VHHA
JULY 2018

REVIEW

Virginia's magazine for hospitals and health systems

Combating the Opioid Crisis

— Virginia Hospitals Respond to a Public Health Challenge —

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Published By

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Board Chair

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> **"In collaborative and unique ways, hospitals have taken decisive action to help patients, families, and communities dealing with the opioid crisis."**

In trying times when public health challenges emerge, hospitals are there to meet patient needs. Virginia hospitals' response to the opioid epidemic is an example of that. In collaborative and unique ways, hospitals have taken decisive action to help patients, families, and communities dealing with the opioid crisis. Hospitals implemented new prescribing protocols, supported community-based efforts to combat this crisis, engaged in statewide task force response efforts, and worked with public agencies and elected officials to develop state-specific policy solutions to address this important issue.

This edition of *REVIEW Magazine* highlights examples of some unique and innovative approaches hospitals and health systems throughout the Commonwealth have implemented to combat the opioid epidemic while meeting patient needs for medical attention and pain relief.

Nationally, opioids including heroin and prescription drugs killed more than 42,000 people in 2016, more than any year on record, according to the U.S. Centers for Disease Control and Prevention (CDC), which notes that 40 percent of all opioid overdose deaths involve a prescription opioid. Virginia has not been immune to this troubling trend. From 2007-2017, Virginia health officials reported more than 7,250 fatal opioid overdoses. That's essentially two deaths per day in Virginia.

In the Northern Shenandoah Valley region, Valley Health and other community partners came together in 2013 in response to an unacceptable rise in the number of local drug overdose deaths. Out of this collaboration, a unique regional public-private response to the opioid addiction crisis took shape. A task force was formed in 2014 as a precursor to what is now the Northern Shenandoah Valley Substance Abuse Coalition (NSVSAC) that brings together law enforcement, the judicial system, community social services, health care providers, schools, the faith community, and families to participate in the response effort. Valley Health helped establish NSVSAC and continues to support Coalition efforts around prevention, treatment, recovery, and practical responses to the opioid crisis that give families a sense of hope.

Additional collaborative efforts involving hospitals and health systems are happening around the Commonwealth to address the opioid epidemic. The Virginia Hospital & Healthcare Association's (VHHA) Board of Directors in January 2016 called for the formation of an opioid task force and directed it to examine ways to reduce opioid abuse, particularly related to emergency room prescribing practices. Following deliberation and research, the task force that featured representatives from VHHA-member organizations, the Virginia College of Emergency Physicians, and the Virginia Chapter of the American Academy of Emergency Physicians, developed a set of 14 recommendations to help guide Virginia hospital emergency departments and physicians therein with setting general standards on opioid prescribing.

Hospitals and health care providers are by no means alone in addressing this issue. As the opioid epidemic became pervasive in recent years, stakeholders across the landscape have engaged in multi-pronged response efforts. Virginia elected leaders in the General Assembly and executive branch have worked in bi-partisan fashion to put policies in place to help curb opioid misuse. All of these efforts are part of the continuing community and stakeholder response to help the lives of those impacted by the opioid epidemic.

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A Successful Combination:
Managing Post-Op Pain and Curbing Dependence

Henrico, Parham & Retreat Doctors' Hospitals
HCA Va
AN HCA AFFILIATE / CAMPUSES OF HENRICO DOCTORS' HOSPITAL

Words and Images by Julian Walker and Erin Ehrlich-Beard

It's mid-May and a conference call is just wrapping up in a wood-lined meeting room inside HCA Virginia's Retreat Doctors' Hospital, a brick edifice tucked among row houses and walk-up storefronts in Richmond's Fan District.

Four doctors – three in pale blue scrubs – and hospital Chief Executive Officer Elizabeth Matish are seated around an oblong table making plans.

The conference call discussion centered on the potential for broader use of a combined set of surgery and anesthesia protocols the hospital and some affiliated practices have found successful in reducing certain post-operative patients' reliance on opiate-based pain medication.


Dr. John V. Booth (left) and Dr. Tony Spensieri (right)

One part of the process is known as Enhanced Recovery After Surgery (ERAS). It is a research-based, perioperative care protocol for surgical patients designed, as its name indicates, to enhance patients' recovery, and decrease complications, cost, and the use of pain medication.

By combining it with an ultrasound-guided transverse abdominis plane, or TAP, block technique to anesthetize nerves near the abdominal wall, surgeons working with Retreat Hospital have discovered some encouraging results for certain surgical patients.

Neither ERAS or TAP block are new techniques.

Yet physicians performing certain urology surgeries at Retreat and applying them in tandem for those procedures wonder if together they might unlock a successful combination to help more post-op patients reduce their use of opiates to ease pain, and by extension limit the likelihood of addiction.

Early analysis is encouraging.

A review of cases involving "30 consecutive patients" whose urological surgery incorporated ERAS protocols and a TAP block found that "28 out of 30 of those patients had stopped their narcotics within five to seven days," noted Dr. David B. Glazier, a board-certified urologist whose lilting accent reveals his Dubliner roots.

THE OPIOID CRISIS

BY THE NUMBERS

214.8 Million

Prescriptions written for opioids in 2016, according to the CDC National Center for Injury Prevention and Control

170,000

People used heroin for the first time in 2016, according to the U.S. Department of Health and Human Services

While that sample is admittedly small, the doctors at the conference table, and their colleagues on the other end of the call, are excited by its potential at a time when the health care community is combating the opioid crisis, and dealing with an availability shortage for certain intravenous pain medications.

Having previously adopted "enhanced surgical recovery in our facilities," explained Henrico Doctors' Hospital Chief Medical Officer Dr. Anthony "Tony" Spensieri, MD, MBA, FHM, "now we're thinking about how do we build on top of that and look for other unique areas to benefit our patients."

A confluence of factors contributed to the rise of the opioid crisis and its current throes. Its fateful origins are rooted in the 1990s when, according to the National Institute on Drug Abuse, "pharmaceutical companies reassured the medical community that patients would not become addicted to prescription opioid pain relievers, and health care providers began to prescribe them at greater rates."

Over time, this trend led to a rise in misuse of these drugs and addiction to them. Some users graduated to illicit opiates like heroin. Overdoses and related-fatalities surged. In 2015, more than 33,000 American deaths were attributed to opioid overdoses. The following year, 2016, opioids were blamed for 42,000 deaths.

The Commonwealth has faced similar challenges and tragedy. Over a 10-year period through 2017, more than 7,250

fatal opioid overdoses have been reported in Virginia. Each day, opioids claim the lives of more than 115 people in the United States.

Access to pain medication did not, however, improve pain outcomes for many patients, according to Dr. Glazier, Director of the Virginia Urology Continence Center.

"Between 1999 and 2011, there was no change in pain scores but there was a four-fold increase in narcotic usage," he said.

Pain medication usage, comes with an attendant risk that new exposure can lead to addiction. A study released in

Reston Hospital Center: Taking

With the implementation of an Enhanced Surgical Recovery (ESR) program, the Reston Hospital Center surgical team is making strides in improving the experience for patients undergoing certain procedures. ESR is a proven, research-based approach using selected pre- (before), intra- (during), and post- (after) interventions to optimize outcomes and patient experience.

The ESR program at Reston Hospital Center has demonstrated significant reductions in length of stay, time to ambulation (walking or movement), and the need for narcotic pain medication. At the same time, ESR has increased patient satisfaction on pain management.

Reston Hospital Center
HCA Virginia Health System

ESR Programs provide patients with a variety of benefits including:

- Eating sooner after surgery;
- Shorter hospital stays;
- Reduction of nausea and vomiting;
- Faster recovery; and
- Improved management of pain with a decrease in narcotics.

Appropriate management of pain is a nationwide goal that health care providers continuously work to enhance. Managing pain begins with pre-operative education about what kind of pain may occur, and to what extent that pain can be expected, depending on the surgical procedure being conducted. With a better management of the expectations regarding pain, patients are more accurately able to describe their true levels of pain with respect to their individual

Surgical Care to the Next Level

procedures. This is a key element in aiding providers in decreasing the amount of narcotics or opioids being prescribed at discharge.

The ESR program has several components that require patient participation. Before surgery, patients meet with the care team for a thorough discussion of pain management and mobility. As a part of this discussion, patients work with the care team to set realistic goals about managing pain and post-op mobilization.

Hydration is another key component of a successful ESR program plan. Patients are asked to continue drinking water normally both the evening before and up to a defined number of hours prior to a scheduled procedure. In addition to maintaining water intake, patients are asked to drink a carbohydrate-rich beverage a few hours prior to a scheduled procedure. Maintaining hydration and increasing carbohydrate intake help improve recovery and wound healing.

ESR programs continue after the procedure is complete. Patient participation is required through moving, standing, and walking around as much as possible following surgery, and through communicating accurate pain levels to clinical care team members and revisiting goals.

Upon discharge, care teams evaluate a patient's pain level and prescribe medications accordingly. Educating patients about reasonable pain expectations means providers are often able to prescribe non-narcotic medications for pain, reducing opioid prescribing.

The ESR program at Reston Hospital Center is designed to encourage surgical patients to be engaged in their care. The goal is to provide patients with excellent outcomes and experiences, and the ESR program is one more way that helps meet the commitment to this goal.

2017 by the University of Michigan's Institute for Healthcare Policy and Innovation found that "six percent of people who have never taken a pain medication before are at greater risk for abusing the medication after surgery."

Patients with pre-existing risk factors can be susceptible to misuse in those circumstances. Researchers involved in that study conclude that knowing those details can help physicians develop prescribing plans to account for that.

Dr. Glazier and his colleagues already have.

"It used to be I would write a (post-operative) prescription for 30 pain pills, routinely. And now what I find is I write a prescription for 15 or 10. And now I'm actually going to take it down to 10," he said.

This prescription step-down approach is consistent across the health care continuum. According to the U.S. Centers for Disease Control and Prevention, physicians wrote 72.4 opioid prescriptions per 100 people in 2006. The annual rate continued to rise through 2012, before declining in subsequent years and reaching 66.5 prescriptions per 100 people in 2016.

Virginia Medicare and commercial insurance prescription data from 2015 and 2016 analyzed by VHHA's Analytics Team reflects a similar trend which indicates opioid prescribing volumes in Virginia declined considerably during that two-year period.

Meanwhile, policymakers are taking steps to combat this crisis by implementing additional standards for opioid prescription dispensing.

For example, the Virginia General Assembly in 2017 and 2018 enacted several new laws in response to the opioid crisis including requirements for prescribers to check the state's Prescription Monitoring Program prior to dispensing opioids beyond a certain number of days, among other controls and disclosure standards.

As an anesthesia method, TAP blocks can be applied to a range of surgeries including hysterectomy, prostectomy, hernia, colon, and appendix surgery, and caesarian section childbirth, among others.

Right now, the combined ERAS and TAP block idea is a "novel idea that pertains to a specific sub-set of urological patients," Dr. Spensieri noted.

What's unique about what Retreat Hospital is exploring is that it takes a longer view of potential patient benefits, added Dr. John V. Booth, an anesthesiologist with North American Partners in Anesthesia.

"While many enhanced recovery programs have looked at the intra-operative and the hospital portion of the benefit (for patients), what we are trying to do is see does the enhanced recovery system with the TAP blocks impact patients longer term," he explained. "Does that make a difference to their opioid usage when they go home? And will that then eventually lead to a decreased chance of addiction in a year's time?"

THE OPIOID CRISIS

BY THE NUMBERS

42,249

Americans died due to an opioid overdose in 2016, according to the U.S. Department of Health and Human Services

$504 Million

The 2016 economic cost of the opioid epidemic, according to the U.S. Department of Health and Human Services

Inset Image (left to right): Dr. Eugene V. Kramolowsky, Dr. John V. Booth, Dr. David B. Glazier

It also helps to have a clinical team where the surgeons and anesthesiologists work side-by-side at a hospital that's been recognized several times over by Healthgrades for excellence in prostate surgery, Spensieri added.

To hear Dr. Booth tell it in his thick brogue, a partnership like the one he and Dr. Glazier share is almost uncanny.

"It really is a kind of wonderful collaboration. The idea of having a Scotsman and an Irishman work together on something is just . . ."

He trails off for a moment as the room erupts in laughter.

"But honestly, we actually do hope this really makes a difference. There are enough people out there – people we know, our families know, I know. We are all aware of it. This is a huge crisis. Our neighbors live with this stuff. It's tearing families apart. People are dying. It's a really serious issue," Dr. Booth said moments later, noting that a close family member of his has struggled with substance misuse. "So though we're having a bit of fun chatting, we are absolutely, utterly, and deeply committed to this because it truly is an epidemic and we have to do something about it."

Dr. Glazier is confident the combination of ERAS, patient education, and anesthesia techniques "really has, I believe, benefitted patients. There is really a potentially undiscovered little gem that could help people with decreasing narcotic dependency."

Next comes demonstrating its effectiveness for patients on a larger scale, which Dr. Spensieri is optimistic about given HCA's track record on groundbreaking medical research in pursuit of "innovation and collaboration for that next level of care."

"So maybe this time next year we'll be having a different conversation with some of the data from the initial phone call that we just made today," he said. "But absolutely we're thinking about: 'How do you go to the next level? How do we think of research in different, unique models? How do we collaborate inside of HCA?'"

Bon Secours Opioid Sparing Initiatives

Bon Secours Virginia recognizes the growing epidemic and potential harm of long-term opioid use. Overdoses from prescription opioids are a driving factor in the 19-year increase in opioid overdose deaths. Deaths from prescription opioids — drugs like oxycodone, hydrocodone, and methadone — have more than quadrupled since 1999.

Bon Secours set forth with the following goals for therapy to address this growing problem:

- Improve prescribing of opioids, expand treatment of addiction, and reduce access to illegal opioids.
- Improve opioid prescribing practices to reduce exposure to opioids, prevent abuse, and stop addiction.
- Expand access to evidence-based substance abuse treatment, such as medication-assisted treatment, for people already struggling with opioid addiction.
- Expand access and use of naloxone — a safe antidote to reverse opioid overdose.
- Promote the use of state prescription drug monitoring programs, which give health care providers information to improve patient safety and prevent abuse.
- Implement and strengthen state strategies that help prevent high-risk prescribing and prevent opioid overdose.

This Bon Secours Virginia program is designed for patients with chronic opioid dependence, those at risk for opioid dependence and abuse, and those with opioid addiction.

After an initial trial at Memorial Regional Medical Center, Bon Secours Virginia has employed the following strategies at other hospitals in the health system:

Best Practice Alerts (BPA)

Harnessing technology to support these efforts has allowed otherwise commonly overlooked dangerous drug interactions and prescribing practices to be immediately alerted to the prescribing provider. A BPA was built into the electronic medical record (EMR) system to alert a provider if a patient is being prescribed greater than 50 MME of narcotics per day, or if a benzodiazepine and a narcotic are prescribed concomitantly. This alert warns the prescriber and offers to additionally prescribe naloxone as a rescue agent.

Position Letter and Opioid Prescribing Brochure

This provided a framework for efforts that advocate for access to opioids for the proactive treatment of severe acute pain, using reasonable precautions to avoid misuse, diversion, and other adverse outcomes. It conveys to patients that Bon Secours recommends adherence to, and promotion of, local opioid prescribing guidelines, with special attention to assessing the supportive evidence with appropriate scientific rigor.

Establishing ALternatives To Opioids (ALTO)

These are evidence-based, algorithm-driven tools that provide alternative non-narcotic therapeutic options to common acute and chronic pain complaints that present to the Emergency Departments. Initial rollout was aimed at ALTO treatments for acute headaches.

Intervention and Referral Process Resources

The emergency department has a unique opportunity to capture patients in need of intervention and referral for chronic pain and opioid abuse. Each emergency department community that Bon Secours serves has culled their pain management and addiction medicine resources into an easily sourced list for quick reference by patients. Emergency medical providers use these lists as discussion tools with patients and include these lists with patients' discharge instructions.

Scripting for Providers

Chronic pain and addiction are emotionally scary topics for patients. Many providers have never been trained in these types of discussions. Contextual scripts, in the form of laminated cards, have been developed that arm providers with the tools to talk about opioids so that patients will listen, and how to listen so that patients will talk.

Addressing the opioid epidemic is inherent in our culture, and we will continue to develop mechanisms to address this patient need. The mission of Bon Secours remains one of "Good Help" that has a foundation in the past, is standing in the present, and is reaching for the future as we are serving these patients.

The latest episode of the *Patients Come First* podcast features Virginia Governor Ralph Northam, MD. Send questions, comments, or feedback to pcfpodcast@vhha.com. Learn more about the podcast series at www.vhha.com.

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Confronting Substance Abuse

Valley Health Responds to Alarming Rise in Heroin Deaths

A dramatic increase in heroin overdoses and deaths has stunned health care providers, law enforcement, and residents throughout Valley Health's service area. In the first six months of 2014, for instance, 15 people died and at least 25 overdosed in the Northwest Virginia region, most of them young adults.

In 2010, opioid overdoses surpassed car crashes as the leading cause of accidental death in the United States.

Since that time, Valley Health's six hospital emergency departments have seen a significant increase in heroin overdoses, and Winchester Medical Center has had a three-fold increase in substance-exposed newborns. The stories are heart-wrenching and confirm that drug addiction knows no socioeconomic boundaries.

Heroin summits convened by the Northwest Virginia Regional Drug Task Force, and meetings in other communities, have brought together experts to share facts and strategize about solutions. What's clear is that this very complex problem requires a coordinated, regional approach that includes awareness, prevention, law enforcement, and treatment.

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Healthier, together.

Understanding Addiction

- Drug addiction is not a lifestyle choice. It's a chronic neurobiological disease that changes how brain cells organize to process information. It leads to behaviors that jeopardize work life and loving relationships.
- Genetics is responsible for almost half of addictive tendencies.
- As little as one heroin use can trigger addiction.

The Prescription Pill-Heroin Connection

- Prescription drug misuse is the nation's fastest growing drug problem. This includes medications to manage pain, as well as anxiety, insomnia, ADD/ADHD, and depression.
- Every 14 minutes a person in the U.S. dies from unintentional drug overdose.
- Prescription opioid abuse often begins the cycle to heroin use.

Confronting a Culture of Expectation

Valley Health's Emergency Departments and Urgent Care centers recently adopted a new pain management protocol, and its hospitals are looking more holistically at chronic pain management to discourage opioid medication abuse.

"With the best of intentions, physicians have tried to control discomfort and prevent suffering," explains Jack Potter, MD, Director of Emergency Medicine at Winchester Medical Center. "Unfortunately there is now a national expectation that even mild pain should be heavily medicated. Our goal is to help patients find relief from severe or nagging pain, but avoid creating an unhealthy drug dependence."

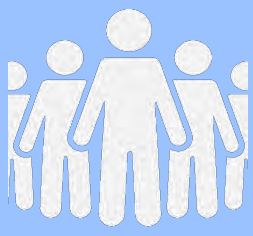
What You Can Do

- Understand your pain and ask about options for controlling it.
- Lock up, monitor, and clean out your medicine cabinet. (Look for drug take-back events in your community, which ensure unused medications are incinerated and kept out of the landfill and water supply.)
- Educate yourself and reach out to at-risk family and friends.

For more information visit: www.valleyhealthlink.com/substanceabuse.

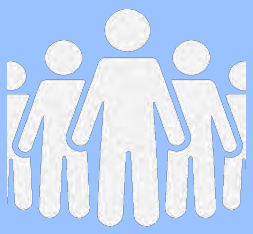
THE OPIOID CRISIS

BY THE NUMBERS



2 Million

In the U.S. suffered from a substance use disorder related to prescribed opioids in 2015, according to the National Institute on Drug Abuse

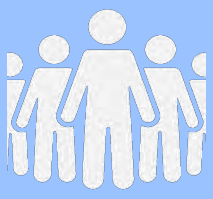


591,000

In the U.S. suffered from heroin use disorder in 2015, according to the National Institute on Drug Abuse

THE OPIOID CRISIS
BY THE NUMBERS

17,087
Deaths attributed to overdoses involving commonly prescribed opioids in 2016, according to the U.S. Department of Health and Human Services



115
The average number of Americans who die each day from an opioid overdose, according to the U.S. Centers for Disease Control and Prevention

SUBSTANCE TREATMENT IN SOUTHERN VIRGINIA

As the opioid epidemic escalates in Southern Virginia, Sentara Halifax Regional Hospital is taking a comprehensive approach to combating this crisis by developing services in the emergency department, as well as its behavioral health practice.

SENTARA®

"In the ER, we do our best to address pain in the safest, most responsible manner," Emergency Department Manager Janelle Slabach, RN, MSN, said about the Sentara Halifax approach to limiting opioid access while still meeting patient needs. "While narcotic pain control may be needed for acute injuries or illnesses, we do not treat chronic pain with narcotics because we feel that only a primary care provider or pain management specialist is able to safely treat with narcotic medications long term. We are aware that the use of opiates can lead to additional physical and psychological problems and this risk increases if prescriptions are obtained from a variety of sources. Due to this, all emergency medicine providers have access to a state database that can pull prescriptions filled by a patient. This data shows who prescribed a medication and the quantity provided to assist in determining what medication can and should be prescribed to a patient who presents to the ER with a complaint of pain."

Even with emergency department safeguards in place, Sentara Halifax Regional Hospital officials recognize the chemical dependency crisis is growing in Southern Virginia. In response, Sentara Halifax Behavioral Health Manager Mary Jane Collie has worked to help bring necessary treatment services to communities served by the hospital that need accessible, behavioral health services and chemical dependency treatment options.

"Sentara Halifax Behavioral Health offers an intensive outpatient program (IOP) to meet the needs of the opioid- and other chemically-dependent individuals beginning recovery," said Collie. "This type of program, unlike traditional rehab, allows people to receive the help and therapy they need with minimal disruption to their lives. Participants in the program will develop the skills necessary to understand addiction, recovery, and identify triggers that may lead to relapse. Typically, participants attend the program three hours a day, three days a week. The duration of the program is determined through an individualized treatment plan developed in collaboration between the participant and a licensed therapist. The goal of the program is to provide quality care in a structured but relaxed setting that acknowledges the individual's dignity, motivation, and ability to effectively manage his or her own life."

The IOP program is staffed by mental health professionals, including licensed therapists and a psychiatric nurse practitioner, and it provides strict confidentiality for patients. In addition to the IOP, Collie and her staff have established a partial hospitalization program (PHP) to provide treatment to patients with more advanced addiction in Southside Virginia.

"This is a more intensive program for patients who require more treatment for their chemical dependency," said Collie. "Program participants come to the hospital at 9 a.m. and return home at 3 p.m. each day. The number of days per week patients attend and the types of therapy they take part in vary, based on individual treatment plans."

The program offers group therapy, educational workshops, stress management classes, psychiatric evaluations, and medication management. Staff members have specific training in cognitive behavioral therapy, family systems, grief and loss issues, relaxation and stress management, relationship enhancement, health education, substance abuse/chemical dependency, nutrition counseling, mediation/conflict resolution, complementary health, and wellness and spirituality. Collie projects the new PHP will accept its first patients during the last quarter of 2018.

Given the challenges of the opioid crisis in the region, said Sentara Halifax Regional Hospital President Jason Studley, "Now, more than ever, we are seeing the importance of stepping up to the plate with a plan in place as this epidemic becomes more prevalent. I am proud of the program that we have built and am confident that it is changing the lives of chemically dependent individuals in southern Virginia."

Carilion Clinic Organizes Task Force for Opioid Crisis Response

According to the Virginia Department of Health, 1,227 Virginians died of opioid-related overdoses last year. In Roanoke, the dramatic increase in drug deaths from 2016 to 2017 was almost four-fold. To address this community health challenge, Carilion Clinic employees are responding to the opioid epidemic in every corner of the community.

Last fall, Carilion President and CEO Nancy Howell Agee and Chief Medical Officer Patrice Weiss, MD, brought together an organizational task force to tackle thorny issues surrounding opioid use, abuse, and dependence in Southwest Virginia. Dr. Robert Trestman, PhD, MD, Professor and Chair of Psychiatry and Behavioral Medicine, and Gary Scott, Vice President for Surgical Services, were chosen to spearhead the effort. The Task Force is a new way of organizing Carilion's opioid-related work, even though many departments have been addressing the opioid crisis from the beginning. Here are some examples:

- Carilion has installed drug take-back boxes in the organization's retail pharmacies so patients can dispose of unused medications.
- Through a grant from the Carilion Clinic Foundation, Carilion providers in Franklin County are handing out drug deactivation bags to certain patients who are prescribed narcotics or Schedule I-II drugs. The biodegradable bags use water and activated carbon to make drugs chemically inactive so they can be thrown away.
- After observing the rate at which they prescribed opioid medications, emergency department physicians several years ago began drastically reducing the number of opioids prescribed.

Carilion continues to explore non-pharmacological pain management techniques like acupuncture, mindfulness, and cognitive behavioral therapy in addition to traditional drugs. "The goal of our task force is to connect all of those existing opioid-related initiatives," said Dr. Trestman. "We want to make the ideas that work — the ones that are having the greatest impact — easier to implement across the organization. I'm impressed by the passion that so many have to help with this challenge."

Carilion's task force has six committees. Each is working on one aspect of the crisis:

- The **Community-Based Addictions Subcommittee** is developing pathways to treatment for several higher-risk populations in the community.
- The **Education and Information Subcommittee** works to inform and educate Carilion employees, including clinical staff, and the public on the steps the organization is taking to address the opioid crisis.
- The **Prescription-Based Subcommittee** is working on making sure opioid policies, procedures, guidelines, and reference materials are consistent across the organization.
- The **Research Subcommittee** is identifying research projects to address opioid use, abuse, and dependence.
- The **Technology, Informatics, and Analytics Subcommittee** is working to improve workflows in Carilion's electronic health records system, Epic, and developing monitoring programs to allow the task force to measure progress.
- The **Policy and Legislation Subcommittee** advocates for changes to laws and regulations related to the crisis.

The task force and its subcommittees meet regularly to advance the cause. Where appropriate, subcommittees are in regular contact with community groups and state agencies that are addressing opioid use, abuse, and dependence to align efforts. Most importantly, the task force is nimble enough to address trends, so it can meet the needs of the community.

Research Findings: Surgical Anesthesia + Limiting Opioids = Improved Pain Scores, Less Post-Op Drug Use

A study of more than 100,000 surgical cases at University of Virginia Health System found patients' pain scores improved even as doctors gave fewer opioids.

UVA anesthesiologists reviewed 101,484 surgeries between March 2011 and November 2015 where patients received general anesthesia. During that timeframe, the average amount of opioids given per surgery at UVA declined 37 percent. At the same time, surgical patients' self-rated average pain score on a zero-to-10 scale in a post-surgery recovery unit declined from 5.5 to 3.8 – a 31 percent improvement.

As health officials across the U.S. look for ways to combat an opioid addiction crisis, UVA researchers believe these findings highlight one way to address the problem.

"There is very clear evidence that people can become opioid dependent because of the drugs they get during and after surgery," said Marcel Durieux, MD, PhD, one of three UVA anesthesiologists who conducted the study. "I think that by substantially limiting opioids during surgery, we've made an important step in addressing that problem."

Keys to Improving Pain Scores

Durieux points to two factors in how UVA has been able to cut patients' pain while using fewer opioids. One factor, he said, is that research has shown opioids make patients more sensitive to pain, though the reason why that occurs is unclear. So reducing the amount of opioids given to patients might by itself improve pain scores.

The second factor is a significant increase in the use of non-opioid pain medications, such as lidocaine and acetaminophen, which is commonly used in over-the-counter pain medications. Anesthesiologists at UVA have regularly shared data with their colleagues about the benefits of using fewer opioids, Durieux said. In 2013, UVA also began implementing the Enhanced Recovery After Surgery (ERAS) program, which includes limiting opioids, for colorectal surgery patients.

The average amount of non-opioid pain medications given per surgical case at UVA increased 120 percent during the study period. While the non-opioid medications have a lower risk for addiction, Durieux said, they cannot be used for all patients. For example, they can cause bleeding in some patients, and can cause kidney problems.

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US Acute Care Solutions

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Find out your diabetes risk factors today at **AskScreenKnow.com**, and encourage others to do the same.

References:

1 Tarasova VD, Caballero IA, Turner P, Inzucchi SE. Speaking to patients about diabetes risk: is terminology important? *Clinical Diabetes*. 2014;32(2):90-95.

2 Treatment and Care for African Americans. American Diabetes Association website. http://www.diabetes.org/living-with-diabetes/treatment-and-care/high-risk-populations/treatment-african-americans.html. Published November 12, 2013. Updated October 1, 2014. Accessed March 30, 2016.

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THE OPIOID CRISIS
BY THE NUMBERS

819
Virginia babies diagnosed with Neonatal Abstinence Syndrome in 2017, according to the Virginia Inpatient Hospitalization Database

4,076
Administrations of Narcan (overdose treatment medication) in Virginia in 2016, according to the Virginia Department of Health

Treating Substance Use in Pregnant Mothers and their Babies

For mothers in the midst of addiction, the obstacles to treatment are numerous — from the fear of losing a child to the challenge of finding a health care provider knowledgeable about their condition. Treatment options for pregnant women have not kept pace with the overwhelming increase in opioid abuse in Virginia, which the Commonwealth declared an epidemic in 2016. It has been shown that substance abuse treatment during pregnancy can be more effective than at any other time in a woman's life.

Witnessing the increase in neonatal abstinence syndrome (NAS) cases, Centra began its program in 2015, with the hiring of a perinatal navigator. Shannon Miles, the perinatal navigator, is a registered nurse certified in maternal newborn nursing. She and Dr. Andrea Stutesman joined forces and began a specific program for pregnant, addicted mothers. Miles and Dr. Stutesman formed the Medication Assistance Treatment Center for Obstetrics. Since its inception, the Center has helped more than 100 addicted mothers and their babies. The Center is a certified opioid outpatient based program at Centra Virginia Baptist Hospital. The program includes medication-assisted treatment, as well as counseling, care coordination, assistance in locating resources in the community, and helping ensure each patient is compliant with their prenatal care. Patients are seen weekly in the clinic until they are stable, and then bi-weekly. Patients are drug screened at every visit, and are given enough medications to last for seven days.

Miles, the perinatal nurse navigator, attends all appointments and assesses each patient for withdrawal symptoms.

Rounding out the program for mothers is a residential program that provides pregnant women with a safe place to live while undergoing treatment. The home is located on Oak Lane, just across the street from Virginia Baptist Hospital and its obstetric and neonatal intensive care services. The home is intended to accommodate up to four mothers and their infants. The women receive coaching and intensive non-medical support, as well as clinical substance abuse treatment and mental health services from Centra. This residential home is the first of if its kind in the Central Virginia Region.

CENTRA

While babies recover in the neonatal intensive care unit at Virginia Baptist Hospital, Centra implemented a "cuddler" program in 2016 that brings in volunteers to rock and hold newborns. The increase in NAS babies forced the hospital to recruit more volunteers to work with those babies, who are often inconsolable because of the withdrawal symptoms.

Miles and Dr. Stutesman have devoted their careers to helping this population of patients. Early on, they developed a community coalition to address the epidemic and subsequently developed programs for treatment. Centra continues to evaluate the communities needs as they help combat the opioid epidemic that has swept through the state.

EMERGENCY DEPARTMENT

Protocols for Prescribing Opioids to Patients

1. Emergency department Response

- Review the patient's health and prescription history to determine the best approach to managing pain.
- Prescribe the most appropriate pain medication favoring those with the lowest risk of addiction or overdose, and for no longer than necessary – maximum three-to-five days total.
- Disallow refills of stolen or lost prescriptions for medication.
- Disallow prescribing missed methadone doses or long-acting pain medication that has a high risk of addiction or overdose.
- When prescribing medications, take into consideration whether pain medication has been received from another health care provider or emergency department.

FAUQUIER HEALTH

LIFEPOINT HEALTH

2. Dissemination by the pharmacy team to emergency department providers of prescribing data including percent of controlled substances by provider and ranked by controlled category.

3. Implementation of drug take back days annually on campus; in addition local police department supports with a drop box within the department for 24/7 drop off.

4. Implementation of action items by the Fauquier Regulatory & Accreditation team to meet the Joint Commission *Sentinel Event Alert Issue 49: Safe Use of Opioids in Hospitals*.

5. Development of an emergency management approach to opioid exposure to health care workers being exposed to toxic levels of opioids in the emergency department.

Training Counselors to Help Patients Overcome Addiction

A new non-credit education program at Virginia Commonwealth University (VCU) unites addiction counseling professionals with professionals in health, law, and education, along with community members who have personal experience with addiction.

VCU's new Addiction Studies Continuing Education program weaves the latest translational research in addiction studies into a wide selection of interdisciplinary, interactive, and evidence-based course offerings.

The program is jointly led by the Department of Rehabilitation Counseling in the VCU School of Allied Health Professions and the VCU Office of Continuing and Professional Education.

"Addiction isn't just one profession's issue," said Laurie Cathers, PhD, a Research Associate in the Department of Rehabilitation Counseling. "The program is interdisciplinary, accessible, and relevant to the community need to respond to the opioid public health crisis and other addictions."

In 2016, former Virginia Governor Terry McAuliffe and then-State Health Commissioner Dr. Marissa Levine, MD, declared the opioid addiction crisis a public health emergency in the Commonwealth.

In the fall of that year, Virginia was ranked seventh among the top 15 hiring regions in the U.S. for job postings with keywords related to substance abuse, according to Burning Glass Technologies' Labor Insight Tool, which is a real-time labor-market gauge. At the time, there had been nearly 7,000 job postings with substance abuse competencies in the previous year in Virginia.

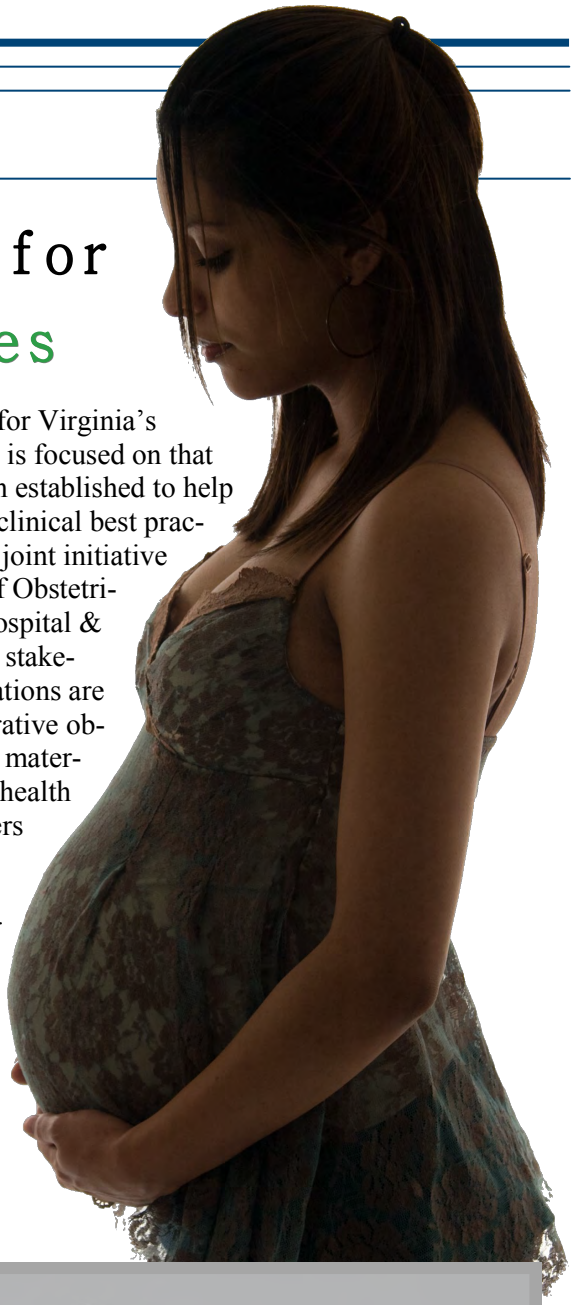
Through the Addiction Studies Continuing Education program, participants can earn a non-credit Certificate in Addiction Studies that can be applied toward the education requirement for certification as a substance abuse counselor through the Virginia Board of Counseling. Program courses are also approved as continuing education credits from the Commission on Rehabilitation Counselor Certification and the Association for Addiction Professionals.

Courses were created with both professionals, and those who have been personally affected by addiction, in mind. Modules such as "The Craving Mind: Why We Get Hooked" and "How We Can Break Free of Addiction Habits" are intended to develop counselor skills and provide information to professionals in sectors such as law enforcement, education, and health care. The program will also apply to family, friends, and community members who have been impacted by addiction.

"There is a focus in this program on getting people who have been impacted by addiction and who are treating addiction out of silos and into recovery-oriented conversations," said Denise Hall, Clinical Coordinator in the Department of Rehabilitation Counseling. "We will have people taking the courses with limited professional knowledge, but more personal experience, along with people who have been working in the field for a long time. We designed the classes to bring people together."

To learn more about the program and to enroll, visit addictionce.vcu.edu.

Health Care Collaboration for Healthy Mothers and Babies



Giving new mothers and their babies the best possible start is a priority for Virginia's health care community. A new partnership involving key stakeholders is focused on that work. The Virginia Neonatal Perinatal Collaborative (VNPC) has been established to help improve pregnancy and birth outcomes by advancing evidence-based clinical best practices to enhance the quality of care provided to pregnant women and infants. This joint initiative involves cooperation from key partner organizations — the American Congress of Obstetricians & Gynecologists (ACOG), the March of Dimes (MOD), and the Virginia Hospital & Healthcare Association (VHHA) — among other stakeholders and health care providers. These organizations are working to advance funding to facilitate Collaborative objectives such as reducing pre-term birth rates and maternal morbidity and mortality by bringing together health care providers who specialize in caring for mothers and babies.

VNPC
Virginia Neonatal Perinatal Collaborative

Crucial support for this work comes from leaders in Virginia's General Assembly. During the 2017 legislative session, Delegate Chris Stolle, an obstetrician-gynecologist from Virginia Beach, successfully patroned House Joint Resolution 745 to raise awareness for efforts to improve birth health by designating the first week of July as Substance-Exposed Infant Awareness Week in the Commonwealth. That resolution was part of a package of legislation introduced to address Virginia's opioid crisis.

The fiscal year state budget cycle that began July 1, 2017 included funding to support the establishment of the VNPC thanks to the work of Senator Siobhan

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THE POLITICAL ACTION COMMITTEE FOR THE VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION

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HosPAC is VHHA's political action committee. The mission of HosPAC is to provide organized and effective political action, and to support state candidates who will work to improve quality health care through policies supported by Virginia's hospital and health systems. As elected officials in Virginia and Washington make critical decisions affecting Virginia's hospitals and health systems, HosPAC supports candidates for office whose actions show consideration for Virginia health care providers and the communities they serve. To learn more about HosPAC, or to contribute, visit www.vahospac.com.

Dunnavant, an obstetrician-gynecologist from Henrico County. That funding supports VNPC efforts to reduce by 10 percent the inpatient length of stay of NAS infants at participating Virginia nurseries and neonatal intensive care units (NICU) by December 2018.

While many pregnancy outcomes in Virginia show improvement, the ongoing opioid crisis exposes the challenge of Neonatal Abstinence Syndrome (NAS), a condition that afflicts babies experiencing withdrawal symptoms after being exposed to drugs in the womb during pregnancy. According to Virginia Health Information (VHI) hospital discharge data, the NAS rate doubled from 2.9 per 1,000 live births in 2011 to 6.1 per 1,000 live births in 2015. In 2016, more than 770 Virginia newborns, out of nearly 96,000 live births, were diagnosed with NAS, according to state inpatient database figures. In 2017, Virginia had 819 NAS hospitalizations, an 11 percent increase from the previous year. And data shows the number of infants diagnosed with NAS quadrupled from 2012-2016. This is a significant concern because babies born with NAS can be prone to involuntary behaviors atypical in infanthood such as reduced quality and length of sleep following a feeding; increased muscle tone, tremors, and convulsions; respiratory-related issues such as sweating, frequent yawning, and sneezing; and gastrointestinal issues such as excessive sucking, poor feeding, vomiting, and loose stools. Often, these symptoms are relatively short-lived. Yet some research suggests that this condition could have longer-lasting effects on children's pediatric development. In an effort to combat this public health challenge, VNPC is prioritizing improvements in care for pregnant women diagnosed with substance use disorders and infants impacted by NAS.

In addition to NAS, the VNPC is also focusing efforts on maternal opioid use disorder, antibiotic stewardship in the NICU, obstetric hemorrhage, and reducing preterm births.

The groundwork for the VNPC was laid three years ago when a group of neonatologists began meeting to share insights and best practices from NICUs around the state, and to bring in speakers with expertise on these issues. The Collaborative grew out of those gatherings, and in the past year has intensified its focus on NAS by working with clinicians from around the Commonwealth, partner organizations and stakeholders, and by engaging with public health agency officials.

The VNPC formally launched during a extensively covered news conference at the State Capitol in June 2017, and in October 2017 the organization held its first annual conference in Richmond, attracting about 250 attendees to the one-day event. More recently, the VNPC launched the Vermont Oxford Network's NAS Universal Training Program to standardize care and improve outcomes for babies and families impacted by substance use, which is a significant public health challenge. As part of this work, 38 NICUs and birthing hospitals in Virginia will implement a training and audit package focused on improved NAS care. Virginia is among seven states focused in this way on addressing the opioid epidemic's impact on newborns and families.

VHHA Analytics harnesses the power of big data and modern technology tools to provide Virginia hospital and health system members with important insights to support enhanced operational efficiency. The VHHA Analytics Team has developed interactive data tools to help hospital officials improve performance, reduce costs, better serve patients, and effectively communicate health care issues. The data portal enable users to access an array of detailed and customized data that can yield hospital-specific, regional, and state trend reports on topics including 30-day readmissions, opioid use, performance improvement metrics, and much more. To learn more about VHHA Analytics, view video tutorials, and request a demo, visit:

https://tinyurl.com/y9ud7u8z

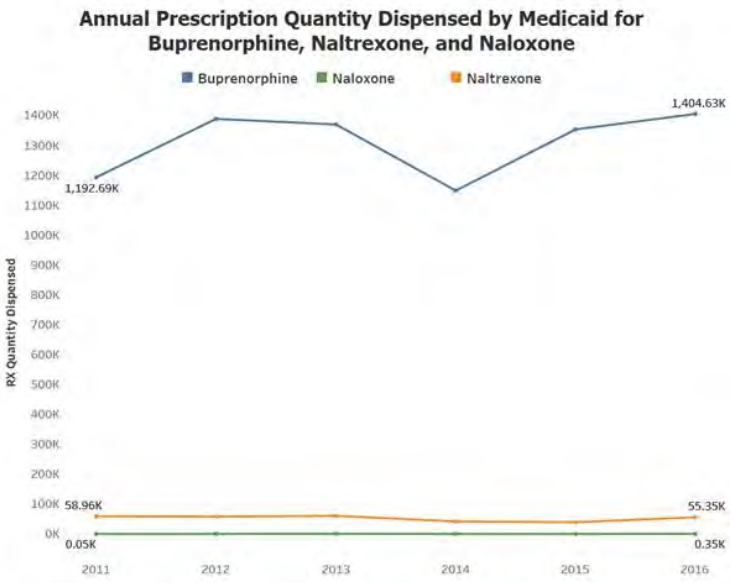
Research Corner: In-Depth Data Analysis

Words and Images by VHHA Analytics Team

The Role of Medicaid Expansion in Treating Opioid Misuse (July 2018)

A recently published Urban Institute study about the role of Medicaid expansion under the Affordable Care Act (ACA) in treating people affected by the opioid crisis shows the demand for such services has dramatically grown in recent years.[1] In particular, the study found significant increases in prescriptions for drugs commonly used to treat patients experiencing opioid misuse disorder. The growth has been greatest in Medicaid expansion states, though prescriptions have also increased in non-expansion states. Increased access to treatment is a positive development. But it also has implications for state health care funding. Now that Medicaid expansion has been approved in Virginia, should the Commonwealth expect to experience similar trends in prescription growth? To examine this question, VHHA's Analytics Team reviewed Virginia's All-Payer Claims Database to analyze buprenorphine, naltrexone, and naloxone prescribing patterns. Those three drugs were chosen because they are commonly used in treating opioid use disorder. Buprenorphine is used in medication-assisted treatment (MAT) to help patients reduce, or discontinue, their dependence on heroin or other opiates such as pain relievers like morphine. Naltrexone is an opiate antagonist. It blocks the euphoric and sedative effects of drugs such as heroin, morphine, and codeine. It also decreases the desire to take opiates. Naloxone is a so-called "rescue" drug that blocks the effects of opioids and reverses an overdose. The chart below shows Virginia's experience regarding prescribing trends for those drugs from 2011-2016. The data shows the pattern in Virginia is similar to the national trend documented in the Urban Institute study. The Y-axis reflects the amount of drug for each prescription, not the volume of prescriptions. The amount of drug prescribed is used rather than the number of prescriptions because the amount prescribed can change from one prescription to the next. Over a five-year period, the amount of buprenorphine prescribed increased by 17.8 percent. The amount of Naltrexone prescribed remained consistent. And the amount of naloxone increase by 600 percent. As a rescue drug, this increase illustrates the importance of continued access to treatment for opioid use disorder. Because Medicaid expansion is expected to increase access to treatment options for people with substance addiction, Virginia can expect to continue to see a rise in the amounts of buprenorphine and naloxone prescribed while the opioid epidemic remains a challenge.

[1] https://www.urban.org/urban-wire/medicaid-covered-opioid-overdose-and-treatment-drugs-reveal-growth-opioid-crisis



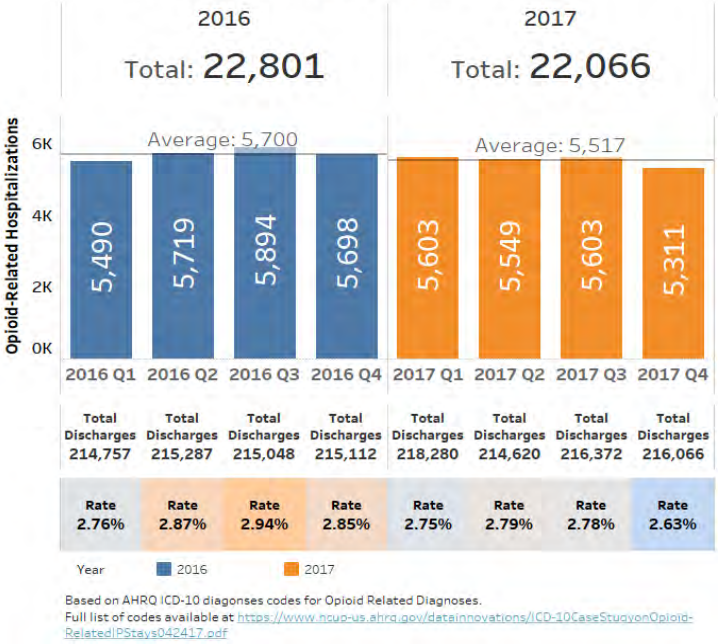
Tracking Opioid-Related Hospitalizations in Virginia (May 2018)

Widespread misuse of opioids has led to a spike in overdoses. Opioid-related overdoses kill 90 people in the U.S. each day, and opioid poisonings cost the nation more than $20 billion annually in emergency department and hospital care.[1] What's more, people who are hospitalized due to an opioid-related condition are four times more likely to die now than they were in 2000.[2] To help better understand this alarming trend, the VHHA Analytics team tracked more than 100 ICD-10 codes in the statewide inpatient database to assess the scope of opioid-related hospitalizations in the Commonwealth. Opi-

oid-related hospital stays involving misuse of prescription pain relievers or illicit opioids such as heroin decreased in Virginia from the first quarter of 2016 to the fourth quarter of 2017. The decrease in the number of opioid-related hospital stays has not been proportional across all regions in Virginia, however. Opioid-related hospitalizations decreased sharply in Eastern, Northern, and Northwestern Virginia. In contrast, Southwest Virginia, which accounts for roughly one-fourth of all opioid-related hospitalization in Virginia, experienced a significant increase in hospitalizations during 2017.

[1] https://www.ahrq.gov/news/newsroom/press-releases/opioid-related-hospitalizations.html
[2] https://news.harvard.edu/gazette/story/2017/12/opioid-driven-hospitalizations-show-major-increase-in-death-rate/

Figure 1: Tracking Opioid-Related Hospitalizations in Virginia Hospitals



Rate of NAS Babies Rose 11 Percent in 2017 (March 2018)

Neonatal abstinence syndrome (NAS) is a condition that afflicts babies born experiencing symptoms associated with withdrawal from exposure to certain drugs in the womb before birth. NAS is most often caused when a mother misuses opioids during pregnancy. In the United States, the incidence of NAS has steadily increased since the 1970s and has now become a significant public health problem.[1] Nationally, NICU admissions due to NAS have increased from 7 cases per 1,000 admissions in 2004 to 27 cases per 1,000 admissions in 2013, with an increase in the median length of stay for infants with NAS from 13 to 19 days, resulting in increased hospital costs.[2,3] In Virginia, the total number of NAS hospitalizations (ICD diagnosis code P96.1) increased from 741 in 2016 to 819 in 2017, a nearly 11 percent increase in one year. The rising number of babies diagnosed with NAS has an impact on Virginia's finances; on average, three out of four NAS infants in the Commonwealth are covered by Medicaid. As part of the ongoing monitoring of this troubling trend, the VHHA Analytics Team also mapped the prevalence of NAS by region and found that 2017 NAS cases increased 31 percent in Southwest Virginia.

[1] Patrick SW, Dudley J, Martin PR, Harrell FE, Warren MD, Hartmann KE, et al. Prescription opioid epidemic and infant outcomes. Pediatrics (2015) http://www.ncbi.nlm.nih.gov/sites/entrez?Db=pubmed&Cmd=ShowDetailView&TermToSearch=25869370
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[3] Gomez-Pomar E and Finnegan LP (2018) The Epidemic of Neonatal Abstinence Syndrome, Historical References of Its' Origins, Assessment, and Management. *Front. Pediatr.* https://www.frontiersin.org/articles/10.3389/fped.2018.00033/full#B28

About the Authors

Jay Andrews serves as Vice President of Financial Policy for VHHA, joining the organization in November 2010. With VHHA, Jay develops and provides rate analysis on Medicare and Medicaid and works on other policy-related budgetary and legislative issues. He is a graduate of Virginia Tech with a degree in Accounting and obtained his CPA certificate in 1987.

David Vaamonde is VHHA's Vice President of Data and Analytics. He develops tools and analyses to meet members' needs, and manages the Association's data resources. David earned his bachelor's degree in Biology and a Master of Public Health from the University of Virginia, which he attended as a Bayly-Tiffany Scholar.

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Virginia Ranked In The Top 10 Nationally For Health Care Quality

"The Commonwealth of Virginia was rated among the top 10 states for health care quality in the latest annual National Healthcare Quality and Disparities Report. The report is mandated by Congress to provide a comprehensive overview of the quality of health care received by the general U.S. population, as well as disparities in care experienced by different ethnic and socioeconomic groups. Among all states, Virginia ranked ninth overall with a score of 62.5 out of 100 for the most recent data year."

Dozens Of Virginia Hospitals Earn "A" Grades For Patient Safety And Satisfaction From National Ratings Organizations

"Dozens of Virginia hospitals earned top marks for exceptional patient safety performance in the Fall 2017 Hospital Safety Grade scores from the Leapfrog Group. In all, 41 Virginia hospitals received 'A' grades from Leapfrog, a national health care patient safety ranking organization. In the current rankings, eight Virginia hospitals were recognized for receiving an 'A' grade 12 consecutive times. The new Leapfrog results place Virginia among the top five states with the highest percentage of 'A' grade hospitals."

Focused Efforts By Virginia Hospitals Result In The Lowest Early Elective Delivery Rate In The Nation

"Over the past four years, Virginia has reduced its EED rate from 8 percent to 1.3 percent, ranking the Commonwealth first in the nation in reducing EEDs, according to federal Hospital Compare data for 2016. Virginia previously had been ranked 24th in the nation on EED rate based on Hospital Compare data in 2014. Research has shown that babies carried to full term after 39 weeks of gestational age have improved birth outcomes leading to lasting positive effects on lifelong health."

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