicaid programs.

Bon Secours Charity Health System, Saint Francis Hospital, Saint Luke's Hospital System plan alliance

Bon Secours Charity Health System (Suffern, NY), Saint Francis Hospital (Poughkeepsie, NY), and Saint Luke's Cornwall Hospital Health System (Newburgh, NY) plan to form an alliance to explore potential service collaborations and savings opportunities. Called Hudson Health Partners LLC (Newburgh, NY), the alliance will try to expand patients' care options to include home health and wellness programs, increase physician recruitment, and support clinical quality and efficiency initiatives. The groups will make a formal announcement with additional details later in September 2012.

Ascension Health Ventures to acquire Marian Health, with 3 sub-IDNs and 36 hospitals

Ascension Health Alliance (St. Louis, MO) signed a memo of understanding to acquire Marian Health System (Tulsa, OK), with three regional divisions, 36 affiliated hospitals, and more than 150 clinics in Wisconsin, Minnesota, Oklahoma, and Kansas. The transaction, for which financial terms were not disclosed, is expected to close by the end of Q1 2013. Marian's three divisions are Ministry Health Care (Milwaukee, WI), Saint John Health System (Tulsa, OK), and Via Christi (Wichita, KS), which is already affiliated with Ascension. Ascension's rationale for the acquisition is that it is seeking to grow to be in better position to launch population health management strategies. Marian will switch sponsorships from the Sisters of the Sorrowful Mother to Ascension Health Ministries. Local leadership will not be changed.

AHRQ patient safety project reduces rate of central-line associated infections by 40%

A nationwide patient safety project funded by the Agency for Healthcare Research and Quality (AHRQ) (Rockville, MD) reduced the rate of central line-associated bloodstream infections (CLABSIs) in intensive care units by 40 percent. The four-year project involved hospital teams at more than 1,100 adult ICUs in 44 states. Preliminary findings indicate that participating hospitals reduced the rate of CLABSIs nationally from 1.903 infections per 1,000 central line days to 1.137 infections per 1,000 line days. According to the AHRQ, the project prevented more than 2,000 CLABSIs, saving more than 500 lives and avoiding more than $34 million in healthcare costs. The AHRQ recently discussed these findings at its annual conference and introduced the Comprehensive Unit-based Safety Program (CUSP) toolkit that helped hospitals accomplish this reduction. Details about AHRQ's national CUSP project are available at www.ahrq.gov/qual/hais.htm, and the CUSP toolkit is available at www.ahrq.gov/cusptoolkit/.

AHRMM

AHRMM Annual

Conference & Exhibition

July 28-31, 2013

San Diego, Calif.

ASCP (American Society

of Consultant Pharmacists)

Annual Meeting and Exhibition

Nov. 7-9, 2012

National Harbor, Md.

Health Connect Partners

Spring 2013 Hospital Pharmacy Conference

May 6-8, 2013

Hilton Atlanta

Atlanta, Ga.

Radiology and Imaging Conference

April 29 - May 1, 2013

Hilton Atlanta

Atlanta, Ga.

Hospital O.R. & Surgery Center Conference

May 1-3, 2013

Hilton Atlanta

Atlanta, Ga.

Health Industry Distributors Association (HIDA)

Streamlining Healthcare Conference

Oct. 10-12, 2012

Hyatt Regency

Chicago, Ill.

IDN Summit

2013 Spring IDN Summit & Expo

April 22-24, 2013

Omni Orlando Resort at ChampionsGate

Orlando, Fla.

2013 Fall IDN Summit & Expo

Sept. 24-26, 2013

Arizona Biltmore

Phoenix, Ariz.

MedAssets

Healthcare Business Summit

April 2-4, 2013

Mandalay Bay Resort

Las Vegas, Nev.

Premier

Breakthroughs Conference

June 11-14, 2013

San Antonio, Texas

By Mark Thill

Yes, and

Recently we went to Second City, a comedy club here in Chicago. One of its strengths is improvisation. In fact, most of the revues that end up on the main stage were born of improvisation.

In the lobby, I noticed, among the T-shirts for sale, one that said "Yes, and." That's all it said, and I wondered what it meant. Later I found out.

It turns out that improvisation – as wild and unplanned as it is – has some rules. One of the most basic rules is, you must respect the other person's reality. Someone who works at Second City gave us this example.

Person A says to Person B, "The kids are driving me crazy." Person B CANNOT then say, "Kids? What kids? We don't have any kids." If that occurs, the improv session quickly deteriorates. Instead, Person B has to go with it, and build upon what Person A just said.

That's where "Yes, and" comes from. You have to accept what the other person says, and build from there.

In a way, respecting the other person's reality is one of the most basic lessons of life, business and, yes, healthcare supply chain management. How many arguments do we get into with those we love because we fail to listen to their point of view, or we reject it outright? Same thing goes for our business relationships.

For business and supply chain management, "respecting the other person's reality" is a little like adhering to "the customer is always right" strategy. What *JHC* reader hasn't encountered a stubborn, even ornery, internal customer? It could be a nurse, a doctor, a department head, an administrator. It's pointless to get into an argument with them. Like the improv session, things deteriorate quickly that way.

I'm reminded of someone in medical sales who lived by the philosophy, "Never say 'no' to a customer." That doesn't mean you have to accede to every request made. But it means you never shut down the other person; you accept what they're saying, and offer what you can. It seems like a successful sales technique…and one that a customer-service-minded supply chain department can use as well.

For business and supply chain management, "respecting the other person's reality" is a little like adhering to "the customer is always right" strategy.

"Yes, and" is a winning strategy. Not always easy to execute. Sometimes, our anger, impatience or frustration can cloud our better judgment. Still, it's something to strive for. **JHC**

SAVE TIME, MONEY, RESOURCES, AND THE ENVIRONMENT.

MEDICAL ACTION INDUSTRIES INC.
PRESENTS

MACS
MEDICAL ACTION CONTAINMENT SOLUTIONS

MACS PROGRAM KEY FEATURES:

- Improved product utilization to ensure right product for right application
- Value-priced, quality-made alternatives to present products
- Knowledgeable, professional help meeting regulatory compliance
- Reduced supply chain costs through vendor consolidation
- Elimination of redundant and unnecessary SKUs to reduce costs and inventory
- Reduction of plastic in the waste stream

Time is money:

Conducting an in-house assessment of your hospital's containment needs is a time-intensive undertaking. With all the duties you have to perform, it makes sense to leverage the cost-saving power of the MACS program.

www.medical-action.com • 800-645-7042

Medical Action
INDUSTRIES INC.

Custom Procedure Trays – Minor Procedure Kits – OR Essentials – Patient Plastics – Containment for Medical Waste

THE BUSINESS OF HEALTHCARE TRANSFORMED℠

Achieve immediate and sustainable savings with HealthTrust Purchasing Group.

HealthTrust Purchasing Group is the only committed model group purchasing organization. The foundation of our success is aligned decision making and compliance across our membership. The result is a comprehensive portfolio that is consistently 10 percent better than any other purchasing alliance.

As fellow operators, we have daily accountability to deliver—more than 1,400 hospitals are counting on us. No other consultant can say that.

Contact us at 615.344.3000 or sales@healthtrustpg.com
and watch your savings soar.

HEALTHTRUST®
PURCHASING GROUP

HealthTrust Purchasing Group • Supply Chain Solutions • Business Performance Group • Workforce Management Solutions