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The Journal of Healthcare CONTRACTING

Providing Insight, Understanding and Community

Tackling Supply Shortages

Supply chain leaders discuss how their organizations are navigating the backlogs, delays and disruptions.

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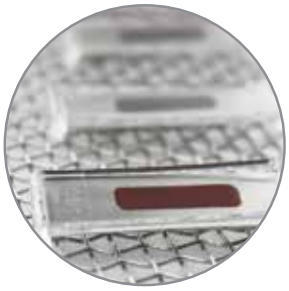

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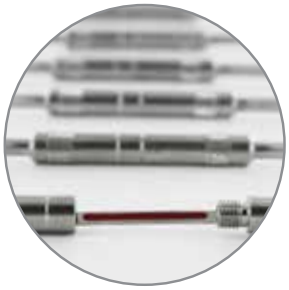

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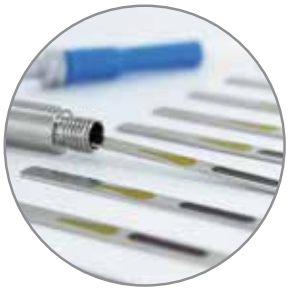

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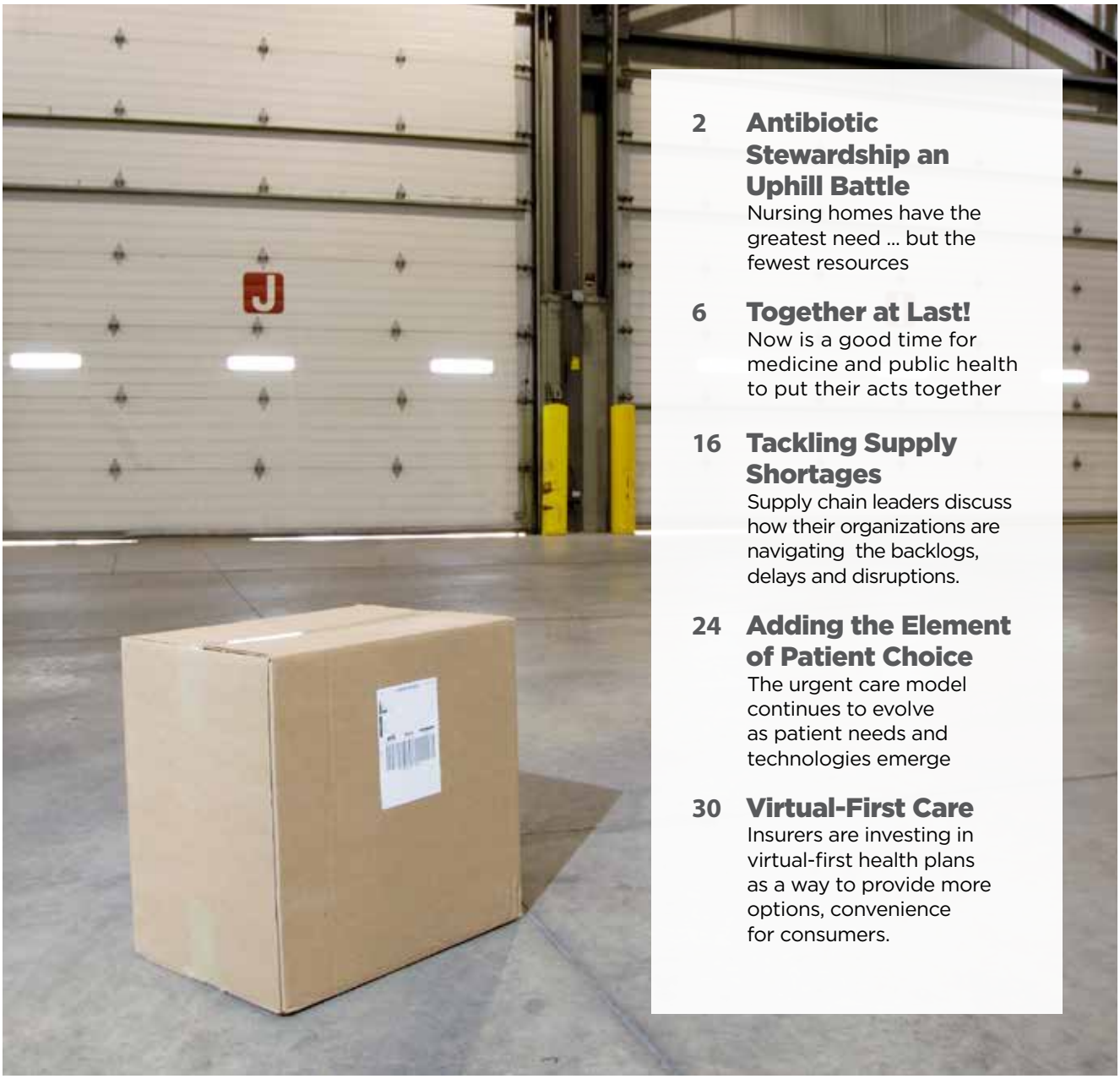
CONTENTS »» JANUARY 2022



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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

EDITOR
Graham Garrison
ggarrison@sharemovingmedia.com

ART DIRECTOR
Brent Cashman
bcashman@sharemovingmedia.com

DIRECTOR OF BUSINESS DEVELOPMENT.
Anna McCormick
amccormick@sharemovingmedia.com

SENIOR EDITOR
Daniel Beaird
dbeaird@sharemovingmedia.com

CIRCULATION
Laura Gantert
lgantert@sharemovingmedia.com

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Antibiotic Stewardship an Uphill Battle

Nursing homes have the greatest need ... but the fewest resources

Since the mass production of penicillin began in the 1940s, antimicrobials have drastically improved human health, preventing death from bacterial infection and lowering the risk associated with surgery and other lifesaving medical procedures, point out the authors of a recent report from the National Academy of Medicine, "Combating Antimicrobial Resistance and Protecting the Miracle of Modern Medicine."

But almost as quickly as the first family of antibacterials was introduced, its usefulness declined. Within six years of the introduction of penicillin, roughly a quarter of staphylococcal infections in hospitals (where the drug was often used) were no longer susceptible to it. Penicillin resistance continued to spread, and by the 1970s was as common in community-acquired infections as in hospitals.

Hospitals still face an uphill battle against antimicrobial resistance today, but post-acute and long-term-care facilities even more. That's because unlike hospitals, nursing homes typically lack the expertise of a full-time infection prevention staff or an onsite medical director. Nor do they have the information systems that could help staff identify potential misuse of antibiotics.

Foggy guidelines

Sadly, antibiotic resistance is a fact of life. In its report, the NAM points out that microbes are constantly responding to selective pressures, including the pressures from antimicrobial medicines. "One response is a classic, Darwinian evolution wherein beneficial traits are passed from one generation to another. ... The genetic adaptability of microbes contributes to the emergence of resistance."

The misuse or overuse of antibiotics exacerbates the problem. Claims data suggest that roughly 17% of antibiotic prescriptions in the United States are made in the absence of any diagnosis of infection, while another 20% to 30% are not associated with any clinical visit at all, according to the NAM.

Confusion over treatment guidelines is another problem. Long treatment regimens with antimicrobials were common historically, driven partly by a limited understanding of their effectiveness. The optimal duration of antibiotic therapy even for common infections, such as community-acquired pneumonia, was not established for decades, according to the NAM authors.

And the results?

In 2019, the Centers for Disease Control and Prevention estimated that every year, 2.8 million resistant infections in the United States lead to 35,900 deaths, with C difficile infection killing another 12,800 people. The Organisation for Economic Co-operation and Development estimates that 1.75 million years of healthy life are lost to antimicrobial-resistant infections every year among its 33 European member countries.

Urinary tract infections

Older Americans make up 15% of the U.S. population but account for more than one-third of the deaths from antibiotic-resistant bacterial infections, according to a recent study from The Pew Charitable Trusts, University of Utah, and Infectious Diseases Society of America. In nursing homes – which accommodate an estimated 1.3 million Americans, about 80% of whom are over age 65 – antibiotic usage is common, according to the NAM researchers.

Suspected urinary tract infection (UTI) could be the most common indication for antibiotics in U.S. nursing homes, a group of researchers reported in August 2021. But some of those prescriptions are, at best, unnecessary, and at worst, contributory to antibiotic resistance.

"The clinical suspicion of UTI among nursing home residents is most often triggered by subjective changes in behavior or falls, which can also be caused by many noninfectious conditions common to older adults," according to the NAM researchers. Accordingly, NAM recommends that in the absence of fever or symptoms localized to the urinary tract, providers avoid urine cultures and antibiotic treatment.

"Automatically reaching for that antibiotic isn't a benign decision," Christopher Crnich, M.D., PhD, Infectious Diseases Faculty, Veterans Administration Hospital in Madison, Wisconsin, told Repertoire. (Crnich was one of two authors of an editorial in JAMA in April 2021 titled "Opportunities to Improve Antimicrobial Use in US Nursing Homes.")

"There has been a lot of misinformation in clinical training, particularly around the presentation of infection in older adults, and that has led to or promoted overutilization of antibiotics for nonspecific geriatric manifestations," he says. "That's a tough nut to crack because you have to 'de-implement' decades of training. Building systems that force clinicians to consider alternative explanations for a resident's condition or situation is necessary." The good news, he says, is that a new generation of clinicians is learning that subtle behavior changes among nursing home residents don't necessarily point to UTI.

Antibiotic stewardship programs

Most experts believe that healthcare providers – including long-term-care facilities – need to address antibiotic resistance with antibiotic stewardship programs, intended to measure and improve how antibiotics are prescribed by clinicians and used by patients. Among those experts are the federal government.

'Automatically reaching for that antibiotic isn't a benign decision.'

In 2015, the CDC released its "Core Elements of Antibiotic Stewardship for Nursing Homes," and in 2016, the Centers for Medicare & Medicaid Services finalized a rule requiring that nursing homes have antimicrobial stewardship programs in place by late 2017. In addition, The Joint Commission standards require nursing care centers to develop antimicrobial stewardship programs based on the core principles published by the CDC.

But it's not clear how many nursing homes have such programs in place, or how well-developed those programs are. The Joint Commission reports that, based on its survey of accredited organizations, only 2% were scored for non-compliance related to the requirement. However, in 2020 researchers reported in the American Journal of Infection Control that among 861 nursing homes surveyed, just 33% had "comprehensive" antibiotic stewardship programs and 41% had "moderately comprehensive" plans.

Crnich believes that those figures – particularly the 33% with comprehensive programs – "are probably a best-case estimate, given how the sampling was conducted," as those surveyed were in the CDC's National Healthcare Safety Network, a widely used healthcare-associated infection tracking system. "But it's premature to criticize nursing homes, given this is a relatively new regulatory requirement, even though the clinical need has been longstanding."

Hospitals – where stewardship programs began – have a leg up on long-term-care because they have onsite expertise in infectious diseases and pharmacy, as well as automated data systems to help them monitor and improve their stewardship activities, he says. It's true that every nursing home is required by regulation to have a medical director, but not every medical director is engaged in facility operations in a meaningful way. Similarly, every nursing home has a consultant pharmacist, but again, whether that person is engaged in antibiotic stewardship is variable, depending on the facility. In many cases, it is up to the director of nursing or infection preventionist – who are often one and the same, given staffing challenges facing

long-term-care – to implement an antibiotic stewardship program.

Nevertheless, Crnich sees progress. "The fact that CMS in collaboration with other public health agencies decided to explicitly incorporate stewardship into the regulatory language will help drive change," he says. And, if there is a silver lining to COVID, it may be growing recognition that infection prevention in long-term care is a serious issue. Crnich also believes that information technology infrastructure in nursing homes is improving, which should help staff direct their efforts toward antibiotic resistance more precisely.

Hospitals have a leg up on long-term-care because they have onsite expertise in infectious diseases and pharmacy.

Up and running

"High staff turnover and challenges in training staff on antibiotic stewardship protocols may present obstacles to comprehensive stewardship programs in [the long-term-care] setting," says Sarah Kabbani, M.D., medical officer at the CDC in the National Center for Emerging and Zoonotic Infectious Diseases, Office of Antibiotic Stewardship. Another barrier is limited access to facility antibiotic use data. "Tracking and reporting antibiotic use are important to identify opportunities for improving antibiotic use and engaging healthcare professionals to improve prescribing practices."

Nevertheless, Kabbani sees increasing awareness of the importance of antibiotic stewardship in nursing homes, and points to a recently published study by the CDC's Office of Antibiotic Stewardship that reflects growing usage of its "Core Elements" program.

Nursing homes around the country are engaged with academic partners in innovative programs to identify residents at risk for multidrug-resistant pathogens and reduce the spread of these germs, she says. Two examples:

- The Targeted Infection Prevention program led by Lona Mody from the University of Michigan, which is focused on improving care of residents with indwelling-medical devices at risk for antibiotic-resistant infections.
- The SHIELD Orange County quality improvement project led by Susan Huang, University of California-Irvine in collaboration with Orange County Public Health, to evaluate use of an antibacterial bathing strategy to reduce prevalence of antibiotic-resistant organisms in nursing homes, long-term acute care hospitals and hospitals caring for patients and residents in the same community.

"Through these experiences, there is a growing body of evidence to inform practices in nursing homes that will protect residents from the harms due to antibiotic resistance," she says.

CDC is investing $2.1 billion to improve infection prevention and control activities across the U.S. public health and healthcare sectors, a portion of which will be dedicated to antibiotic stewardship. Funds will support state data analyses of antibiotic use and programs to improve antibiotic prescribing across communities and address health disparities related to antibiotic use, including in long-term care settings.

Bringing hospitals into the picture

Long-term-care facilities can't do it alone, wrote Crnich in his JAMA editorial. To have any chance of reducing antibiotic resistance among the post-acute-care nursing home population, they must work with referring hospitals.

Researchers in the JAMA study found that higher antimicrobial usage was observed among short-stay residents admitted for post-acute skilled nursing or rehabilitation care, and among residents most recently admitted to the nursing home. They found that residents receiving antimicrobials during days 1 and 2 of their stay were most likely initiated before nursing home admission.

"It definitely is an area that requires focused attention," says Crnich. "We are collaborating with investigators at Oregon Health and Science University to identify opportunities and targets for intervention. Whether those are identified prior to the patient's discharge from the hospital or during post-discharge monitoring by the acute-care provider is not entirely clear. My initial bias is that there will have to be ongoing post-discharge monitoring by acute care, but that can only be accomplished through collaboration between acute and post-acute care. I hope we see these types of models emerging."

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Together at Last!

Now is a good time for medicine and public health to put their acts together

Prior to COVID-19, did you know the names of the medical officers of your state or county public health departments? Did the physicians you call on know their names?

It was the lack of coordination between medical providers and public health that led to failures in testing and vaccination during the pandemic, writes healthcare expert Atul Gawande in an August 2021 *New Yorker* article, "Costa Ricans Live Longer Than We Do. What's the Secret?" In many cases, public health departments "were forced to launch their own operations, such as drive-through testing sites and stadium vaccination clinics – and they had to do so from scratch, in a mad rush." More proof, he says, that the U.S. healthcare system "is designed for the great breakthrough – not the great follow-through."

And it's been that way for a long time.

Separate ways

From the start of the 20th century, public health and medicine developed as separate disciplines, notes the American Public Health Association (APHA). Medical and public health practitioners were educated in separate schools and upon graduation, the two disciplines went their separate ways.

But with escalating healthcare costs, continuing growth in the ranks of the uninsured, increasing emphasis on healthcare quality and outcomes, chronic disease, ever-widening health disparities, and outbreaks of emerging infectious diseases, greater collaboration between the two professions is not an option, but a pressing mandate, concluded researchers from the Florida State University College of Medicine in a study 15 years ago.

That's just as true – or more so – today.

A matter of perspective

Here's the problem: The two disciplines – medicine and public health – look at health very differently. In 1996, Donna Shalala, Secretary of Health and Human Services under President Clinton, compared them to trains on parallel tracks, with windows facing opposite directions. Those on the medical train see individual trees, with subtle differences in size, color, age and health, she said. Those aboard the public health train see a forest, that is, populations of similar trees, growing together and weathering the same storms.

Put another way, public health agencies define "population" on the basis of residential location, divided up by demographic factors such as race, ethnicity, gender, age, language, disability, or disease status, explains the American Academy of Family Physicians (AAFP) in its 2015 position paper on "Integration of Primary Care and Public Health." Meanwhile, the medical community defines "population" as those individuals to whom a healthcare entity provides care – in other words, the practice panel. (And payers look at "population" in terms of the members of their insurance plans.)

What kind of a world would it be?

If a primary care practice were to become more integrated with the local public health department, physicians would consider more carefully the social and physical environments in which their patients live, and then work to improve health outcomes, says AAFP.

It might also lead to advocacy – even community activism – on the part of doctors.

"There is a growing and exciting understanding that much of what determines health happens outside the exam room," Mark Del Monte, J.D., CEO of the American Academy of Pediatrics (AAP), told *The Journal of Healthcare Contracting*. "Medicine can play an incredibly important role collaborating with public health, community-based organizations, schools and local governments and working on the social drivers that are powering health disparities."

In its Advocacy Guide, the AAP defines advocacy as "taking the care, the information, and the resources that you provide to individual children and families and sharing those stories and experiences at the community, state, or federal level to help create systemic change. Community advocacy takes into consideration the environmental and social factors influencing child health, such as exposure to violence, safe places to play, poverty, child abuse, and access to healthy foods, and addresses ways in which child advocates – including pediatricians – can work with community partners to address these issues."

A data-driven approach

Advances in information technology, including medical records systems and geographic information systems (GIS), make collaboration between medical and public health professionals more feasible than ever.

Researchers from RAND Corp. point out that mapping hospitalizations for ambulatory-care-sensitive admissions, such as asthma or cellulitis, can identify small geographic areas in which community-level intervention may be needed. Health insurers can play a role too. The National Health Plan Collaborative, a group of health insurers aiming to reduce disparities in care, says that by geocoding the addresses of health plan enrollees and linking them to quality-of-care data, plans can identify "hot spots" of poor quality.

The RAND researchers found that one insurance carrier determined that Hispanic members with diabetes were less likely to receive LDL testing. Initially, they contemplated sending a mass, Spanish-language mailing to all Hispanic members with diabetes, reminding them of the importance of lipid testing. But using GIS, the plan mapped the distribution of members with diabetes in a predominantly Hispanic region, then focused on a small hot spot with many members who had not received LDL testing. They found that the neighborhood was linguistically isolated and as a result, they decided to focus their resources on a language-appropriate intervention in that area.

In October 2021, the Primary Care Collaborative, a nonprofit organization working to advance primary care, and the Robert Graham Center, a family medicine and primary care research organization, released a report, "Primary Care and COVID-19: It's Complicated – Leveraging Primary Care, Public Health and Social Assets."

"A key innovation of this report for both public health and primary care is this notion of the community health index," says Del Monte, who in addition to his duties at AAP is vice chair of the Primary Care Collaborative, "They used a data-driven analytical process to describe the interrelatedness between primary care and public health. It's very clear that if we don't have a strong primary care system and a strong public health system, we fail to optimize either one of them."

'Wrong pockets'

Tradition and history aside, money – or the lack thereof – is one of the biggest factors preventing medical and public health professionals from collaborating.

"Public health and primary care both try to prevent illness and even address the upstream conditions – the social determinants of health – that cause poor health, but there is not enough funding for this type of integrated approach," Seiji Hayashi, MD, MPH, FAAFP, chief transformation officer and medical director for Mary's Center, a federally qualified health center in Washington, D.C., told *The Journal of Healthcare Contracting*.

Commenting on the PCC/Graham Center report, Hayashi points to siloed funding as one of the biggest barriers. "Stuart Butler from the Brookings Institution and other policy researchers have been writing about the 'wrong pockets' problem, where even though funding for housing, transportation, and education can improve health, there isn't an appetite for healthcare to transfer money to other sectors," he says. "Investing in primary care and public health that tries to prevent illness is counter to most parts of the healthcare industry, where more care means more money."

"Funding is unfortunately a large barrier and often holds back progress," says Julie Wood, M.D., MPH, AAFP's senior vice president for research, science and health of the public. "Public health and primary care are both underfunded by disparate ... systems that often have common interests but are not structured to work well together."

Financially, public health has been particularly hard hit for the past 10 years or so. Since 2010, spending for state public health departments has dropped by 16% per capita and spending for local health departments has fallen by 18%, according to a KHN and Associated Press analysis of government spending. At least 38,000 state and local public health jobs have disappeared since the 2008 recession, and more than three-quarters of Americans live in states that spend less than $100 per person annually on public health.

In California, "public health nurses, microbiologists, epidemiologists, health officers and other staff members ... are

abandoning the field," according to the analysts. "It's a problem that temporary boosts in funding can't fix."

Bright spots

No one said it would be easy to integrate medicine and public health. But there are bright spots.

"It's not a moment in time; it's a transition," says Wood. "There are exemplary practices and communities, but the most exciting progress we are seeing is a transition in training. Family medicine residents are training from this perspective now, longitudinally, throughout their residency – looking at the data of their community and applying it to how they practice both at the community and individual practice level. They are coming out of training already prepared with knowledge and skills of how to work with their public health colleagues and with community information."

Says Hayashi, "The unprecedented expansion of community health centers through the Affordable Care Act and subsequent federal support increased primary care capacity in underserved communities. Many public health departments leveraged these new primary care access points to tackle public health crises. For example, public health and primary care have been working together to address the opioid epidemic. Reducing environmental hazards like lead poisoning is a public health/primary care success story with screening and remediation. We still have much to do, though."

There are bright spots around the world from which U.S. medical and public health practitioners can learn. "The concept used in the U.S., however, comes from principles of Community-Oriented Primary Care (COPC), which was developed in rural South Africa," says Hayashi. "Community health centers in the U.S. were founded on this principle, and they are accustomed to the idea of serving a geographically defined area. In fact, this is one of the grant criteria for health centers receiving money from HRSA, the federal agency that funds and oversees community health centers."

In his New Yorker article, Gawande speaks about the Costa Rican healthcare system, which, he says, "braids together public health and individual health." In that Central American country, the "ATAP" is a clinician who has the skills of a medical worker and a public health aide. A local primary care team called an "EBAIS," consisting of a physician, nurse and ATAP, are assigned to groups of several thousand people, and call on them regularly at their homes.

Lessons from the pandemic

Experts believe that the time to integrate medical and public health is now, while the lessons of the pandemic are still fresh.

One in 500 Americans has died from the virus, and the U.S. COVID-19 death toll accounts for nearly 20% of the world's deaths, despite the U.S. being just over 4% of the world's population, point out the authors of the PCC/Graham Center report. This even though the U.S. had one of the earliest and most robust supply of vaccines.

"It does not matter that vaccines are developed if communities cannot access them or individuals do not want them," the authors write. "This is where public health and primary care integration can help."

Pediatricians in the community

Since 1993, the Community Access to Child Health (CATCH) program of the American Academy of Pediatricians has given grants to support pediatric residents and pediatricians in planning or implementing community-based child health initiatives. According to AAP, potential roles that pediatricians can play at the community advocacy level include:

- Initiating a community project or forming a partnership, alliance, or coalition to address a problem.
- Informing community leaders, about issues affecting children in the community.
- Inviting decision-makers to visit their professional setting.
- Providing testimony and telling their story at community forums, events, and in the local media.
- Serving on the board of organizations that support children's health well-being or interests, such as a school board.
- Offering medical expertise to schools, youth organizations or institutions, and child care centers.

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Two perspectives

Editor's note: *This table, from the Harvard School of Public Health, demonstrates how differently medicine and public health view healthcare.*

Public health	Medicine
Primary focus on populations	Primary focus on individual
Emphasis on disease prevention and health promotion for the whole community	Emphasis on disease diagnosis, treatment and care for the individual patient
Interventions aimed at the environment, human behavior, lifestyle and medical care	Predominant emphasis on medical care
Lines of specialization organization by: › Analytical method (epidemiology, toxicology) › Setting and population (occupational health, global health) › Substantive health problem (environmental, health, nutrition)	Lines of specialization organized by: › Organ system (cardiology, neurology) › Patient group (obstetrics, pediatrics) › Etiology and pathophysiology (infectious disease, oncology) › Technical skill (radiology, surgery)
Research moves between laboratory and field	Research moves laboratory and bedside
Population sciences and quantitative disciplines essential features of analysis and training	Numerical sciences increasing in prominence, but still a relatively minor part of training

Source: Harvard T.H. Chan School of Public Health

But amidst the failures during the pandemic lay glimmers of progress.

In communities with the most robust primary care, the strongest public health infrastructures, and the fewest social vulnerabilities, residents were 42% less likely to die from COVID-19 and 12% less likely to get infected with the virus, as compared to communities on the other end of the spectrum, according to the PCC/Graham Center report.

The COVID-19 pandemic showed how primary care and public health together can save lives, says Hayashi. "Public health provided expertise, resources, and supplies like test kits and vaccines. Primary care was the vehicle to deliver the testing and vaccines. Hospitals played a large role, but primary care was the trusted source of information and care to keep people from needing to go to ERs and hospitals. I can't call most of this a model of public health-primary care integration, but it's a start."

"There is opportunity for improvement in infrastructure across the country as we begin to consider recovery," says Wood. "We are certainly thinking about the important role of primary care and especially collaboration with our public health colleagues and how we rebuild that partnership to be stronger together."

"With a new shared understanding of the definition of population, the integration of primary care and public health can foster an effective collaboration that understands that the health of a population is not simply a product of functionality or funding of healthcare services," says the AAFP in its position paper. "Rather, it includes the conditions in which people are born, grow, live, work, and age, and encompasses inequities in power, money, and resources."

Says Wood, "Ideally, a practice is already a team, but when integrated with public health, the team is even bigger, with more resources and services to offer patients and the community. There's also the opportunity to have more information, show outcomes and often seek funding to support these programs." Some state AAFP chapters already work with their local or state public health departments to help with tobacco prevention and cessation programs and other wellness programs.

"Incremental changes make a difference as well. Partnering with community health workers or the public health department can broaden the reach beyond the walls of the clinic and be helpful to patients, the primary care physician, and their team."

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

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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.

Preparing for the healthcare supply chain 'new normal' in 2022

In early November, the White House released key performance indicators measuring progress in clearing bottlenecks throughout the U.S. supply chain. The metrics showed an "abnormally high" number of container ships awaiting berth at the ports of Los Angeles and Long Beach, which together handle 40% of containerized imports entering the country.[1]

Congestion at major ports of discharge translates to product backorders and delays further down the supply chain across industries. Increased freight, transportation and materials costs — along with labor shortages — also factor into this.

However, if we narrow the focus to the healthcare supply chain, the short-term outlook materializes as a steady state through the end of 2021, with relief just over the horizon. "We hope to see improvement in 2022 as we all learn how to better navigate the landscape," says Jack Slagle, vice president of category management at McKesson Medical- Surgical.

"It's just a slow and murky supply chain right now, and it will take time to dig out of transportation challenges," adds Slagle. "The good news is that manufacturing lines are up and running, and overall production is healthy."

Healthcare-specific products

Amid current supply chain uncertainty, McKesson monitors more than 41,000 critical care products and communicates areas of concern to customers. Proactive oversight reveals that most suppliers' production levels are at full capacity for goods needed by primary care providers, according to Slagle. For instance, after periods of widespread shortages, personal protective equipment and infection-prevention items (for example, gowns, N95 masks and gloves) are readily available.

"This is largely attributable to McKesson's due diligence to diversify and expand our domestic and global supplier base to ensure that we are providing our customers with quality products from socially responsible manufacturers," Slagle explains.

At-risk categories include durable medical equipment, exam tables and other exam room items that have extended lead times. Other challenges vary by manufacturer. "Suppliers that produce full truckload shipments of large, bulky products are typically in a tougher situation than a supplier that produces sutures," Slagle points out.

Moving forward, enhanced healthcare supply chain management is going to require transparency, collaboration and frequent communication between distributors and suppliers. Organizations across the medical supply chain must work together to help improve production and smooth out problem areas in order to achieve a "new normal."

McKesson's recent action items include running backhauls to suppliers, expanding ordering lead times and providing more accurate forecasting to customers. Additionally, some suppliers have agreed to cut back production in low-demand categories to help increase and expedite production in high-demand categories.

Assistance and advice for providers

Just as suppliers and distributors need to collaborate, healthcare providers should maintain an open dialogue with distribution teams regarding supply chain requirements. According to Scott McDade, company relentlessly strives to improve customer service levels and can help in the following areas:

- Working with manufacturers to ship products directly to customers

McKESSON

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Non-acute supply chain strategies that support better patient outcomes

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- Utilizing technology and data analytics to view current inventory levels and cross-reference for alternative products
- Requesting formulary adjustments and/or identifying conservation strategies for critical and high-demand categories
- Expanding customers' networks to include neighboring systems, local manufacturers and suppliers

Further, as the cold/flu season approaches its peak, primary care practices must make sure that they have enough vital supplies. "Plan, prepare and perform," advises John Harris, vice president of strategic accounts, laboratory at McKesson. "Proactively work with your distributor to assess market conditions and stay up to date with your product needs and availability. This includes monitoring disease prevalence in your area and understanding trending patient care needs and acuity levels. [And] have flexible protocols in place to accept alternative options and methods if you can."

Expect to see more physician offices and retail pharmacy chains setting up clinical services, including rapid COVID tests and other lab offerings. Harris noted that McKesson plans on being ready with respiratory testing solutions it can administer to patients at the point of care.

Managing day-to-day inventory concerns

It takes a resourceful collaborator to work through the unique medical and pharmaceutical supply chain issues that have cropped up at health systems and provider practices across the country. McKesson Medical-Surgical's experience includes these recent examples:

- When a customer needed 100 wheelchairs to support a vaccine center, only 40 were available at the time. McKesson searched for alternatives through its SupplyManager℠ online ordering tool, which enables product comparisons, and located 60 transport chairs as acceptable substitutes.
- Another customer requested a specific type of hand sanitizer for wall-mounted dispensers at their facility. Although the exact sanitizer was not available, McKesson worked with three different manufacturers to ship alternative options from their existing inventories of ready-to-sell products.
- When a health system needed a large order of traditional crutches, which were unavailable, McKesson supplied forearm crutches as a viable alternative.
- Nurses at another health system needed an out-of-stock size of surgical masks. McKesson located a supply of children's masks that successfully completed the order and fit the nurses who needed them.

Staying ahead of the curve

As we look toward the first half of 2022, healthcare supply chain stakeholders — public and private — are going to prioritize medical supply movement through the U.S. transportation system. Consequently, flexibility, teamwork and planning are going to prove key components of effective supply chain management in the months ahead.

Customers should keep in mind that distributors and their representatives can "do the heavy lifting for you," comments Slagle. "McKesson specializes in the non-acute, alternative-site distribution business and can provide the solutions and strategies that support getting customers through some of the recent challenges." Nonetheless, he recommends, "If you have significant product needs or are working on an expansion project that will require new equipment, large supply or pharmaceutical orders, let your distributor(s) know as soon as possible. The more time you allow for order planning, the better the outcome will be for you and your patients."

Concurrently, healthcare providers can do their part to help avoid potential supply chain concerns. "Stay in close contact with your distributor to understand the measures they are taking and categories that may present challenges in the near future," suggests McDade. "Take action now to build alternative product formularies so you can make decisions before an issue arises." Finally, "Make sure your teams exercise conservation efforts in at-risk categories," he adds.

In an environment of across-the-board collaboration, organizations of all types are committing resources to help improve the medical supply chain. McKesson plans on continuing to advocate for providers in nonacute, alternate care site facilities "to make sure we have the appropriate processes in place to get products to physician offices, surgery centers and even patients' homes," observes McDade.

"With time and patience, we are confident that things will continue to improve, and we are working hard to make this a better supply chain overall," Slagle concludes. ■

[1] https://www.whitehouse.gov/briefingroom/blog/2021/11/03/improving-and-tracking-supply-chains-link-bylink/#content

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Tackling Supply Shortages

Supply chain leaders discuss how their organizations are navigating the backlogs, delays and disruptions.


Amanda Chawla


Erik Walerius


George Godfrey


Steve Faup

Amid a striking uptick in COVID patients due to the latest surge over the holidays, health systems are also facing extended medical supply shortages and continuing to care for other patients. These supply deficits are impacting many necessities of care and are driven by raw material shortfalls, port backlogs, shipping delays and truck driver shortages for transporting goods. They include everything from crutches to syringes, needles, tubing, gloves catheters, drapes for surgery, suction canisters for medical waste, urine cups and more.

Supply shortages are so severe that some health systems have even asked their local communities for donations of gently used crutches and other medical equipment. Raw material shortfalls like aluminum for crutches, for example, impede the production of medical devices as well as labor shortages related to COVID sweeping through manufacturing facilities. These issues were acerbated by consumer demand during the holidays that assured supply chain problems were sustained, and parts needed for medical devices were used in other consumer products.

The Journal of Healthcare Contracting (*JHC*) surveyed supply chain leaders from health systems about the medical supply shortages.

***JHC*: Have you experienced any of these disruptions and shortages? If so, how are you mitigating them?**

Amanda Chawla, VP and Chief Supply Chain Officer of Stanford Health Care (Stanford, CA): Yes, anyone who works in the supply chain can attest to its impact on the way we operate in how we prepare and respond. Supply disruptions are not a matter of IF anymore, but a matter of WHEN. Affected categories have been wide ranging. The most notable include solutions, pediatric-specific supplies, core lab supplies, sterile surgical gloves and other products like suction canisters, DME (durable medical equipment) and OR specific. Some categories have limited options on alternatives.

Our number of product disruptions on a monthly basis is approximately 1,300. Daily, we receive about 80% of our orders from distributors. However, through the phenomenal work of our shortages task force and teams, including the substitution task force, the empty bin rate at the PAR locations is only 2% with no viable substitute – either due to clinical requirement or lack of product reliability.

Stanford has a multipronged approach in response to, mitigation of, and preparation for disruptions. From a dedicated resiliency team to warehouse and stockpiling strategies, which are least preferred, to an operating daily and clinical integration infrastructure. Stanford Supply Chain has a cross-functional, intra-supply chain team that incorporates every department within the supply chain organization, along with our primary distributor, into a shortage's task force. There are two external interactive taskforces: one known as the Substitution Taskforce (STF) and the other as the Supply Chain Utilization Practice Taskforce (SCUP). These teams meet regularly to support and manage the response to disruptions.

Steve Faup, Divisional Director, Supply Chain of Capital Health (Trenton, NJ): We've experienced all of [these disruptions and shortages] and more. For example, a vendor was working on a follow-up to a delivery problem and admitted the shipment was in transit at a staging center 600 miles away but there were no drivers available. It's apparent there is frustration realized by everyone involved.

We have grown from an average of 20 backorders per day in August to up to 40 per day now. Sometimes [substitutes] are available, but not necessarily through the original vendor of choice. Also, substitutes can create a change in process or practice, which might require clinical education.

We work with our customers to identify options and utilize all our internal supply chain resources to cycle through the vendors for products. We developed some new vendor relationships during the past 18 months that were not part of the typical healthcare supply chain, and we've continued to include them as resources. And a couple of our vendors have committed to a longer term pipeline for specific products.

George Godfrey, Corporate VP and Chief Supply Chain Officer of Baptist Health (South Florida): We have been experiencing these types of shortages since fall 2020. The shortages have been in all areas. It has affected mostly overseas production of finished goods and we are notified of approximately 20 to 25 distinct backorders per day.

We are closely monitoring on-hand, available stock within our distribution center, while maintaining a data set of clinically approved substitutes and finding alternative sourcing throughout multiple avenues.

Erik Walerius, Chief Supply Chain Officer of UW Medicine (Seattle, WA): Hundreds of products continue to be on allocation or backordered across multiple categories including bedside care, when items drop off and new ones are added. Currently, we have 450 backordered items. Substitutes are available for many but not all items.

> **"Supply shortages and disruptions will always occur. The question is to what frequency and degree of impact."**
>
> – Amanda Chawla, VP and Chief Supply Chain Officer of Stanford Health Care

***JHC*: Have you asked clinicians to conserve supplies?**

Chawla, Stanford Health Care: Yes, particularly in instances where clinical equivalent substitutes are not reliable or not available. Bringing about awareness fosters partnerships and helps to eliminate any waste while promoting sustainability.

Faup, Capital Health: Yes [we have]. Some good examples include targeted processes like utilizing vacutainers for only what is necessary during a blood draw and avoiding wasted tubes. Past practice included filling a predetermined volume of tubes as backups. The pharmacy department has designated specific

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departments to receive vendor-supplied prefilled syringes based on the need for longer expiration dating. Pharmacy staff is building prefills for departments that will use them in a shorter time period.

These options are available and supported because of strong clinical leadership.

Godfrey, Baptist Health: Not in all instances of product shortages. We did put conservation strategies in place early in the pandemic for PPE and other specific product shortages. However, our hospitals demonstrate an absolute need for clinical supply with each request for product, so we do our best to find another avenue to source product whenever possible and only use restricted ordering in the most severe of shortages.

Walerius, UW Medicine: Yes, via committee decisions in partnership with members representing clinicians, clinical education, infection prevention and supply chain. Conservation tactics were needed when substitutes were not deemed clinically acceptable.

***JHC*: Have you paid for expedited shipping due to long lead times?**

Chawla, Stanford Health Care: Yes. With volume increases and the lack of reliable, proactive information on disruptions, Stanford has had to respond at times with rush and expedited orders.

Faup, Capital Health: [We have] since March 2020. While most PPE supplies have become more readily available, the supply and demand issues with other items has forced the continued practice of expedited shipping. The product shortages are unpredictable. A steadily flowing item through our supply distribution system can become an allocated or unavailable item in a few days.

Godfrey, Baptist Health: We have, but before we rush to a judgement on expediting shipments, we first review our inventory position versus demand and only accelerate the shipping on urgent and low on-hand inventory. We have also empowered our procurement teams to expedite inbound stock when usage outweighs available stock.

Walerius, UW Medicine: Yes.

***JHC*: How long do you anticipate these supply delays and shortages to persist?**

Chawla, Stanford Health Care: Supply shortages and disruptions will always occur. The question is to what frequency and degree of impact. Both of which are unknown and almost impossible to forecast in the current climate.

Faup, Capital Health: Who predicted the current issues would exist? At the beginning of the pandemic, it was a three- to six-month prediction, then eventually it was 18 months. Now there are predictions for another 18 to 24 months. That would make a total timeframe of three and a half years. Other factors are popping up to create new hurdles, including available warehouse space and the rising costs associated with it. For example, available storage and warehouse space is decreasing on a regional basis while increased lease costs are ranging from 25% to 60%.

These are all real components and without fixing each one, roadblocks in the flow of goods will continue. Infrastructure is not an overnight fix. And while healthcare does not represent a majority of goods, we should have better representation as a critical component of need.

Godfrey, Baptist Health: We anticipate at least another nine to 15 months of supply constraints. The bullwhip effect on supply chain seems to have a long tail of recovery.

Walerius, UW Medicine: Most, if not all, of CY 2022 and potentially spilling into CY 2023 for various items and categories.

***JHC*: If you are contracted with a GPO, have you had to purchase supplies outside of the contract? Are you concerned about contracting prices when they come up for renewal?**

Chawla, Stanford Health Care: When products are not available through the primary or preferred or contracted channel, we will turn to alternate sourcing options to ensure our healing hands have the right products at the right time to care for our patients.

Yes, there is a concern about price increases, and equally, there is a need for greater visibility into the supply chain and reliability. We have experienced price increases with a few contracted supplies as well.

Faup, Capital Health: Through my conversations with various hospital and health system supply chain leaders, we have all purchased outside of contracts when products and services weren't available within the existing agreements. We view all products as having the potential for price increases beyond what has been the industry benchmark. I believe GPOs should be able to utilize their larger relationships to help manage these increases.

Godfrey, Baptist Health: We engage our GPO partners early in the communication to source outside of the contractual path for the understanding of deviations.

Walerius, UW Medicine: Yes, requests for price increases are already occurring.

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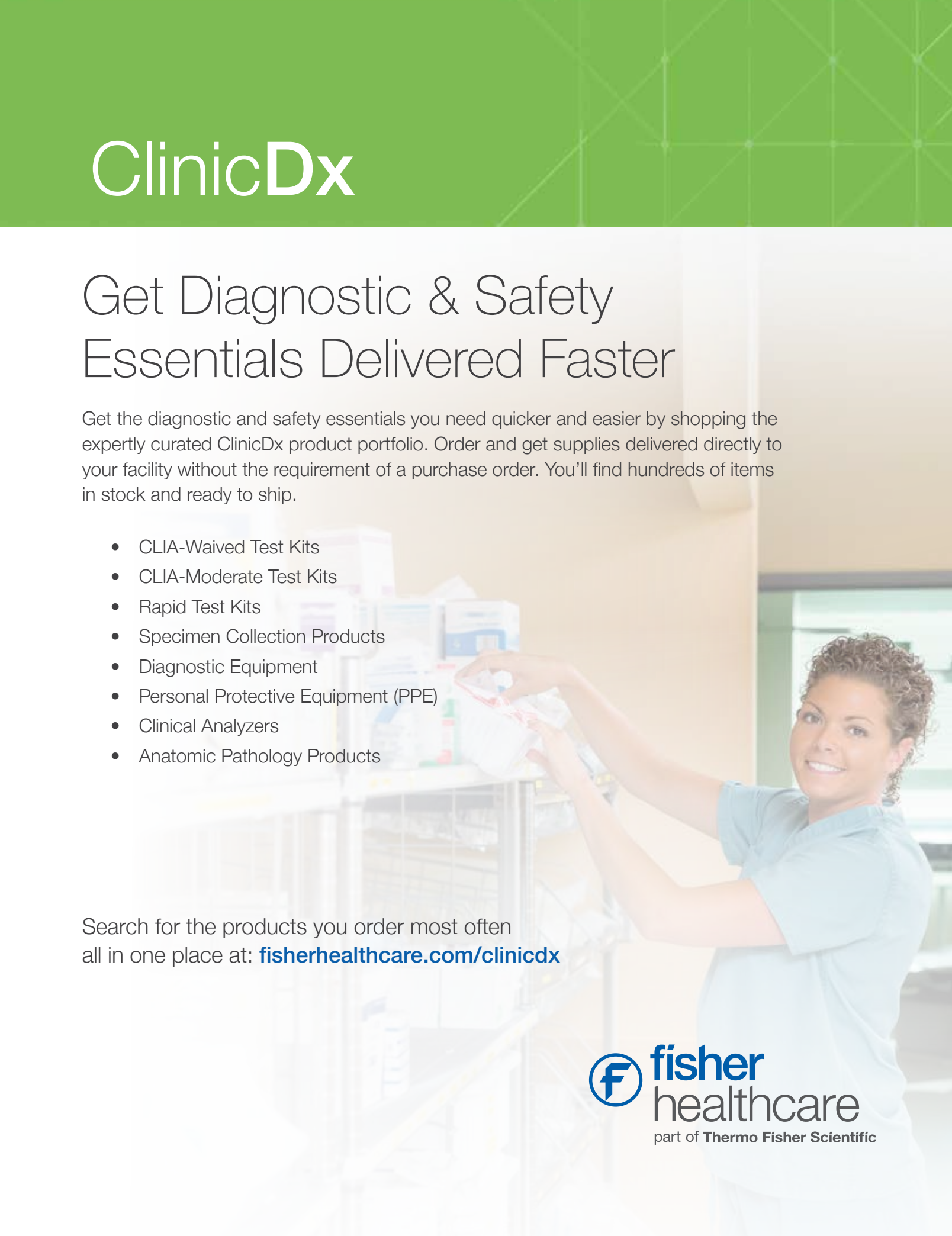

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Dressing for Work and Weather Doesn't Mean Giving Up Functionality, Comfort and Style

Wherever your healthcare facility is located, the seasonal changes occurring now are likely the most distinct. It's necessary for some to prepare for extreme events like blizzards, ice storms and dense fog; others just have to put on a light layer heading to or from their jobs. Whatever the weather throws at us, healthcare workers want uniform apparel that continues to feel and look good while being highly functional.

What Not to Wear

With apologies to the long-running TLC series What Not to Wear, certain garments and fabrics don't work in a healthcare setting. As the weather gets cooler or colder, depending on your location, your employees may be tempted to add their own layer to keep warm on the job. But studies have shown that high-pile fleece is more likely to carry bacteria or contaminate patients. Also, it's important to avoid bulky clothing; your employees' apparel should never restrict their ability to provide top-notch care.

Healthcare Workers Want Functionality

Like all of us, healthcare employees have individual preferences when it comes to their work apparel. However, we've seen an increase in requests for ***performance fabrics*** for healthcare settings, looking at the trends. Athletic fabrics with low-pile, french terry, or modern heat regulation have gained popularity. Most importantly, the uniform apparel fabrics must be protective yet breathable. Going from chilly to sweaty and back again does not serve your care staff well and can be distracting.

Like a runner who wants a secure spot for their car keys or mobile phone, your employees want their seasonable apparel to make it easier to do their jobs. From the emergency department to the bedside to the physician's office, some prefer zippered clothing, others prefer snaps, but it's all about multi-use pockets. Accessing the tools they need for the job makes it easier for them to face whatever comes their way efficiently.

Speaking of the ED, it's the part of your facility most exposed to the elements. We've found that most emergency department employees prefer ***layering options***. These can include a long-sleeved wicking performance tee, a scrub top or jacket, and a performance vest or jacket. All should be made of fabrics that adhere to safety standards, fit comfortably but not tightly, come in multiple styles and colors (particularly for facilities that color-code uniform apparel by role) and can be easily laundered.

Many Ways to Say "Thank You"

People working in healthcare have endured nearly two years of unimaginable working conditions. From trying to keep themselves safe from COVID-19 to urgently treating the waves of seriously ill virus sufferers, they have been pushed to the extreme both physically and mentally. As a result, many facilities have experienced high employee turnover. If you haven't already, it's time to do anything you can to show appreciation to your employees — such as increasing your professional healthcare apparel offerings. No matter the weather, being comfortable will be a bright spot in yet another winter of unknowns. That is the least we owe these dedicated professionals! ■

Deanna Leonard is Vice President and General Manager - Professional Healthcare Apparel Encompass Group, LLC.

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Adding the Element of Patient Choice

The urgent care model continues to evolve as patient needs and technologies emerge

The Urgent Care Association (UCA) is an organization of leaders, providers and suppliers in on-demand healthcare. It supports success through advocacy, education, research and collaboration. Its CEO Lou Ellen Horwitz recently spoke with JHC about the organization, some of the biggest changes in the urgent care marketplace since its inception in 2004 and how urgent care centers were affected by the pandemic.

JHC: **The Urgent Care Association was started in 2004. Can you tell us the reason behind its creation, and the number of initial members?**

Horwitz: UCA was started by a group of urgent care owners who wanted to connect with and share best practices with other owners across what was then a nascent industry. Urgent care was the first "walk-in" medicine outside of the emergency room, which added the element of patient choice and patient experience into an existing ecosystem of how we delivered healthcare in the U.S. Initially, there were a few hundred members – we do not have an exact count.

Lou Ellen Horwitz

JHC: **What are some of the biggest changes in the marketplace since 2004 that UCA has helped its members navigate?**

Horwitz: The biggest changes have been the introduction of retail clinics (drugstores), the interest in our sector by external investors from private equity to large health insurers, and the growing presence of health system ownership.

The introduction of retail clinics was initially met with concern about fragmenting the walk-in care space, but it became clear that urgent care centers and retail

clinics have different scopes and goals and can work well together in a community.

The investments have led to exponential growth in the number of centers, increased sophistication in operations, and increased visibility of urgent care centers across the nation by all stakeholders. Health system ownership – either directly or through JV-type relationships – has grown from almost nothing to almost half the industry.

***JHC:* Walk through the most common ownership models.**

Horwitz: The most common ownership model is through health systems or closely affiliated. Some de novo but mostly through acquisition or joint ventures. The second most common is privately held with private equity backing. Some of these also have health system affiliations without ownership. And third is privately held by individual owners – single/double site locations make up almost half of the centers in the country.

***JHC:* When did you begin to see health systems take an interest in acquiring/owning urgent care centers?**

Horwitz: Health systems first tried urgent care in the mid-1990s but backed away after limited success. Interest resurged in approximately 2010 when acquisitions began in earnest, but in a different model from the 1990s version. It has met much more success.

***JHC:* Where do today's urgent care centers fit in services and care for patients? What are their strengths?**

Horwitz: Urgent care centers handle a wide variety of non-emergent illness and injury on a walk-in or appointment basis. Their scope is typically well beyond that of a retail clinic, somewhat beyond a primary care office, and slightly under an emergency room.

Their strengths begin with good medicine and safe patient care, of course, but their distinctive elements are a broad scope of care capabilities and an elemental focus on the patient experience. This has led to extremely high patient satisfaction with the model because systems are set up to make it easy and convenient to access high-quality care across a wide variety of conditions.

Value-based care has yet to include urgent care, but it's a natural opportunity to proactively move non-emergent care into lower cost sites, so it's expected in the future.

***JHC:* How were urgent care centers affected by the pandemic?**

Horwitz: Urgent care centers were tremendously affected – both medically and financially. Visit volumes have tripled or more and remain at extraordinary levels even today. Operationally, they had to navigate:

- PPE shortages
- Varying medical guidance
- Confused and unhappy patients
- Fluctuating requirements for physical plant changes
- Variations in regulations from state to state
- Staffing shortages
- Inconsistent payer reimbursement for visits
- Instantaneous telemedicine adoption and more

In some ways it has been an opportunity for urgent cares to show what they can do, from their ability to adapt and pivot quickly, to form partnerships easily, and to stay open in extremely difficult circumstances. The willingness to jump in and participate from day one of the pandemic has been lauded by federal and state stakeholders, who were unaware of urgent care's significant role in communities prior to the pandemic.

***JHC:* What do you forecast the marketplace to look like in five years? Ten years?**

Horwitz: Urgent care has long adapted to, and even led through, change throughout its existence. It's a model for forward-thinking care and continues to evolve as consumer needs and technologies emerge. Adoption of telemedicine, in some form, is fairly ubiquitous and geographically there are still underserved communities that could benefit from urgent care.

The payer landscape, however, has not yet caught up with the potential of urgent care to serve rural communities and lower overall costs of care from treating the non-emergent cases currently seen in the emergency room. Experimentation with hybrid urgent care/primary care models continues, as does the primary care shortage, so there is potential there as well.

Value-based care has yet to include urgent care, but it's a natural opportunity to proactively move non-emergent care into lower cost sites, so it's expected in the future. Private equity interest remains strong, as does consolidation via merger and acquisition activity. With the right shifts from the payer community, urgent care's potential is promising for many years to come. ■

Healthcare Equipment Delays? Channel Partnerships Can Help!

Opening a new clinic or ambulatory surgery center on-time is always wrought with many challenges, including equipment lead times, construction delays, product loss/damage, and getting required biomedical checks completed. During the COVID-19 pandemic these challenges have become amplified. Demand is high, raw materials diminished, and logistics are bottlenecked all over the world. Lead times have lengthened considerably, including not only the healthcare equipment needed for a new healthcare facility but also construction materials. Exacerbated workforce shortages caused by the pandemic affects many phases of the supply chain, including manufacturing, planning, purchasing, warehousing, assembly, delivery, and biomedical start-up checks.

When faced with these new challenges, the healthcare supply chain responded in many constructive ways. Collaboration between manufacturers, distributors and customers intensified, and many innovative solutions evolved to meet ambitious construction deadlines. One of the harder hit product categories during COVID-19 was the Storage Solutions sector. Most stainless steel, chrome, and plastic, the three most prevalent storage materials, come from outside the US. Lead times for most items were approximately four weeks prior to COVID-19. They have increased to more than four months over the last two years.

CME Corp is an equipment-centric full-service distributor that offers turn-key solutions for new construction projects. Metro is the world's leading manufacturer of storage equipment. They teamed up these past two years to innovate some storage solutions and meet some very tight timelines for their mutual customers.

Metro top track system

Nevada Ortho Clinic Needs Equipment in Eight Weeks

Late in 2020, when the healthcare supply chain was really starting to feel the effects of the COVID-19 pandemic, a new 18 room orthopedic clinic was built in western Nevada. The equipment needed for the new clinic was ordered in mid-December, with a go-live date in mid-February, a tough timeline in even the best of times! They ordered a Metro top track system for their storage needs. When the order first was submitted, the system was backordered until mid-March, which was not acceptable to the customer. Metro, CME, and the customer got together to strategize on how to meet this near impossible goal. Metro shipped in temporary loaner carts and prioritized/expedited the top tracks. Since items were shipped piecemeal, CME had to deploy their installation team several times to complete the install. They had enough shelving configured early enough so the clinic could stock most of their supplies. The installation took three deliveries over a two-week period, the last delivery being on the day the clinic opened. CME's install team went beyond the call of duty, as there was also a massive snowstorm during this timeframe. The CME project management team, Metro's customer service, and the customer communicated almost daily during this project, which was crucial to getting it completed. The clinic opened on time and the customer was extremely satisfied!

Massachusetts Ambulatory Surgery Center Passes DPH Inspection

Early in 2021, a Boston-area surgery center (ASC) expanded their footprint and added six new operating rooms. The facility needed extra storage space, and a walk-

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through with Metro and CME account managers culminated in a CAD drawing that detailed several areas of high density, mobile, and stationary shelving solutions. The DPH inspection was scheduled for mid-May so that the new space could be certified for use. As time passed, Metro realized some of the items would not meet this inspection date. CME, Metro, and the customer met virtually to discuss options and possible solutions. With the customer's blessing, Metro substituted some of the materials and carts to be able to meet the deadlines. The CME team was able to complete 80% of the installation in time for the inspection. The customer was ecstatic and the ORs were in use the next week.

Customized CAD drawing of top track shelving

Nashville MOB Maximizes Storage Space

In early 2021, a Nashville-area medical center was expanding their medical office building (MOB). At their current location they had big storage issues, as supplies were literally falling off shelves due to inadequate space. The new build-out was 61,500 sq. ft. and the storage space needed to be planned in advance to meet their needs. Metro, CME, the customer project manager, and the architect worked on the layout collaboratively and decided on top track shelving to maximize the storage space. The project included 201 shelving units with 1,058 shelves and 5,290 linear feet of shelving. The customer would never have supplies falling off the shelves in this new space! CME's account manager worked with the customer and Metro early enough so that they could plan for extended lead-times on this project. The order was placed in September and all items will be delivered on-time to meet a February, 2022 need-by date.

Lessons Learned

The current pandemic continues to cripple the healthcare supply chain and will not resolve itself anytime soon. Healthcare systems need to be mindful when addressing new construction needs. Here are five things we recommend:

- Plan early and include distributors, manufacturers, and fellow team members in this early development stage. Get lead times well ahead of the project so that timelines can be met.
- Order early and work with partners who will over-communicate and give you visibility into where your products are at all times.
- Look at alternate products if lead-times move out too far.
- Find a partner who can help augment your depleted workforce including logistics and biomedical services.
- Be flexible and look for partners who are flexible also. These are tough times, and the best solutions can come from collaboration and being adaptable.

CME Corp is a full-service healthcare equipment and turn-key logistics company providing personalized support and service. With service centers nationwide, CME offers more than 2 million medical products from a total of over 2,000 manufacturers. CME is a healthcare system's complete equipment solution by providing product selection, sales, warehousing, assembly, staging, direct-to-site delivery, installation, and biomedical services for all its equipment.

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BY PETE MERCER

Virtual-First Care

Insurers are investing in virtual-first health plans as a way to provide more options, convenience for consumers.

All it took was a pandemic. Among many other things, the coronavirus pan-demic revealed the fragility of our healthcare infrastructure in the face of a massive disruption. Accessibility weaknesses laid bare, primary care and physician offices had to think of a creative way to ensure that their patients received the care that they required, while maintaining COVID safety protocols. In an effort to keep people as safe as possible, many primary care offices moved services to virtual appointments that allowed patients to be seen at the height of the COVID-19 surges.

Virtual health care is a precious commodity in a time when access to health care is more strained than ever. McKinsey conducted a study in July that found that "telehealth utilization has stabilized at levels 38 times higher than before the pandemic." Not only is telemedicine a valuable resource for those who need it, but it's becoming more popular as people see the benefits of leveraging virtual care for their needs.

Cigna recently announced that it is significantly expanding access to covered virtual care services for millions of customers. After the recent acquisition of MDLIVE by Evernorth, Cigna's health services business, Cigna is pushing to be an innovative provider of virtual care services at a time when people are most interested. In a media release, Dr. Cynthia Zelis, chief medical officer at MDLIVE, said, "Together, we are creating a best-in-class, coordinated virtual care experience for millions of patients – improving each person's unique health journey with support from a wide network of providers."

Despite its inherent limitations, virtual health care provides patients and providers with a unique opportunity to maintain a consistent level of care in a time rampant with inconsistency. In the height of the pandemic, telehealth was a critical tool for primary care practitioners who had to close their offices. Even if the standard of care isn't quite the same as when patients are in the office, virtual care affords the patients an opportunity to be seen from the comfort of their own home and the convenience of their own schedule.

Heather Dlogolenski, senior vice president, Solutions, Cigna, said in a media release, "At Cigna, we are constantly innovating our plan designs to meet the needs of our customers while continuing to make health care more affordable, predictable and simple. Expanding into virtual-first health plans is the next step in providing a convenient and comprehensive care experience."

How it works

Beginning in January 2022, all Cigna customers who are enrolled in employer-sponsored plans will have access to MDLIVE's network of virtual primary care providers for routine care visits, sick visits, prescription refills, or to follow up on a condition that wasn't addressed during a wellness visit. In addition to the virtual care visits that Cigna customers can schedule at their convenience, it will also seamlessly transition to an in-person visit as needed.

MDLIVE will refer to Cigna's network of high-performing providers when

face-to-face care is needed, with in-network specialists, lab work, and biometrics at in-network facilities. MDLIVE will also utilize the data provided by Cigna to proactively work with patients to close gaps in care, offer better care coordination and overall meet clinical medical needs. This coordination between MDLIVE providers or brick-and-mortar providers will be a critical component to ensure customers have a connected health care experience.

Dr. William Lopez, the national director of Virtual Care at Everworth, explained that MDLIVE is designed to make the patient experience seamless between virtual and in-person visits. "The partnership we have with brick-and-mortar providers in Cigna's network remains an important tenet of our virtual care strategy, and our core commitment to them remains the same – to ensure they can continue to deliver care how, when, and where they want to," he said. "That's why we also offer our network of brick-and-mortar providers – including primary care physicians – the ability to leverage virtual care as part of their care offering through our Virtual Care Reimbursement Policy."

Addressing the challenges in healthcare

One of the most significant and consistent challenges in healthcare is accessibility. Whether it's geographic challenges in rural areas or transportation barriers for low-income people, accessibility is one of the hot button issues facing healthcare. Virtual care provides a unique opportunity for greater access across the spectrum, creating convenience for a wider range of people.

"The substantial expansion in MDLIVE services provides even more choices to our customers, continuing our trend of removing access-to-care limitations that some consumers face," Lopez said. "Customers who have relationships with in-person providers will not be required to switch to a virtual provider. For many, virtual care offers another convenient way to receive care, and allows them to access care when are where they need it."

Virtual care presents its own set of challenges for patients and primary care physicians. Despite the convenience and ease of access that a telemedicine call affords the patient, it's impossible to address all of the patient's needs using a remote service. While it still allows the patient to be seen by a medical professional, some appointments are simply better for in-person visits. MDLIVE is addressing the challenges of virtual care by ensuring that their customers are offered the best choices for what they need.

Additionally, Cigna customers will be able to use the MDLIVE services to address their mental health needs. "Since 2020, Cigna customers have had access to MDLIVE's behavioral health care team in addition to the many other virtual providers within Cigna's vast behavioral health care network," Lopez said.

Virtual care in a post-pandemic world

While virtual care has become an invaluable resource to patients during the pandemic, what will happen once we move past COVID-19? In a post-pandemic world, will there still be a need for virtual care?

Lopez believes that virtual care options "will remain a preference of customers, clients, and providers in a post-pandemic environment." In fact, that's part of why Cigna has implemented the virtual-first benefit plan pilot, as well as the permanent coverage of certain virtual services for their network of brick-and-mortar providers.

"The massive acceptance and adoption of virtual care during the pandemic has reshaped the delivery of medical and behavioral health care," he said. "In addition, consumers have come to expect the same level of convenience in health care as they see in other industries such as finance and retail. Our customers and clients value convenient access to high quality care and are increasingly finding virtual care is a great way to meet their health needs. We also know that virtual provides an access point to health care, allowing customers to have more flexibility when it comes to care. In fact, more than 75 percent of Cigna customers who had an MDLIVE virtual wellness screening in 2020 did not have a PCP – and two-thirds identified a health condition as a result of the virtual screening."

In the post-pandemic world, there will still be a need for easy access to healthcare for rural communities and low-income families, as well as a variety of choices for customers who have come to expect a virtual health solution to their needs.

"Our customers value convenient access to high-quality care and are increasingly finding virtual care is a great way to meet their health needs. This substantial expansion in MDLIVE services provides even more of those choices to our customers," Dlogolenski said. "Not only will this give more people an additional entry point to the health care system, but patients will be able to build lasting relationships with their preferred MDLIVE provider just as they would in a traditional office setting." ■

McKesson's Response to Supply Chain Disruptions

Scott Adams, publisher of *The Journal of Healthcare Contracting* and *Repertoire* Magazine, recently hosted a roundtable podcast to discuss Global Supply Chain Disruptions in Healthcare with four supply chain team members from McKesson, including:

- Jon Archer, Senior Manager of Transportation
- Terry Henderson, Senior Director of Global Procurement
- Jack Slagle, Vice President of Category Management
- Krista Durst, Field Service Representative

Their conversation centered around supply chain and managing it every day to support health systems and alternate sites across the U.S. They discussed what's been going on, what's currently going on and a vision of the next three to six months.

Scott Adams: COVID-19 exposed the fragile nature of the supply chain over the last 18-20 months. Jon – what impact has McKesson seen, as a whole, on the healthcare supply chain?

Jon Archer, McKesson: We've seen longer lead times and inconsistencies at multiple points within the supply chain with all carriers. We've seen big increases in costs associated with all different modes and equipment shortages both domestically and at origin. All of that is driving inconsistency,

longer lead times and additional costs. And finally, the one that flies under the radar is the data ambiguity around it all. There's a gray area around when things are arriving because there's so much congestion at so many points in the supply chain.

We work with government partners to create solutions. We have a good partnership with HIDA and the ports of Los Angeles and Long Beach to prioritize medical containers. We're also working with about 400 other medical distributors to create a template to prioritize medical containers. We hope that can be an "easy button" to identify PPE and critical medical items to expedite through the ports.

Adams: Terry – what are some logistical actions and operational changes that McKesson has done to help with the disruption for providers?

Terry Henderson, McKesson: We break it down into two different parts. We think about the inbound shipments coming into our warehouses and network, and the outbound going to our customers. What we've learned during the past 18-20 months is there needs to be flexibility. We have Plan A, which is how we want things to work. We have Plan B, which is our next best option. And we have Plan C. We're changing many of our normal distribution lanes for inbound products.

For example, we would typically ship containers directly to Chicago. But that's become a chokepoint. So, Plan B is to get a container dropped on the West Coast, unload it and have it shipped across the country for redistribution. We're coming up with a flexible distribution model with a series of those planned. We're starting to see a lot of those things come together. We're shipping things around to make sure we can get the products through.

We're scaling up on the outbound side, knowing we're having challenges in getting products to the right place. Our first priority is always to ship to our customers from the closest warehouse. But we can end up with misbalances sometimes, so we utilize our entire network. If we're out of product in Warehouse A, we'll ship it from Warehouse B. It may not be an ideal shipment, but they're still getting what they need.

Adams: Jack – let's look ahead to the next three to six months for just-in-time inventory and lean inventory systems. Talk about some of your relationships with suppliers.

Jack Slagle, McKesson: My team manages all of our supplier relationships. We work with a lot of the branded manufacturers. We've been talking to their supply chain teams weekly, if not more often. We see improvement, but it's gradual and varies from supplier to supplier.

There are many challenges with any supplier that has full truckload shipments. Large, bulky products are more difficult to manage than for a supplier who's in sutures, for example. Also, raw materials and labor intensive needs will directly impact a supplier's challenges.

Transparency and collaboration between distributors and suppliers is very high. It's all focused on improving the experiences for our end user customers. Organizations are doing anything they can to expedite the process. We're changing our lead times for ordering and we're trying to provide better forecasting, and suppliers are cutting products for more capacity and to streamline production. The industry, as a whole, is working hard.

But the hole is so deep, it's going to take some time to dig out. As we get into January, February and March of next year, we should start to see some gradual improvement. But I don't think the supply chain will fully bounce back to what it was two years ago for quite some time.

Adams: Terry – can you expand on the relationships and partnerships with suppliers, manufacturers, GPOs and providers? What are some of the best practices seen to manage the day-to-day?

"What we've learned during the past 18-20 months is there needs to be flexibility. We have Plan A, which is how we want things to work. We have Plan B, which is our next best option. And we have Plan C. We're changing many of our normal distribution lanes for inbound products."

– Terry Henderson, McKesson

Henderson: On my end, most the new partnerships that have stepped up are related to carriers, some third-party logistics and transload operations – things like that that have been able to help and provide alternate source for where we can stock product or move it inland. Some of those partners have helped us as we've dealt with the challenges. Today, we have

strong partners and carriers that help us in a pinch.

Twenty months ago, we didn't have a need for that. Things just happened on clockwork. Today, that's not the situation. We find ourselves needing additional support, maybe in a city where we don't have a big presence. Those have been instrumental in getting things back on track.

Slagle: Some of the best practices have been from our supplier partners who are as transparent as possible. As an example, we received a couple of requests recently from suppliers saying they're anticipating labor issues within their organizations from drivers to warehouse workers. They asked f McKesson could increase the lead time from the time we cut our order to the time they ship it. Traditionally, if it was a week then push it out to two to three weeks.

homes, for example, will advocate to make sure that we're getting product to smaller or more remote sites of care. A lot of our suppliers have started to become advocates for that in partnership with HIDA.

Adams: What about PPE availability today versus last year?

Slagle: We have stoplight view we review with our sales teams on a weekly basis. PPE is considered to be green across the board. It's readily available and demand for it has dropped off considerably. There's excess supply. The diversification efforts of many distributors to add on new suppliers – more suppliers and different locations around the globe – has helped strengthen that category.

We're all leery of just-in-time inventory right now, but exploring sources closer to the U.S. or in the U.S. allows our supply chain to be quicker with more options to purchase from. Most categories with supply chain challenges are not PPE related, but it's a lot of our other core business.

> **"We use our technology to show the customer what we have, what they can get now and what will go on back order. Also, we show them what we can find to use in the meantime."**
>
> – Krista Durst, McKesson

That allows us to be savvy and carry more inventory. If it allows the supply chain to work more effectively, then that works best for both parties. That's an example of two organizations working together to improve the supply chain challenges.

From McKesson's perspective, it's taken a while to get suppliers and the government aware of the alternate site. Distributors like us that service nursing

Adams: Krista – talk about how McKesson has helped providers with inventory product delays and different allocations. Share some best practices in place to help your customers.

Krista Durst, McKesson: It's been challenging, but we work with our other health systems behind the scenes and on the frontlines. If the product's not exactly what they want, then what's a close enough alternative? We use our technology to show the customer what we have, what they can get now and what will go on back order. Also, we show them what we can find to use in the meantime.

For example, during the pandemic, we couldn't get the sanitizer dispensers on the walls, and I worked with one of our manufacturer partners and three different reps shipped me what they had in the trunks of their cars and garages so that we could get something on the walls.

Adams: And finally, Jack – give me some things you'd recommend to providers in the next three to six months for working through supply chain issues.

Slagle: The good news is most manufacturers are producing and making product. The manufacturing lines are up and running. Things are cooking out there. It's just a slow and murky supply chain right now. That will take time to dig out from.

When thinking about your product needs, just be flexible. For example, if your distributor can't get you crutches, for example, you might have to use a different brand. Or when some come in, you might want to get them while you can. And work with your distributor's sales teams because they need to know your product needs.

Lastly, plan ahead and be proactive. If you have significant product needs with a new buildout, renovation or large order, it will take longer than it has in the past to get product. But things will improve. A lot of folks are working hard to make it a better supply chain overall. ■

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1 https://www.ama-assn.org/system/files/2020-11/in-office-bp-measurement-infographic.pdf

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