The Journal of
Healthcare CONTRACTING
Providing Insight, Understanding and Community
July 2021 • Vol.12 • No.4

Cyberattacks Threaten U.S. Hospitals

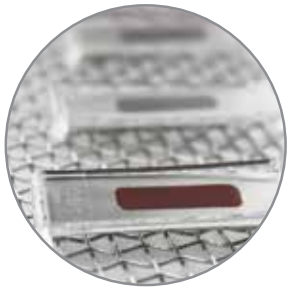
Premier's chief information security officer identifies the organizations most at risk, and how best to safeguard against future attacks

PROFORMANCE™ CLEANING VERIFICATION

CLEARLY VISIBLE, EASY TO INTERPRET, OBJECTIVE TESTS OF CLEANING METHODS

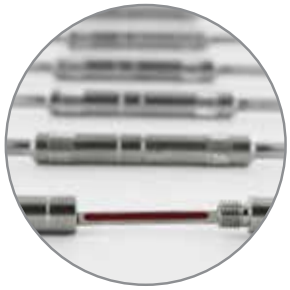
SONOCHECK™

When the ultrasonic cleaner is supplying sufficient energy and conditions are correct, SonoCheck™ will change color. Problems such as insufficient energy, overloading, water level, improper temperature and degassing will increase the time needed for the color change. In the case of major problems the SonoCheck™ will not change color at all.



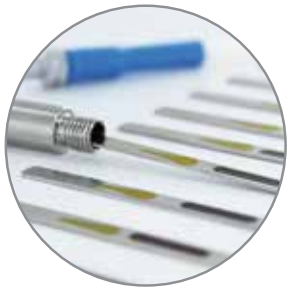
TOSI®

Reveal the hidden areas of instruments with the TOSI® washer test, the easy to use blood soil device that directly correlates to the cleaning challenge of surgical instruments. TOSI® is the first device to provide a consistent, repeatable, and reliable method for evaluating the cleaning effectiveness of the automated instrument washer.



LUMCHECK™

The LumCheck™ is designed as an independent check on the cleaning performance of pulse-flow lumen washers. Embedded on the stainless steel plate is a specially formulated blood soil which includes the toughest components of blood to clean.



FLEXICHECK™

This kit simulates a flexible endoscope channel to challenge the cleaning efficiency of endoscope washers with channel irrigation apparatus. A clear flexible tube is attached to a lumen device with a test coupon placed inside; the entire device is hooked up to the irrigation port of the endoscope washer.

HEMOCHECK™/PROCHEK-II™

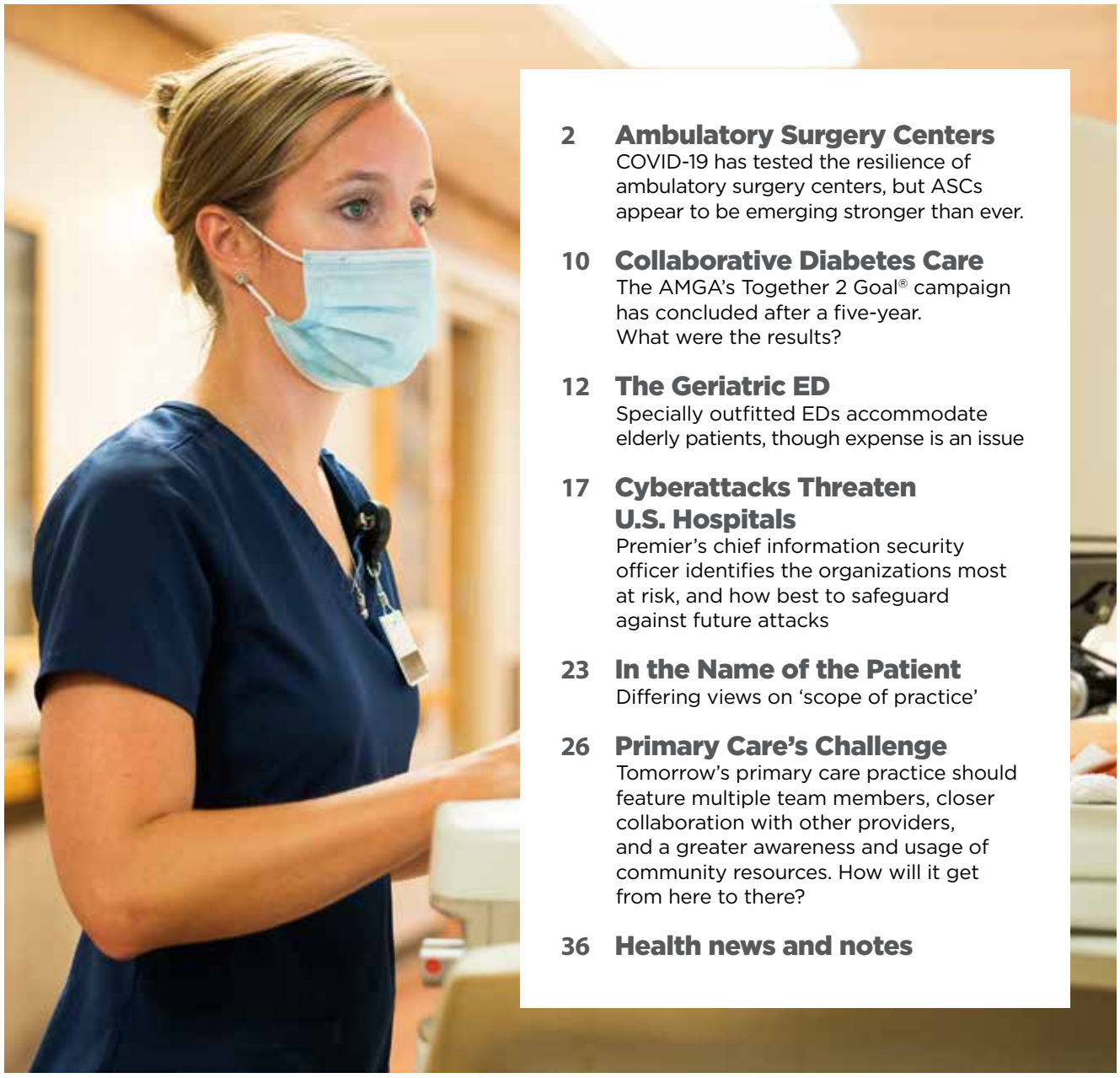
Go beyond what you can see with all-in-one detection kits for blood or protein residue. HemoCheck™ is simple to interpret and indicates blood residue down to 0.1µg. The ProChek-II™ measures for residual protein on surfaces down to 0.1µg.

healthmark

HEALTHMARK INDUSTRIES CO. | HMARK.COM | 800.521.6224 | HEALTHMARK@HMARK.COM

The Journal of Healthcare CONTRACTING

CONTENTS »» JULY 2021



2 Ambulatory Surgery Centers
COVID-19 has tested the resilience of ambulatory surgery centers, but ASCs appear to be emerging stronger than ever.

10 Collaborative Diabetes Care
The AMGA's Together 2 Goal® campaign has concluded after a five-year. What were the results?

12 The Geriatric ED
Specially outfitted EDs accommodate elderly patients, though expense is an issue

17 Cyberattacks Threaten U.S. Hospitals
Premier's chief information security officer identifies the organizations most at risk, and how best to safeguard against future attacks

23 In the Name of the Patient
Differing views on 'scope of practice'

26 Primary Care's Challenge
Tomorrow's primary care practice should feature multiple team members, closer collaboration with other providers, and a greater awareness and usage of community resources. How will it get from here to there?

36 Health news and notes

The Journal of Healthcare Contracting is published bi-monthly
by Share Moving Media
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

PUBLISHER
John Pritchard
jpritchard@sharemovingmedia.com

EVENT COORDINATOR AND ANAE PRODUCT MANAGER
Anna McCormick
amccormick@sharemovingmedia.com

EDITOR
Graham Garrison
ggarrison@sharemovingmedia.com

SENIOR EDITOR
Daniel Beaird
dbeaird@sharemovingmedia.com

Brent Cashman
bcashman@sharemovingmedia.com

CIRCULATION
Laura Gantert
lgantert@sharemovingmedia.com

The Journal of Healthcare Contracting (ISSN 1548-4165) is published bi-monthly by Share Moving Media, 1735 N. Brown Rd. Ste. 140, Lawrenceville, GA 30043-8153.

ART DIRECTOR

Ambulatory Surgery Centers

COVID-19 has tested the resilience of ambulatory surgery centers, but ASCs appear to be emerging stronger than ever.

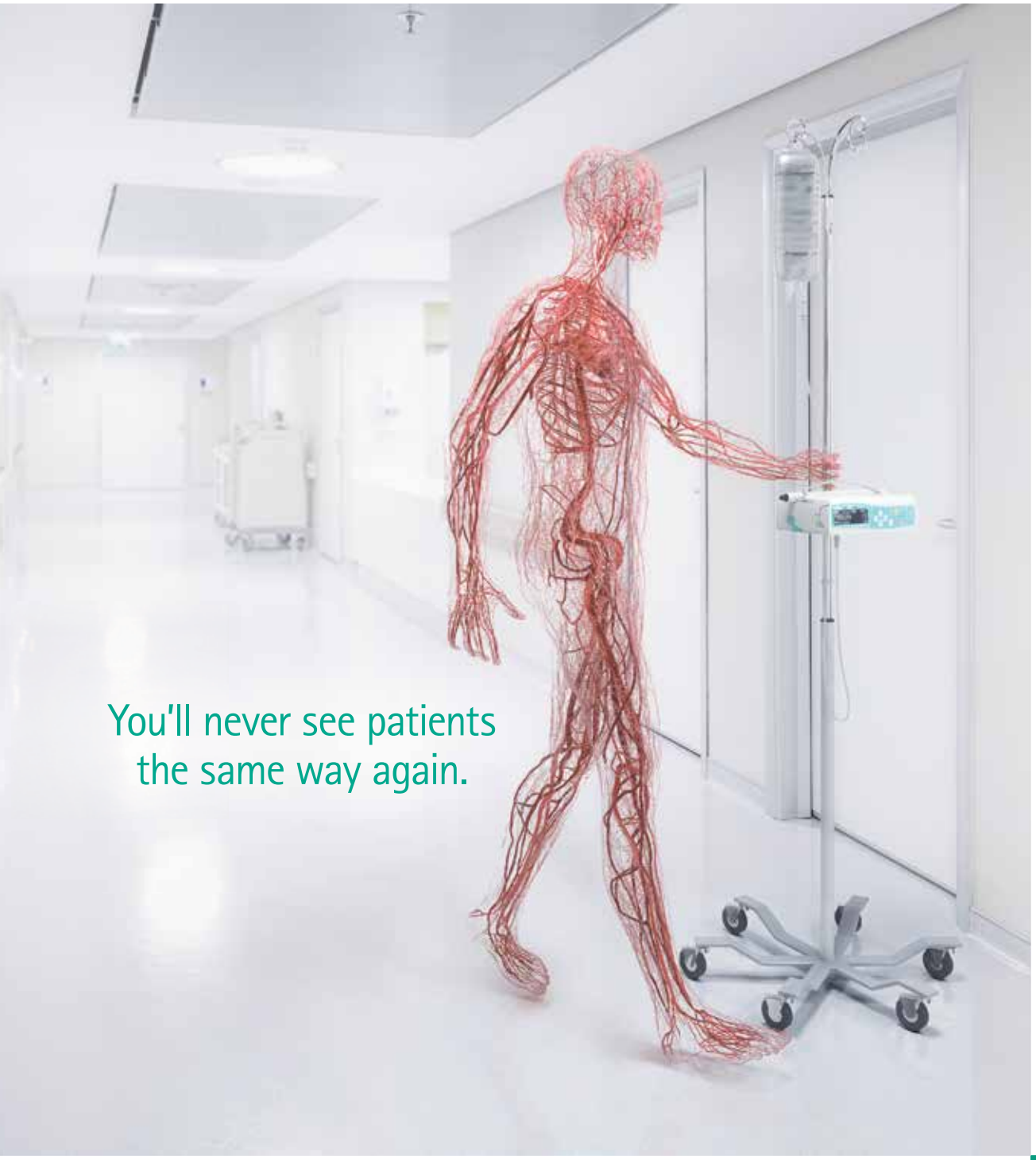
"Certainly, the last year has been difficult for ambulatory surgery centers," says Todd Johnson, who leads the medical device sector for management consulting firm Bain & Company. "Most of their procedures are elective – and those were postponed by law or patient preference for months [due to COVID-19.] But our clients are looking at 2021 as a bounce-back year, given the pent-up demand for cataract surgery, knee procedures, colonoscopies, etc."

In a 2019 report, Johnson co-wrote a report for Bain predicting that single-specialty centers focused on orthopedics, cardiology and spinal surgery would see the fastest growth in volume of procedures. That prediction is still on track.

Orthopedics

At the time, commercial payers had begun reimbursing total joint replacements in ASCs, which led to an eightfold increase in the number of surgery centers performing such procedures. CMS added 11 procedures through their standard review process as well as 267 additional procedures after revising their criteria, resulting in 278 procedures being added to the ASC covered procedures list from January 1, 2021, including total hip arthroplasty, under its standard review process. The agency also finalized its proposal to eliminate the Inpatient Only (IPO) list over a three-year transitional period, beginning with the removal of approximately 300 primarily musculoskeletal-related services. The IPO proposal would extend Medicare coverage to procedures performed in the

B|BRAUN
SHARING EXPERTISE



B. BRAUN'S PERIPHERAL ADVANTAGE® PROGRAM. DATA-DRIVEN PIVC CARE.

At B. Braun, we're committed to improving peripheral IV catheter care. Using data from our Peripheral Advantage® Program to standardize and improve upon your staff's IV insertion best practices, we're equipping clinicians with the training, tools, and data-informed insights they need to elevate the standard of care. Our data-driven PIVC program is designed to focus on fewer complications, longer dwell times, and better outcomes for all.

Learn more at PeripheralAdvantage.com

B. Braun Medical | Bethlehem, PA | 1-800-227-2862

hospital outpatient setting, and experts believe it will lead to increased coverage in ambulatory surgery centers as well.

Given these developments, perhaps it's not surprising that growth in outpatient orthopedics continues to climb, despite COVID-19. In fact, total joint procedures in ambulatory surgery centers grew over 40% in 2020, in an overall market that was flat, says Johnson.

a clinical, customer service, patient experience and affordability standpoint."

AAOS is supportive of Medicare's intent to remove the inpatient-only list, he says. "But we have concerns about unintended consequences," such as payers or health systems pressuring surgeons to perform procedures in an outpatient setting without consideration of risk, says Murrey. "We believe the physician should be the one to decide whether a case is more appropriately performed in the inpatient or outpatient setting."

'Our clients are looking at 2021 as a bounce back year, given the pent-up demand for cataract surgery, knee procedures, colonoscopies.'

ASCs received a vote of confidence in 2016 from the American Academy of Orthopaedic Surgeons. In a position statement, the AAOS voiced its support for ASCs, "regardless of ownership, so long as all potential conflicts of interest are fully disclosed to the patient, payers, and other providers." The Academy also voiced support for "physician and non-physician investment in facilities that deliver high quality and cost-effective healthcare."

The Academy's position remains just as strong today, says Daniel Murrey, M.D., FAAOS, chair of the AAOS Health Care Systems Committee, and chief medical officer for Surgical Care Affiliates, a division of Optum. "Orthopedic surgeons regard ASCs as an extension of their practice. We become deeply engaged from

Cardiovascular

Diagnostic cardiology procedures began shifting to outpatient settings in 2005 with Medicare's approval of outpatient arterial endovascular interventions, according to Bain & Company. In the first half of 2019, CMS added 12 cardiac catheterization procedures to its ASC-covered list, leading Bain to predict that ASCs would be performing between 30% and 35% of all cardio procedures by the mid-2020s.

"As payer support, technological advances and care redesign enable care to be delivered in lower-acuity and lower-cost settings, the opportunity to shift procedures such as electrophysiology, interventional cardiology and vascular services to ambulatory settings is top of mind for providers," says Chad Giese, associate principal, cardiovascular intelligence, Sg2, a health system consultancy. "Similar to the overall shift to ASC settings, however, the pace and extent of the shift is highly market-dependent. A complex combination of forces, including federal and local regulations, workforce, patient population, and the current market landscape, must be assessed to understand if this shift aligns with and supports the broader goals of an organization's cardiovascular program.

"Moreover, for cardiovascular services, this is more complex than just a shift to the ASC," says Giese. Many organizations have pursued a hybrid facility model, operating both as an OBL (office-based lab) or an ASC, depending on the type of procedures scheduled for the day, the resources and staffing needed, and the optimal reimbursement for cases.

OBLs accommodate primarily vascular procedures, while ASCs can accommodate diagnostic catheterizations, percutaneous coronary interventions (formerly known as angioplasties with stents), even pacemaker insertions or generator changeouts.

Insofar as ASC procedures are concerned, cardiology is where GI was 10 or 15 years ago, says Rick Snyder, M.D., FACC, president of HeartPlace P.A., a minority owner of Medfinity ambulatory surgery centers in Texas, and past president of the American College of Cardiology Texas Chapter. "When I started, Medicare wouldn't reimburse me for an angiogram or PCI." But that's changing, and with good reason.

Keeping standards high and allergenicity low

Featuring our innovative PI-KARE™ Technology, Ansell's softer and more durable next generation polyisoprene (PI) gloves have redefined the way PI gloves are made by eliminating standard chemical accelerators known to cause Type IV chemical allergies and sensitivities, effectively reducing the allergenic profile so you can enjoy a worry-free day at work.

Uncover our PI performance advantage and know the difference.

PI-KARE™
Skin-friendly PI Technology

Learn more at ansell.com/pi-kare-JHC

"Clearly, there are some circumstances where you will want to do procedures in hospital outpatient departments," for example, for patients with certain comorbidities, such as kidney disease, or if interventionalists anticipate difficulty with a particular vessel. Safety is always first, he says, citing a consensus statement – of which is a co-author – from the Society of Coronary Angiography and Intervention.

Where it's headed

For distributors and manufacturers more accustomed to servicing large acute-care hospitals, ASCs present "a much more complicated customer environment to cover, and call for a much smarter, more agile supply chain," says Johnson. But they are adapting.

Cardinal Health has a dedicated sales team focused on serving the needs of the ASC market, says Greta Marston, national vice president of ambulatory surgery center sales. The company anticipates continued growth in total joint replacements, says Marston, citing the 2020 Ambulatory Surgery Center HIDA Report, which projects the number of procedures performed in ASCs to grow from 32% in 2020 to 37% in 2022. "An additional area of growth is new-build facilities," she adds. "We're seeing investments across the country to expand through new-build facilities focusing on multispecialty, ortho and cardio procedures."

'Orthopedic surgeons regard ASCs as an extension of their practice.'

But in most cases, the ASC has the same equipment and staff as the hospital outpatient department, or HOPD, and costs a fraction of the latter. Furthermore, during the pandemic, cardiovascular patients who were directed away from the HOPD or inpatient OR to a surgery center found they loved them, he adds. "From a safety standpoint, cost, quality and patient satisfaction, ASCs are a home run."

"Changes by CMS will be one of many factors that accelerate the ongoing shift to the ASC setting," says Ryota Terada, consulting director, orthopedic intelligence, Sg2. "That said, a variety of factors act as brakes or accelerators for the rate and extent of shift to the ASC setting across markets and service lines," including:

- Patient acuity.
- Physician comfort (or lack thereof) with ASCs and patient selection criteria.
- Workflow challenges, including accommodating surgeons' schedules between hospital-based ORs and ASCs.
- State-level regulatory restrictions, such as Certifications of Need (CON), overnight stays and procedures permitted to be performed in ASCs.
- Space restrictions (which could limit the type of procedures offered.)
- Physician alignment models and/or equity and reimbursement considerations.
- Commercial payers' site-of-care policies for select elective procedures.

Says Giese, "Opening a new site sounds appealing, but how you're going to staff it needs to be part of the discussion."

Bill Prentice, CEO of the Ambulatory Surgery Center Association, says, "The health and comorbidities of patients are key in determining where patients safely get the best care. We would argue that many Medicare patients are good candidates to get care in ASCs, and if they did, the system would save billions of dollars."

Despite all of its difficulties, COVID-19 might have provided a shot in the arm for ambulatory surgery centers, says Johnson. "COVID has really changed the game," he says. "Doctors who might have been reluctant to perform total joints or other higher-acuity procedures in the ASC were forced to do so, because of capacity reasons or simply because patients were afraid to go to the hospital. They have become more comfortable with ASCs, which they've found are more convenient for doctors, payers and patients. So we expect continued growth." ■

HEALTH CONNECT PARTNERS

targeted connections

FROM OUR SPRING 2021 SUPPLY CHAIN CONFERENCE

Over the last 18 months, Health Connect Partners has facilitated over 77,000 meetings between hospital decision makers and suppliers in our custom-built Live! ONLINE reverseexpo platform.

Come join us for our Live! ONLINE fall event!

Live! ONLINE August 24–27 reverseexpo

Register NOW! **www.hlthcp.com**

For more information contact **Jim Friedlander,** *Director of Sales* **615.619.6025 jim.friedlander@hlthcp.com**

Valify Solutions Group™

Seeing Clearly

To effectively manage purchased services, start with spend visibility.

by Raelyn Wilson

Raelyn Wilson is AVP Client Success with Valify Solutions Group

When looking back on expense management over the past decade, corralling spend on physician preference items (PPI) was a daunting task. Vendors freely introduced medical devices and operators would buy with little discipline to how they were procured. Contracts, if they existed at all, were created and managed locally and even varied within the same facility.

Today, PPI has been broadly standardized and is often centrally managed. The transformation is a testament to how supply chain has successfully applied scale and effective management to contracting for this broad area of spend.

Purchased-services management is essentially following the same path. Services such as landscaping, laundry, blood, courier services, IT, finance, etc., account for a significant portion of operating expense for hospitals. In many cases, these categories can account for 35% of non-labor spend. And while they are receiving more scrutiny from supply chain and GPOs, there is much need for standardization and centrally managing these contracts.

Similar to PPI, it all starts with spend visibility. You may recall the phrase, "If you can't measure it, you can't manage it." That's why it is imperative to know your spend in real time in order to strategically manage it.

One of the tendencies I see in many health systems is that purchased services are not centrally managed by a single entity such as supply chain. As a result, practices for procuring supplies and services are inconsistent among departments and frequently not market competitive.

Fortunately, we're seeing an increasing trend for hospitals to enlist supply chain to categorize and manage purchased services. Standardizing to one or two suppliers in a category can generate significant savings, whether you are a standalone hospital or a large IDN. The key is having the intelligence to know what you should be paying. Also required is the contracting expertise to effectively negotiate supplier agreements across a diverse set of categories.

With visibility into $600 billion in purchased services spend and standardization spanning 1,300+ categories, Valify Solutions Group is uniquely positioned to help you manage your purchased services spend. The reward for most clients is double-digit savings with minimal clinical disruption.

To learn how you can drive value in purchased services, contact us today at advisory@valifysolutionsgroup.com or (972) 963-5130.

Collaborative Diabetes Care

The AMGA's Together 2 Goal® campaign has concluded after a five-year. What were the results?

The American Medical Group Association announced this spring that its Together 2 Goal® campaign has concluded after a five-year run. Started in 2016, this initiative challenged participating medical groups and health systems to improve care for 1 million people with Type 2 diabetes. Over 150 medical groups and health systems across 36 states participated, utilizing evidence-based care processes to drive improvement. These groups represent 61,000 FTE physicians treating 2 million patients with Type 2 diabetes. All participants sent quarterly reports to measure progress, while using Together 2 Goal® resources and tools to further efforts.

Improving quality of care and patient outcomes

One of the most significant opportunities this campaign provided was to improve the quality of care and patient outcomes for chronic conditions that have the greatest impact on quality of life, productivity, and costs for Americans, the AMGA said. Together 2 Goal® allowed health systems to track and report the data they collected to benchmark progress and performance against their peers. The highest performers were encouraged to collaborate, share their experiences, and adapt new best practices.

Initially, the Together 2 Goal® campaign was only supposed to last three years, but it is important to establish long-term practices for diabetes management, the AMGA noted. One of the difficulties with diabetes management is the chronic symptoms can become challenging to maintain long-term. Because it is so easy for patients to go in and out of states of ideal diabetes management, the AMGA extended the Together 2 Goal® campaign two years to help groups hardwire their improvements and sustain improved diabetes care.

Four best practices for health systems

1 Engage the care team

A coordinated care response is essential for optimal diabetes care. Engaging the care team is a crucial step for coordinated patient care. To effectively engage the care team, you need to establish roles and responsibilities, define your goals for success, support ongoing communication and training, enforce accountability, and empowering staff to function at the top of their license. Because diabetes care often involves many types of health providers, health systems should also consider engaging relevant specialists as a part of their care teams.

2 Empower patients

With the complexity of diabetes, it is important to empower patients with the tools and resources they need to manage their condition. A tailored approach that generates individualized goals and utilizes shared decision-making is the most effective step providers can take with patient care. It is also important to consider the patient's perspective in their care process. What is their patient experience like? What can you do to improve it? Are there external social factors you have not considered, like transportation or housing? Additionally, patients should be referred to diabetes education classes or other resources to find better ways to support themselves daily. Knowledge is power!

3 Harness technology

Part of improving diabetes management is leveraging the available technologies to better understand any gaps in care. Health systems can utilize technology like remote patient monitoring, e-coaching, while telehealth opportunities can help patients manage their diabetes while at home. Additionally, point-of-care tools in electronic health records, patient registries, and population management software can assist health systems identify patients that need diabetes care.

4 Develop external partnerships

When you develop an external partnership, you might have an opportunity to offer services that meet patients where they are. Health systems can reach out to community-based organizations, faith-based organizations, insurance companies, public health organizations, and outside providers.

Let's make a positive impact together.

DUKAL can be a strong long term partner for you in the personal protection equipment category.

We are continuously investing in our capabilities and capacity to bring high quality personal protection equipment to front-line workers. Our PPE products meet or exceed all FDA requirements, holding multiple 510k's for surgical masks and N-95 respirators. DUKAL also offers AAMI level rated isolation gowns.

Let's make a positive impact together. Contact us at sales@dukal.com to learn more about how we can be a long term provider of personal protection equipment for you.

Dukal

Better Health. Better Future.

As a leader in the development and manufacturing of medical products we partner with healthcare professionals to launch innovative solutions to unmet clinical needs.

Learn more about our products by visiting our new website www.dukal.com

The Geriatric ED

Specially outfitted EDs accommodate elderly patients, though expense is an issue

Picture this scenario. You have taken your 90-year-old father to the emergency room at 4 p.m. following a fall. Considering his comorbidities, multiple prescriptions and mild cognitive impairment, his health is probably more complicated than that of others in the waiting area. But since his medical conditions do not require immediate medical intervention, he ends up in the middle of the queue.

You wait … and wait. The doctors and nurses are busy, and they're doing the best they can. If the ED is at capacity and he needs to be seen right away, they can adapt and make room – even in a hallway – to address concerns quickly and safely. But if his evaluation is not completed by 8 p.m. and you determine he's in no condition to wait any longer, you might take him home and make a note to call his primary care doc first thing in the morning.

Had this occurred in a geriatric ED, things might have played out differently. Recognizing that a 90-year-old is more vulnerable than younger patients, the staff may have been able to rapidly usher your father into an area specifically designed for elderly patients. Instead of conducting standard triage, they would view his fall and ED visit as an "unfortunate opportunity." They know that when a 48-year-old person falls, it's most likely an event, whereas when a 90-year-old does, it's a syndrome. So they would check his medications, cognitive abilities and balance. A social worker would assess his nutritional status, the quality of care and attention he is receiving at home, and whether or not he needs additional social resources.

"I am an emergency physician, and I'm proud of doctors and nurses who work in the emergency room," says Kevin Biese, M.D., FACEP, associate professor of emergency medicine and geriatrics at University of North Carolina at Chapel Hill. "This isn't about them not doing a good job. They do amazing work every day in very challenging settings. This is about opportunities to redesign systems to better meet the needs of vulnerable older adults." A greater awareness of the geriatric patient's needs and a structured program can help change that system.

Accreditation

The first self-identified geriatric ED (GED) in the United States was established more than a decade ago. By 2014, the American College of Emergency Physicians (ACEP), the Emergency Nurses Association, American Geriatrics Society and Society for Academic Emergency Medicine had teamed up to create guidelines for a geriatric ED. Four years later, ACEP launched a voluntary accreditation program, classifying GEDs as level 1 (gold), level 2 (silver), or level 3 (bronze), based on staffing, care processes, education, physical environment, and specialized equipment.

Requirements begin with demonstrating that the participating emergency department includes both a physician and nurse on staff with specialized geriatric training, meets environmental criteria such as easy patient access to water and mobility aids, and has a geriatric quality improvement initiative.

Today approximately 250 emergency departments in the country have GED accreditation. As of February 2021, 13 of them had achieved Level 1 accreditation.

"We're thrilled with the progress," says Dr. Biese, who chairs ACEP's accreditation committee. "It speaks to the eagerness of our colleagues in emergency medicine to do a better job for vulnerable older adults, and to the need for a structured approach to accomplish that.

"We're just getting started. There are more than 5,000 emergency departments in the country. At the end of the day, our goal isn't to get every one of them accredited, but certainly to create more awareness of the special needs of geriatric patients and to help our colleagues meet those needs."

Demographics

Between 2000 and 2010, the population 65 years and over increased at a faster rate than the total U.S. population, according to the 2010 Census. The population 85 and older is growing at a rate almost three times the general population. In the U.S., an estimated 10,000 baby boomers turn 65 every day, says ACEP.

This demographic shift brings challenges to healthcare systems, as older adults visit EDs at higher rates than non-seniors, often present with multiple chronic conditions, are at increased risk from polypharmacy, and suffer from complex social and physical challenges, according to ACEP. Seniors make contact with the healthcare system at many points, though perhaps none as frequently and significantly as the emergency department.

The expertise which an ED staff can bring to an encounter with a geriatric patient can meaningfully impact not only the patient's condition, but also the decision to use relatively expensive inpatient modalities or less expensive outpatient treatments. More accurate diagnoses and improved therapeutic measures can expedite and improve inpatient care and outcomes, help providers determine which older adults are likely to benefit from hospitalization versus outpatient care, and can guide the allocation of resources towards a patient population that, in general, uses significantly more resources per event than younger populations.

The vast majority of geriatric EDs are not physically separate from traditional EDs, says Biese. "It's hard to wrangle up [millions of dollars] to build a geriatric ED. We don't want that to be a barrier. Of the 250 accredited EDs, only a handful have a separate space for older adults. But they are all making progress to improve care for vulnerable older adults."

'This is about opportunities to redesign systems to better meet the needs of vulnerable older adults.'

ROI

The cost-effectiveness of geriatric EDs appears to be widely accepted. A study in JAMA Network involved Medicare beneficiaries who visited one of two EDs – Mount Sinai Medical Center in New York City and Northwestern Memorial Hospital in Chicago – that implemented the Geriatric Emergency Department Innovations in Care Through Workforce, Informatics, and Structural Enhancements (GEDI WISE) program, sponsored by the CMS Innovation Center.

The researchers determined that the program was associated with lower Medicare expenditures, with total Medicare savings per beneficiary of $2,436 in the Mount Sinai cohort and $2,905 in the Northwestern Memorial cohort at 30 days after the initial ED encounter. This association remained statistically significant up to 60 days, with a mean savings per beneficiary of $1,200 in the Mount Sinai cohort and $3,202 in the Northwestern Memorial cohort.

But a few things still need to be ironed out before geriatric EDs are widely adopted, wrote Maura Kennedy, M.D., MPH, Department of Emergency Medicine at Massachusetts General Hospital and Harvard Medical School, in an accompanying editorial.

"Evidence that higher-quality models of care, such as GEDs, can reduce health care costs should catalyze the adoption of these models," she said. This is more likely to happen when the savings generated benefit the entity shouldering the costs. However, in the GEDI WISE program, the savings went to the payer, in this case Medicare, while the costs of sustaining this intervention beyond the grant-funded period were borne by the hospitals.

"Asking hospitals to spend their own money to save Medicare money is unlikely to be sustainable. Growth of this care model requires that health care systems also benefit financially from the cost savings."

What makes an ED a geriatric ED?

The list below is a suggested starting point for the design and equipping of a geriatric ED, per the American College of Emergency Physicians.

Furniture

- Exam chairs/reclining chairs may be more comfortable for geriatric patients, and they facilitate transfer processes.
- Furniture should be selected with sturdy armrests, and ED beds should be at levels that allow patients to rise more easily for safe transferring. (Some studies show that bedrails do not reduce the number of falls and may increase the severity of falls.)
- Extra thick/soft gurney mattresses decrease development of skin breakdown and decubitus ulcer formation.
- Upholstery should be soft and moisture-proof to protect the fragile skin of older patients. It should be selected to reduce surface contamination linked to healthcare-associated infections.
- Economic evidence supports early prevention of pressure ulcers in ED patients by the use of pressure-redistributing foam mattresses.
- Reclining chairs in the ED (instead of gurney beds) have been shown to reduce pain and improve patient satisfaction.

Special equipment

- Body warming devices/warm blankets.
- Fluid warmers.
- Non-slip-fall mats.
- Bedside commodes.
- Walking aids/devices.
- Hearing aids.
- Monitoring equipment.
- Respiratory equipment, to include a fiberoptic intubation device.
- Restraint devices.
- Urinary catheters, to include condom catheters. (Minimize risk of CAUTI.)

Visual considerations

- Soft lighting is recommended, but exposure to natural light has also been shown to be beneficial for recovery times and in decreasing delirium.
- Patients should have control of the lighting in their space so they can sleep when other lights are on.
- Light colored walls with a matte sheen and light flooring with a low-glare finish should be used to optimize lighting and reduce glare. Fixtures that bounce light off the ceiling or walls increase overall room lighting while glare can be reduced with the use of matte surfaces.
- Patterns that have dominant contrasts may create a sense of vertigo or even seem to vibrate for older adults. Some older patients may misperceive patterns as obstacles or objects (e.g., leaf patterns on flooring, which may be seen as real leaves).
- Monochromatic color schemes should be avoided. Similar colors look the same for those with poor vision. Instead, allow colors to contrast between horizontal and vertical surfaces.
- Older adults experience a decreased ability to differentiate cool colors (greens, blues) as opposed to warm colors (yellows, oranges). In poorly lit areas, yellow is the most visible. Orange and reds are attention-grabbing. Blues appear hazy and indistinct and may appear gray due to yellowing of the elderly patient's lens.

Acoustics

- Private rooms or acoustically enhanced drapes facilitate better communication and decrease anxiety and delirium.
- Older adults have increased sensitivity to loud sounds. The use of sound-absorbing materials (e.g., carpet, curtains, ceiling tiles) may reduce background noise and can also increase patient privacy.
- Loud noise sources in the hospital (e.g., overhead paging, machines) should be reduced.
- Music can decrease anxiety, heart rate and blood pressure. Patients should be provided with a way to listen to music and choose their programming without disturbing others.
- An enhanced acoustical environment can also increase patient privacy and safety. One study performed in an ED found that patients in curtained spaces reported they withheld portions of their medical history and refused parts of their physical examination because of lack of privacy. None of the patients in rooms with walls reported withholding information.

Source: American College of Emergency Physicians, www.acep.org/globalassets/sites/geda/documnets/geda-guidelines.pdf

McKESSON

Be prepared this respiratory season

5 ways supply chain is critical to delivering better patient care

It's hard to predict what this flu season will bring. As clinicians continue to respond to COVID-19, it's critical that supply chains are well-prepared to help fight the flu, pneumonia and other respiratory illnesses.

Protect your care team with a respiratory preparedness plan built to support you and your patients with better care and outcomes. A complete respiratory plan should include:

- **Vaccination strategies**
- **Infection prevention protocols**
- **Point-of-care lab testing**
- **Respiratory therapy options**
- **Post-acute care resources**

To learn more about our respiratory program offerings, visit mms.mckesson.com/respiratory

Cyberattacks Threaten U.S. Hospitals

Premier's chief information security officer identifies the organizations most at risk, and how best to safeguard against future attacks

If you thought your news feed has been inundated with cyberattack stories in the last few months to a year, you're not wrong.

Ben Schwering, chief information security officer (CISO) for Premier Inc., says the United States has definitely seen an uptick in cyberattacks in an attempt to infiltrate or compromise healthcare organizations during the pandemic.

Threat actors are looking to take advantage of the overall state of unrest. Many healthcare organizations were stretched thin and operating under extreme circumstances, thus more susceptible to things like phishing attempts. "Threat actors were using the pandemic as an opportunity to say, 'Hey, we have an entire industry that's under duress, they may not be as vigilant as they would be under normal circumstances, let's see if we can if we can take advantage of that,"' Schwering said.

The general state of urgency around all things related to COVID added to the vulnerability. "If you had a well-constructed phishing attempt, or well-constructed malicious website, just given the overall sense of urgency, and in some cases panic, it was more enticing and more likely that a person may click on one of those links."

The supply chain was particularly vulnerable as teams scrambled to source product from alternate vendors. Organizations involved in the research, logistics, and distribution of the COVID vaccine also

faced increased attacks. "The threat actors know that if they can compromise you at any leg of that supply chain, that you're going to be more apt to pay the ransom because you're in a state of emergency dealing with the pandemic," said Schwering. "And ultimately, that's their goal."

The attacks can cause many different types of disruptions, including patient care. For instance, some hospitals have had to turn away patients from emergency departments because their IT infrastructure was compromised and they couldn't access health records. While those are extreme cases, hospitals could also be dealing with not being able to admit patients, schedule procedures, or reschedule surgeries because systems are down.

The best safeguards involve sticking to the basics of cybersecurity, Schwering said. "There are a lot of good frameworks out there," he said. Having a strong Incident Response Program, knowing how you would react if an event occurred, is important. And if your organization was compromised, understanding what your processes and procedures are to get back up and running quickly is critical.

"The most successful organizations have layers of automation on top of those traditional protections."

— Ben Schwering, chief information security officer (CISO) for Premier Inc.

On a more tactical perspective, multi factor authentication, network segmentation, vulnerability management, strong malware protection, and strong email protection have been essential building blocks for IT. "The most successful organizations have layers of automation on top of those traditional protections," Schwering said. For instance, if a malicious email gets through but is recognized, automated action can immediately isolate the infected machine that received the email. Having that layer of automation increases the speed in which you can respond to an incident. "And when it comes to incidents like ransomware, or malware, that speed, sometimes a few seconds, matters. Plus, you're not relying on a human being there at 3 a.m. If you have those strong processes, procedures and automation in place to react, your chance of successfully fighting off an attack are greatly increased." ■

Is your **infection risk** under control?

Call AliMed before your Risk Manager calls you!

AliMed has a suite of infection control solutions—from **ultrasonically welded table straps** and **fluid-proof patient positioners** to **antimicrobial-treated transfer boards** and **easily accessible PPE dispensers**—to support any protocol, anywhere.

Scan for more:

800.225.2610 x330

AliMed®
Helping people...help people™

The importance of independent and specialty distributors throughout the pandemic

The pandemic provided its share of challenges for the healthcare supply chain throughout 2020. As health systems scrambled to meet demand brought on by COVID-19, distributors and manufacturers were also asked to adjust to the threat level created by the novel coronavirus. It required resiliency, creativity, and an ability to source—and qualify—excellent product.

True to form, independent and specialty distributors demonstrated their agility. "They went beyond their specializations and provided the best possible products to their customers," said Mark Kline, Chief Commercial Officer for NDC, Inc., a healthcare supply chain company serving multiple markets. "Independent distributors offered the flexibility to change to the models necessary to meet demand."

Supply chain models have evolved over the years from large inventories to just-in-time inventory to stockpiles; and now, the healthcare industry is planning for a post-pandemic model.

"The networks and connections of independent distributors positioned them to broadly serve health systems across the country," said John Cook, Vice President of Sales for NDC. "Their contacts in local communities and regional areas allowed them to operate quickly. Plus, their associations with governments, emergency management departments and healthcare organizations created their agility in the marketplace."

These relationships proved vital to health systems receiving products and resources in a timely and cost-efficient manner during the height of the pandemic, according to Kline and Cook.

"Distributors are an extension of health systems for having resources on hand,"

NDC®
Delivering Efficiency to Healthcare

With over 2,000 independent distributors, manufacturers and GPOs, we help our partners succeed by delivering world-class supply chain solutions, customized marketing services and the best products at competitive prices.

That's simply powerful.

Join the conversation. Be part of the future of healthcare distribution. ***#simpow***

Cook said. "Clinical coordination requires distribution representatives to make sure proper training is occurring on products given to those caring for patients."

Cook added that distributors must serve as a full-service clinical supply chain team and not just as a product provider. "Sales teams must be educated on the clinical needs of the health systems," he said. "It's important to bring the right model fit to customers post-pandemic."

Just as distributors are an extension of health systems, NDC acts as such for distributors. It has evolved into a unique healthcare supply chain company serving the acute care, physician, extended care, physical therapy and veterinary markets. It provides comprehensive and customized master distribution and logistics solutions for more than 1,500 distributors and approximately 400 manufacturers.

Its history as a small buying cooperative of independent healthcare distributors lends itself to NDC offering a specialized collection of business services and tailored marketing tools to its customers.

NuEdge Alliance gives NDC its own GPO

The contract process can be intimidating and complex. We had to simplify the process and build a program of attraction for all supply chain stakeholders, said Dave Rose, Vice President of Business Development for NDC.

While larger group purchasing organizations (GPOs) focus on hospitals, NuEdge Alliance, NDC's own GPO, offers both end-user customers and distributors meaningful contracts applicable to non-acute care markets. "It's our sweet spot," Rose said.

"NuEdge developed a new competitive edge for independent distributors," he added. "It's easy for distributors to enroll their customers on our platform and identify contract opportunities."

Membership Enrollment is completed quickly online and membership for distributors' customers is available at no charge without any on-going fees.

Rose described GPO contracting as complex on the surface from nuances to requirements to rebates to reporting and management of denials.

"We worked with our parent GPO – Provista/Vizient – to improve the engagement through our intuitive program," Rose explained. Plus, NuEdge developed its contract alignment program so that distributors can elect to outsource their rebate process of alignment. That makes it easier for distributors to report through NDC.

Rose described GPO contracting as complex on the surface from nuances to requirements to rebates to reporting and management of denials. But NuEdge is designed to ease these contracting pain-points for its partners.

"We developed a process to access contract pricing essential for independent distributors to compete nationally," Rose said.

NuEdge helps facilitate over 9 million in rebates during 2020 for its 90 distributor members at an average of approximately $113,500 rebates per distributor. "That's meaningful to our member providers in controlling supply and equipment costs," Rose emphasized.

NuEdge Connect is a special aggregation program that brings product focus and volume pricing to our authorized distributors. Manufacturers receive marketing assistance to distributors and unique product solutions are given to providers.

Rose said NuEdge continues to grow its Connect aggregation program and an ancillary services program called NuEdge Business, which launches soon. It will help all supply chain partners through non-product portfolio management like credit card processing, shipping and fleet program discounts.

Rose encouraged independent distributors to keep an open mind as to what a GPO can do for their business and customers.

"Put your foot in the water," he said. "If you've never worked with a GPO, then NuEdge is a great partner to start with. Our business environment is constantly changing. The team is experienced, capable and understands best practices for leveraging contracts for profitability and competitiveness. ■

In the Name of the Patient

Differing views on 'scope of practice'

"Scope of practice" is a term describing the services that a health professional is deemed competent to perform and is permitted to undertake in keeping with their professional license. Sounds straightforward. But in fact, as medicine evolves, so too do the discussions around scope of practice. And they can get quite heated.

Nurse practitioners, physician assistants, nurse anesthetists and others believe that expanding scope of practice is in the best interest of the patient. Here's the rub: Physicians, anesthesiologists, ophthalmologists and others believe that limiting expansion of scope of practice is in patients' best interest.

It's not a new debate. The American Medical Association formed the Scope of Practice Partnership back in 2006. To date, the Partnership has awarded more than $2.3 million in grants to members (national, state and specialty medical associations) to fund advocacy tools and campaigns.

In that same year – 2006 – 14 healthcare professional organizations formed the Coalition for Patients' Rights to "monitor the legislative and regulatory environment to identify efforts to limit the scope of practice of the healthcare professionals it represents," including critical-care nurses, nurse practitioners, occupational therapists, hospice and palliative nurses, and pharmacists.

The divisions fester today. For example, in May 2019, the American Association of Nurse Anesthetists launched a campaign – "CRNAs: We are the Answer" – which included these words: "Anesthesia services are provided the same way by nurses and physicians; in other words, when anesthesia is provided by a CRNA [certified registered nurse anesthetist] or by a physician anesthesiologist, it is impossible to tell the difference between them." The American Society of Anesthesiologists took exception, calling AANA's campaign "malicious" and "irresponsible."

Scope-of-practice struggles are playing out in state legislatures and in the courts today. In January, Massachusetts became the 23rd state to allow nurse practitioners to practice independently. In March, Hawaii lawmakers advanced a bill to allow advanced practice registered nurses (APRNs) to perform abortions.

Also in January, however, New Jersey lawmakers rejected legislation that would have allowed APRNs to prescribe without physician oversight, reports the American Medical Association. And in March, a measure in South Dakota that would have allowed physician assistants to diagnose and treat patients and prescribe substances without physician involvement died in committee.

In her testimony before the South Dakota committee, AMA President Susan Bailey, M.D., said the proposed measure would move healthcare in the wrong direction by removing physicians from care teams. "And when you remove the most highly educated and trained health care professional from the care team, you put patients at risk," she said.

What's next?

"The removal of unnecessary barriers to CRNA practice is an ongoing effort," says Anna Polyak, RN, JD, senior director of state government affairs for AANA. "While CRNAs work collegially with physicians and other providers every day to provide optimal patient care, barriers such as unnecessarily restrictive physician involvement in CRNA practice do not improve care or increase patient safety. Studies have consistently shown that CRNAs and other APRNs, when allowed to practice to the full extent of their education and training, provide increased access to safe, cost-effective patient care.

"There is a great shortage of anesthesia providers around the country," she says. "So, this is not about replacing one provider with another, but rather about improving access to care by allowing all providers to practice to the full extent of their training and education."

'Changes in scope of practice and overlapping responsibilities are inevitable in our current and future health care system.'

The number of nurse practitioners and advanced practice registered nurses is expected to grow faster than that of physicians for the rest of the decade. AANP estimates the current number of nurse practitioners in the United States to be close to 300,000, while the National Commission on Certification of Physician Assistants estimates the number of PAs to be 139,000. The U.S. Bureau of Labor Statistics predicts that the job outlook through 2029 for PAs and CRNAs will be much better than average. So will their median pay ($115,800 for APRNs in 2019, and $112,260 for physician assistants in 2019).

Given all that, this statement about scope of practice from the American Nurses Association sounds accurate: "In a profession as dynamic as nursing, and with evolving health care demands, changes in scope of practice and overlapping responsibilities are inevitable in our current and future health care system." ■

Scope of practice: A concern for many specialties

Scope-of-practice disputes span many medical specialties, including eye care and behavioral health care.

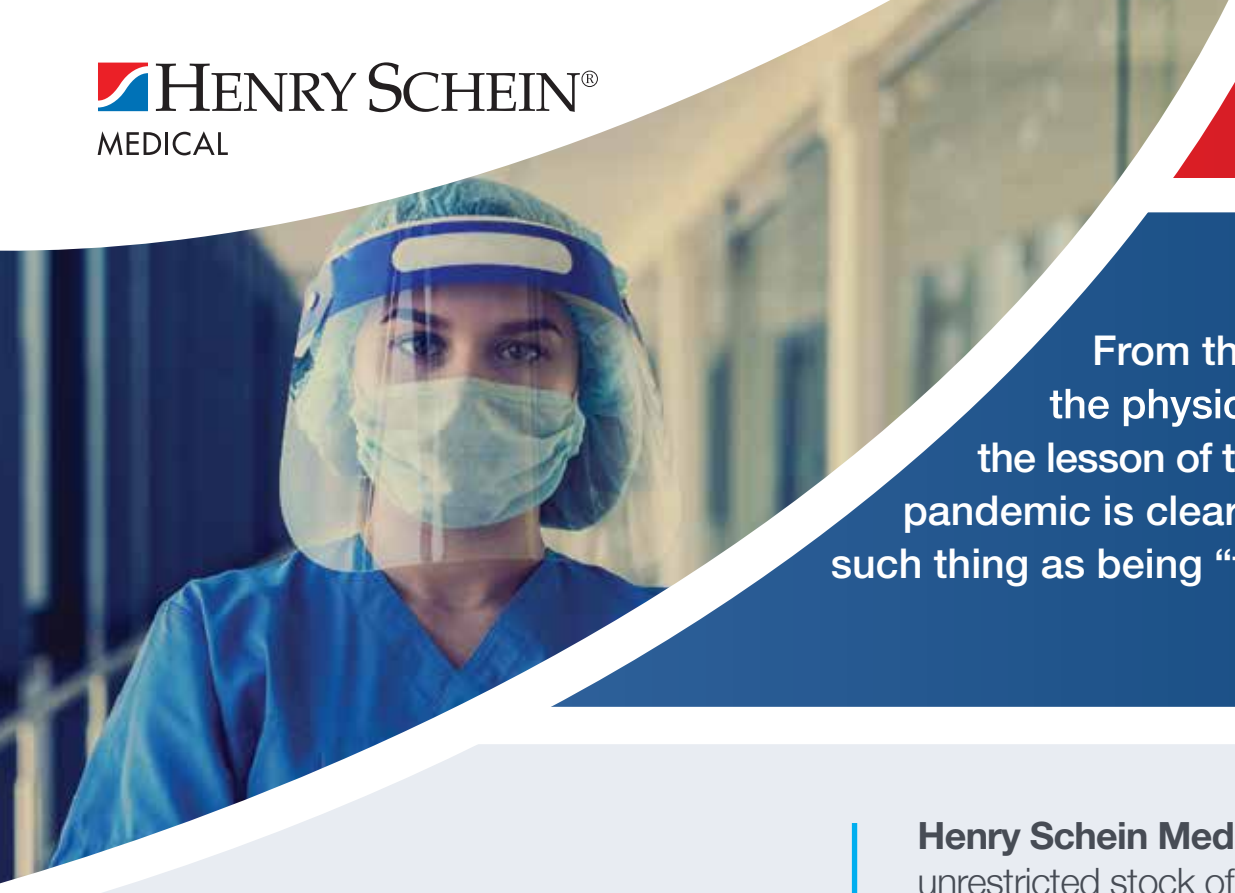
In September 2020, for example, the Arkansas Supreme Court cancelled a scheduled public referendum that would have asked voters to repeal a 2019 bill that allowed optometrists to perform a variety of in-office procedures (with the exception of cataract surgery, LASIK surgery, or other major eye surgeries that ophthalmologists regularly perform). The referendum, backed by Safe Surgery Arkansas, an ophthalmologist-backed advocacy group, was rejected by the high court on technical grounds related to the procedure by which signatures had been collected.

In January 2019, members of the U.S. Congress introduced the Medicare Mental Health Access Act (HR 884), which would have given psychologists independent practice authority in all Medicare treatment settings, and would have expanded the definition of "physician," for purposes of the Medicare program, to include a clinical psychologist with respect to the furnishing of qualified psychologist services.

The American Medical Association, American College of Physicians, American Psychiatric Association, American College of Surgeons and others voiced displeasure with HR 884. In a September 2020 letter to Congressional leaders, the organizations wrote that the proposal "jeopardizes the safety of patients in the Medicare program and would create silos in the delivery of appropriate mental and physical health care," and that the legislation "runs counter to efforts to coordinate and integrate the delivery of care to patients with mental illnesses and co-occurring health conditions."

The bill failed to pass the 116th U.S. Congress, nor has it been reintroduced in the 117th Congress.

HENRY SCHEIN®
MEDICAL



From the front lines to the physician's office, the lesson of the COVID-19 pandemic is clear: there's no such thing as being "too prepared."

Let Henry Schein Medical help protect your practice with

ESSENTIAL PPE SUPPLIES.

Henry Schein Medical currently has unrestricted stock of these products:

- COVERALLS
- PROCEDURAL MASKS
- FACE SHIELDS
- HAND CARE
- ISOLATION GOWNS
- OXIMETERS
- THERMOMETERS
- KN95 AND N95 MASKS

To learn more about Henry Schein Medical's Essential PPE supplies, visit **HENRYSCHEIN.COM/PPE.**

* While supplies last

BECAUSE SO MANY RELY ON YOU.... YOU CAN RELY ON US.

Primary Care's Challenge

Tomorrow's primary care practice should feature multiple team members, closer collaboration with other providers, and a greater awareness and usage of community resources. How will it get from here to there?

Visits to primary care clinicians are declining, the workforce pipeline is shrinking as clinicians opt for more lucrative fields, and many practices are struggling to remain open. Yet primary care is the only part of health care in which an increased supply is associated with better population health and more equitable outcomes.

"A strong foundation of primary care is critical to the health system," conclude the authors of a new report from the National Academies of Sciences, Engineering and Medicine, "Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care." It should be a common good, they say, made available to all individuals in the U.S., promoted by responsible public policy, and supported with the resources to achieve health equity.

The recommendations in the report echo those of a 1996 publication by the Institute of Medicine. But those recommendations "remain fallow," the authors of the new report admit. "[Twenty-five] years since the Institute of Medicine report, 'Primary Care: America's Health in a New Era,' this foundation remains weak and under-resourced, accounting for 35% of health care visits while receiving only about 5% of health care expenditures. The foundation is crumbling."

Some of the report's recommendations cover well-trodden ground, including:

- Shifting away from fee-for-service payment toward value-based models.
- Increasing physician payment for primary care services to more closely match that of specialty services.
- Creating new health centers, particularly in underserved areas.
- Developing digital health technology.

Hillrom™

LET US CHANGE YOUR VIEW

From a name doctors use most and inventor of the world's first direct illuminating ophthalmoscope, we're excited to introduce new Welch Allyn® physical assessment tools to help clinicians take their exams to a new level. We've listened to countless providers and have re-designed our new devices with a familiar form and feel, long-lasting LED technology and views you have to see to believe.

Connect with your Hillrom representative today to see more.

But two recommendations, if implemented, could signal a new direction for the primary physician practices whom *The Journal of Healthcare Contacting* readers call on:

- The development of interprofessional care teams.
- The creation of community-based training programs for primary care providers.

'Family members and other informal caregivers are an important part of overall quality and care of patients.'

Interprofessional teams

Primary care teams should fit the needs of communities, work to the top of their skills, and coordinate care across multiple settings, say the report's authors. To do so, they need to "consider how to meaningfully engage the full range of primary care professions, including physician assistants, nurse practitioners, medical assistants, community health workers, behavioral health specialists, and others." Furthermore, they should make efforts to integrate primary care and public health, behavioral health, oral health and pharmacy.

Interprofessional teams typically include a core team, an extended health care team, and what the authors refer to as an "extended community care team."

- The core team comprises the patient, their family, and various informal caregivers; primary care clinicians, who may be physicians, PAs, NPs, or RNs; and clinical support staff, such as medical assistants and office staff.
- The extended health care team can include community health workers, pharmacists, dentists, social workers, behavioral health specialists, lactation consultants, nutritionists, and physical and occupational therapists.
- The extended community care team includes organizations and groups, such as early childhood educators, social support services, healthy aging services, caregiving services, home health aides, places of worship and other ministries, and disability support services.

"Team-based care improves health care quality, use, and costs among chronically ill patients, and it also leads to lower burnout in primary care," according to the report. But such teams demand skilled leadership, decision-making tools and real-time information. In addition, interprofessional teams:

- Are proactive and provide well-thought-out care, including pre-visit planning and laboratory testing.
- Distribute and share the delivery of care among team members.
- Share clerical tasks, such as documentation, non-physician order entry, and prescription management.
- Enhance communication through a variety of strategies.
- Optimize the function of the team through co-location, team meetings, huddles, and mapping workflow.

"Family members and other informal caregivers are an important part of overall quality and care of patients," says Rachel Buckholtz, a Medical Group Management Association consultant, commenting on the report. "Oftentimes they can provide reliable data that may otherwise get missed, which can help the provider make better decisions for the patient. They are better able to express the true medical condition, especially in the elderly population.

"I see providers relying on resources in the community, but I do feel they need to become more aware and comfortable with all resources available to patients," she adds. "That's a hard ask, but one that is necessary, especially as functional medicine progresses. I have had many providers tell me they 'don't practice that kind of medicine,' not understanding the resources available.

"In some areas it's as simple as telling [patients] where they can participate in co-

Defend with Profend®

Nasal Decolonization Kit for better outcomes with **reduced HAI* risk.**

Efficient, effective bacterial decolonization can help lower HAIs*, length of stays, and costs.[1]

Profend® PVP-Iodine swabs kill 99.7% of *S. aureus* at 10 minutes and 99.9% at 12 hours after application.[2] They are simple for the OR and ICU staff to apply for just 60 seconds, with a compact design for patient comfort. And CDC guidelines recommend nasal decolonization as a core strategy to prevent surgical site infections.

Learn more at www.DefendwithProfend.com

References: 1. Nelson R, Samore M, Smith K, et al. Cost-effectiveness of adding decolonization to a surveillance strategy of screening and isolation for methicillin-resistant *Staphylococcus aureus* carriers. *Clin Microbiol Infect.* 2010;16(12):1740–1746. **2.** PDI *in vivo* Study 0113-CTEVO.

*Healthcare-associated infections

PDI®

BE THE DIFFERENCE®

ops for healthy fruits and vegetables. Many still only focus on treating a patient when they are sick enough for medications, instead of using the community resources to help them make wiser decisions on health before it becomes a chronic issue requiring traditional medications."

Community-based training

Training primary care clinicians individually in inpatient settings will not adequately prepare them to deliver high-quality primary care, says the report. The federal government should support training opportunities in community settings and in rural and underserved areas, and provide economic incentives such as loan forgiveness and salary supplements. Trainees should be given the opportunity to work alongside non-physician care providers and extended care team members.

"Core to the delivery of primary care are competencies underlying team-based care; how to function in an integrated, interprofessional manner; and how to integrate and coordinate care with community-based care team members.… The challenge of achieving those competencies lies in incorporating interprofessional didactic and experiential learning into the already crowded medical and health professional education. Challenges also exist in educating and training students alongside the current workforce, especially in settings where the workforce itself is not functioning as an interprofessional team.

"The ability of a primary care team to address the broad range of population needs, including identifying community expectations, engaging individuals in preventive health care and counseling, and managing simple and moderately complex medical problems, is essential to creating a system in which the requirements of the populations and individuals are addressed efficiently and cost-effectively."

The study – undertaken by the Committee on Implementing High-Quality Primary Care – was sponsored by the Agency for Healthcare Research and Quality, American Academy of Family Physicians, American Academy of Pediatrics, American Board of Pediatrics, American College of Physicians, American Geriatrics Society, Academic Pediatric Association, Alliance for Academic Internal Medicine, Blue Shield of California, the Commonwealth Fund, U.S. Department of Veterans Affairs, Family Medicine for America's Health, Health Resources and Services Administration, New York State Health Foundation, Patient-Centered Outcomes Research Institute, Samueli Foundation, and Society of General Internal Medicine. ■

The dream team

Teams in highly functioning primary care practices:

- See themselves as the linchpin between communities, and link people and families to specialists, acute care hospitals, and chronic care facilities.
- Have a deep grasp of physiology, therapeutics and technical medicine.
- Appreciate the assets and challenges of the communities they serve.
- Understand how the health system is constructed and works.
- Exercise exceptional skills in team-building, communication and collaboration.
- Demonstrate strong leadership and advocacy skills.

Source: "Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care," National Academies of Sciences, Engineering and Medicine

Cepheid®
A better way.

Accurate PCR Testing

Anywhere Patients Seek Care

Standardizing PCR testing throughout your care continuum provides patients with the quality they deserve no matter where and when they seek care.

Get more information about standardizing PCR testing:
→ **www.cepheid.com/jhc-june-2021**

US-IVD. For *In Vitro* Diagnostic Use.

904 Caribbean Drive | **Sunnyvale, CA 94089 USA** | TOLL FREE **+1.888.336.2743** | PHONE **+1.408.541.4191** | FAX **+1.408.541.4192**

Importance of Organizational Culture in Healthcare Settings

What is your organizational culture?

So many incredible attributes contribute to a great healthcare environment, and professionalism definitely rises to the top. It plays an active role in creating and shaping the organizational culture in your workplace. Your workplace culture embodies the shared standards, expectations and values that influence all team members and their actions. A positive workplace culture can lead to motivated employees and better patient outcomes.

Why is organizational culture important?

Organizational culture affects every detail of your organization – down to the bottom line. In fact, having a great culture can attract stellar talent. According to

Group One® Uniform Program
Professional Healthcare Apparel

encompass®

ENCOMPASS GROUP BRINGS YOU 100+ YEARS OF UNIFORM EXPERTISE.

Better care starts with safety and comfort™

Why Group One® Uniform Program?

GROUP ONE®

BRANDING: Create and Maintain Professional Image

SECURITY: Easily Identify Your Staff vs. Unwanted Visitors

PATIENT EXPERIENCE: Help to Improve HCAHPS Scores

EMPLOYEE SATISFACTION: Quality, Style, and Comfort

EASE OF ORDERING: Online Solutions

JOCKEY SCRUBS

Find out why Jockey Scrubs are
The most comfortable scrubs you'll ever wear®.

Request a FREE set of Jockey® Scrubs
(To Qualifying Professionals Only)

https://www.encompassgroup.com/jockey_scrub_evaluate

Glassdoor's Mission & Culture Survey, "77 percent of adults across four countries (the United States, UK, France, Germany) would consider a company's culture before applying for a job there." Applicants are looking for a company whose values mirror their own. They want to believe in an organization and its mission.

Hiring quality employees who fit into your organization's culture should be an integral part of your HR strategy. According to the United States Department of Labor, healthcare occupations are projected to grow 15 percent from 2019 to 2029, which is about 2.4 million new jobs. That is much faster than any other profession. It is important to define your workplace culture so it can be reflected in your recruitment of new healthcare workers for your organization.

Your organization can attract top talent by creating a positive workplace culture. A successful company with a culture that exemplifies positive traits will lead to higher satisfaction, improved performance and better outcomes.

What are the qualities of a great organizational culture?

Your organization can attract top talent by creating a positive workplace culture. A successful company with a culture that exemplifies positive traits will lead to higher satisfaction, improved performance and better outcomes. Organizations with a positive culture place a great emphasis on respect, integrity, adaptability, teamwork and employee engagement. The qualities of your culture are unique to your organization and defined by you and your team. Use our Organizational Culture Checklist to get started on creating your culture!

How we can help you

Your organization's branding and culture should be aligned and integrated. A professional, branded uniform is what will set the tone for employees and patients. The Group One® Staff Uniform Program is an Apparel Solution designed to enhance branding, security, patient experience, and employee satisfaction. With the projection of growth in the healthcare industry, it is imperative to partner with an experienced uniform apparel manufacturer to meet all your needs from marketing to supply chain management. Create and maintain your organization's professional image, reinforce your brand message and celebrate your workplace culture with the help of the Group One® Staff Uniform Program. ■

About Encompass Group, LLC

Encompass Group, LLC is one of the world's leading manufacturers and marketers of reusable textiles, professional apparel, and disposable and single-use medical products. Encompass Group believes that every patient, resident, caregiver, and family member should feel safe and comfortable in today's healthcare environments. Encompass Group enhances the healthcare experience by developing innovative products that are reliably delivered and cost-effective for all providers. Encompass Group serves the acute-care, long-term, and senior-care markets, retail healthcare and hospitality apparel markets, and government operations markets. For more information about Encompass Group, LLC, please visit www.encompassgroup.com. Follow Encompass Group, LLC on LinkedIn (@encompass-group-llc); Twitter (@EncompassGrpLLC); Facebook (@EncompassGrpLLC); and YouTube.

The Journal of Healthcare Contracting recognizes leading supply chain leaders in the non-acute space, either for exclusive roles in a non-acute specific supply chain team, or bridging non-acute with traditional acute care supply chain.

Nominate the 2022 Top Non-Acute Supply Chain Leaders

The Journal of Healthcare CONTRACTING
Providing Insight, Understanding and Community

Contact Anna McCormick, amccormick@sharemovingmedia.com to submit your nominee, please include their health system, and 3-4 sentences on why you are nominating them.

Health news and notes

Aspirin reduces preeclampsia risk

A low-dose aspirin regimen reduces the risk for preeclampsia in pregnant women, leading the US Preventive Services Task Force in February to issue draft guidance recommending 81 mg of aspirin daily for women with certain conditions who are more than 12 weeks pregnant. Preeclampsia is a common cause of maternal death, and women with diabetes, chronic high blood pressure, kidney disease and autoimmune disease are among those at high risk.

Cancer has a longer life than you may think

There is no stronger risk factor for cancer than age. At the time of diagnosis, the median age of patients across all cancers is 66. That moment, however, is the culmination of years of clandestine tumor growth, according to a report in Cell Stem Cell. Reconstructing the lineage history of cancer cells in two individuals with a rare blood cancer, the team calculated when the genetic mutation that gave rise to the disease first appeared. In a 63-year-old patient, it occurred at around age 19; in a 34-year-old patient, at around age 9. The findings add to a growing body of evidence that cancers slowly develop over long periods of time before manifesting as a distinct disease. The results also present insights that could inform new approaches for early detection, prevention or intervention.

Diagnostic Testing Essentials for Improving Value

While 70% of all clinical decisions are based on diagnostics, tests typically make up only 3% of expenditures.

Improve value in your clinical diagnostic lab and get a great return on your investment by ordering affordable, high-value diagnostic products through the Fisher Healthcare channel.

Backed by clinical lab expertise, we offer a broad range of testing supplies to help you grow your lab and exceed quality goals.

Explore our diagnostic testing selection at **fisherhealthcare.com**.

Distributed by Fisher Healthcare. Contact us today:

In the United States
Order online: fisherhealthcare.com
Fax an order: 1-800-290-0290
Call customer service: 1-800-640-0640

fisher healthcare
part of **Thermo Fisher Scientific**

Women with heart attacks fare worse than men

Outcomes from myocardial infarction – heart attacks – continue to be considerably worse for women than men, according to a meta-analysis published in the American Journal of Cardiology. The study covers more than 705,000 STEMI (ST-segment elevation myocardial infarction) patients from 30 countries who received care from January 2000 to December 2019. Thirty-one percent of patients were women. Researchers found that women were associated with longer delays to first medical contact and longer door-to-balloon times. In-hospital rates of mortality, repeat myocardial infarction, stroke and major bleeding events were all also much higher for women. Women also received less optimal STEMI therapy during hospitalization. For example, the rates of primary percutaneous coronary intervention (59.5% vs. 68.2%), aspirin use (89.5% vs. 92.1%) and P2Y12 inhibitors use (67.6% vs. 75.4%) were all lower among women than among men. Researchers provided possible reasons for these trends. The delays in patient care, for instance, may be tied to the ways that STEMI symptoms present – and how men respond to those symptoms compared to how women respond. These delays are likely the result of female STEMI patients being more likely to experience atypical symptoms (i.e., back, shoulder, and/or stomach pain rather than chest pain), and males being more likely to believe that their symptoms are cardiac in nature. In addition, the team added, women often present with myocardial infarctions a full five to 10 years later than men, because estrogen is known to delay the development of cardiovascular disease in premenopausal females.

Stick with it, baby

The dietary patterns of infants and toddlers can influence the trajectory of eating behaviors throughout their lives, according to Dietary Guidelines for Americans, 2020-2025, Office of Disease Prevention and Health Promotion. Taste preferences begin to form during this period, and research shows that early food preferences influence later food choices. As very young children are exposed to new textures and flavors for the first time, it may take them up to 10 exposures to accept a new type of food. Encouraging parents and caregivers to offer new foods such as fruits and vegetables repeatedly increases the likelihood of children accepting them. Offering the healthiest food and beverage choices at an early age can set young children on a path toward making nutrient-dense choices in the years to come.

Food insecurity and obesity

Participants with obesity and food insecurity lost less weight than food-secure participants with obesity over 24 months when following an intensive, lifestyle-based intervention for weight loss. Food insecurity, or the lack of sufficient healthy food to sustain an active, healthy lifestyle, is associated with greater body weight in adults. Researchers from Pennington Biomedical Research Center, Baton Rouge, Louisiana, used data from the PROPEL (Promoting Successful Weight Loss in Primary Care in Louisiana) study, which randomly assigned participants to a high-intensity, lifestyle-based intervention or usual care for weight loss and tracked progress over 24 months, to determine if food insecurity had an effect on weight loss outcomes. Findings from a post hoc analysis of the PROPEL study are published in Annals of Internal Medicine.

midmark™

Designing better care.

Meet IQvitals® Zone™

IQvitals Zone is the only wireless vital signs monitor that auto-connects to a computer using zero clicks and transfers data directly into the EMR, eliminating common data transcription errors. The SPRINT BP Protocol features embedded AHA/AMA-recommended patient positioning guidelines for more accurate blood pressure measurement.[1] It's time for a better way—it's time for IQvitals Zone.

Get to know IQvitals Zone at: midmark.com/IQvitalsZone

[1] https://www.ama-assn.org/delivering-care/hypertension/one-graphic-you-need-accurate-blood-pressure-reading

Obviously, one size doesn't work for everything.

Children are different than adults, which is why Premier created Kiindo. With Kiindo, pediatric hospitals become part of a cost reduction and clinical improvement program that provides a pediatric-focused contract portfolio plus the ability to improve your practice through shared insight and collaboration. Kiindo is just what the pediatrician ordered. Literally.

Kiindo™