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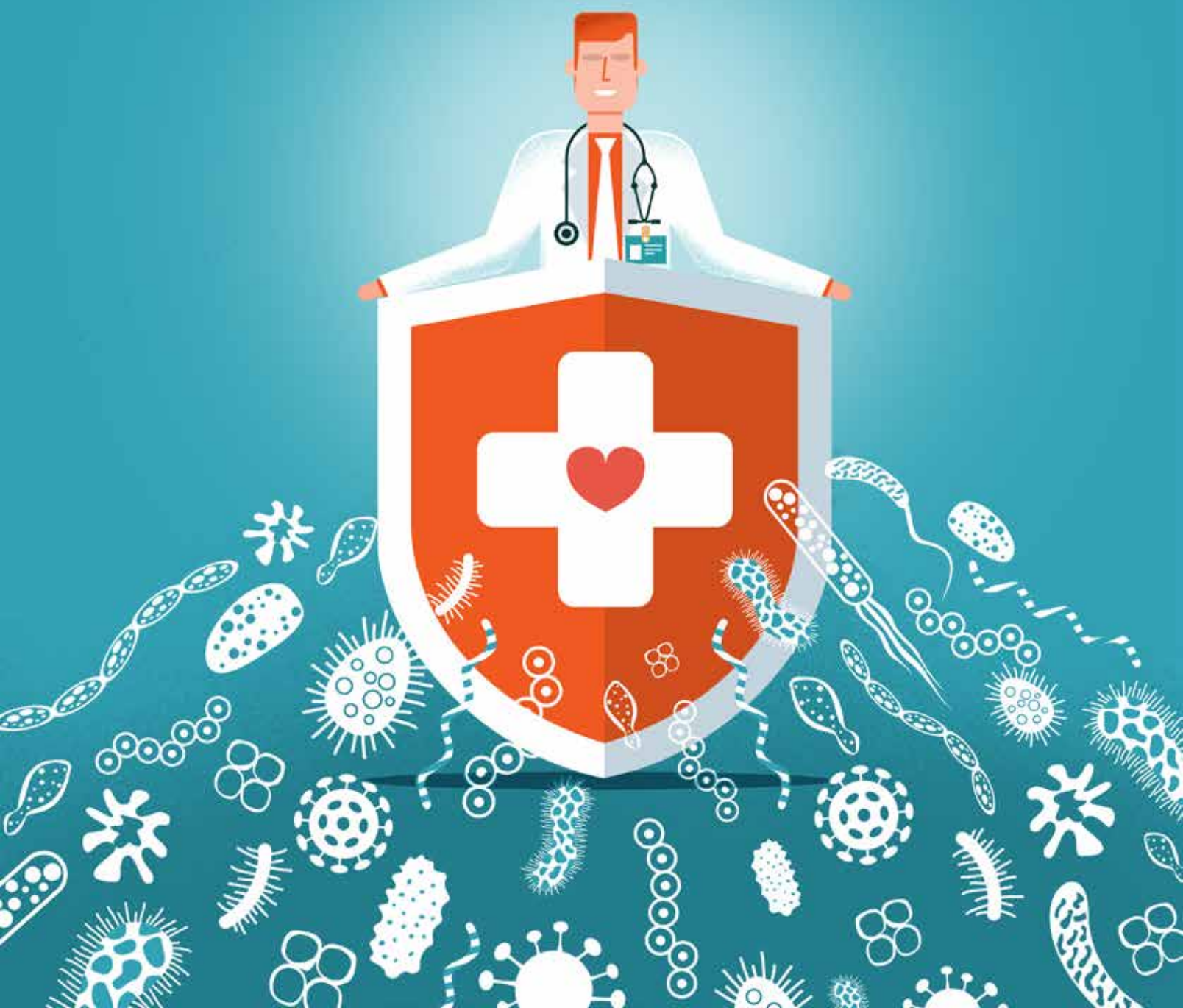
Infection Prevention Practices

Providers adopt creative solutions to infection prevention



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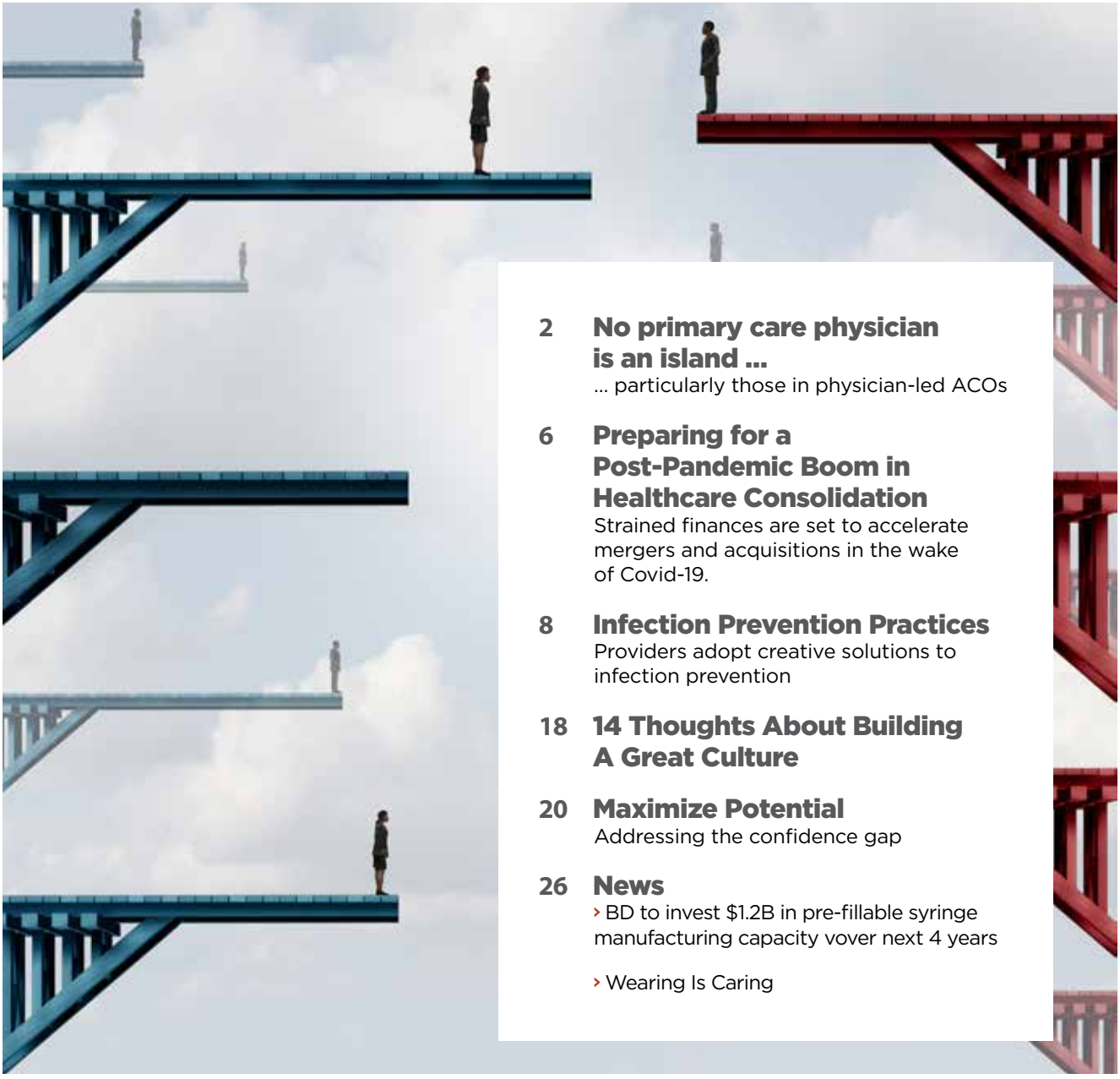

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No primary care physician is an island ...

... particularly those in physician-led ACOs

ACOs are groups of doctors, hospitals, and other healthcare providers who join together to give coordinated, high-quality care to Medicare patients, according to the Centers for Medicare & Medicaid Services. Their common goal is ensuring that patients get the right care at the right time – cost-effectively, of course – while avoiding duplication of services and preventing medical errors. Those that succeed share some of the savings with the Medicare program.

From 2010 to 2015, hospitals or health systems sponsored the majority of new ACOs. But in recent years, the ACO market has seen a shift, as physician group organizations have begun to lead the majority of new ACOs. In 2018, physician-group-led ACOs represented approximately 45% of all ACOs, hospital-led ACOs accounted for approximately 25%, and joint-led ACOs represented 30%. Experts believe there is greater market potential for new physician-led ACOs than for those led by hospital systems.

COVID-19 has been a big driver, according to David Muhlestein, chief strategist and chief research officer, Leavitt Partners. During the pandemic, practices that were dependent on fee-for-service saw dramatic drops in patient volume, and hence, revenues, says Muhlestein, who focuses on healthcare payment and delivery transformation. But those that were paid on another basis, such as value-based care, didn't suffer so much. "The difference in the two types of payments is like the difference between getting paid on commission or salary. Commission is great so long as sales are coming in, but if there's a downturn, salary can be really valuable."

Size doesn't really matter

Muhlestein says physician-led ACOs may include as few as 15 physicians or as many as a thousand or more. Most commonly, however, they tend to be in the 50-to-100-physician range, he says.

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"Some are in the same market as large hospital systems, some are in rural areas, and some are in mid-size markets where there are no other ACOs. All it takes is someone to say, 'We want to take care of patients differently, and now there's a payment model that can accommodate that.'" Third-party companies, referred to as ACO enablers, have arisen to help physician groups manage risk, that is, balance the financial and care-delivery components of an ACO.

Kim Harmon, vice president for ACO services for TMA PracticeEdge, a subsidiary of the Texas Medical Association, notes that its client base represents solo and small physician practices who provide care in their local communities. "While ACO size varies, 50 to 150 physicians will typically generate the 5,000 to 7,000 patient lives required by payers for participation in a contract," she says.

"Low-revenue" ACOs, as physician-led ACOs are increasingly referred to, have performed better than "high-revenue" ACOs, that is, those led by hospitals and health systems, points out CMS Administrator Seema Verma. In 2019, low-revenue ACOs had net per-beneficiary savings of $201 compared to $80 per beneficiary savings for high-revenue ACOs. The trend is the same for ACOs in the new Pathways to Success program, in which low-revenue ACOs had net per-beneficiary savings of $189 while high-revenue ACOs had net per-beneficiary savings of $155. (Introduced in December 2018, Pathways to Success reduced the amount of time an ACO could remain in the program before accepting financial risk along with potential shared savings.)

Two factors favoring physician-led ACOs are market size and potential, says Muhlestein. Simply put, physician groups outnumber health systems, and enjoy many more market opportunities. In addition, physician-led ACOs achieve significant cost-savings by reducing inpatient admissions. On the other hand, health-system-led ACOs, whose inpatient facilities still collect revenues based on admissions, may hesitate to do the same.

For physicians, it's moving away from, 'I am taking care of this patient in front of me,' to 'I need to be aware of everything about this patient, and if he or she has needs I can't provide for, I need to create partnerships or arrangements with other providers.'

No physician ACO is an island

In order to provide the total continuum of care for patients, physician-led ACOs must build relationships with other providers. "Physician-led ACOs are responsible for the cost of care at the global level even though they're unable to directly provide it," says Muhlestein.

Harmon points out that TMA PracticeEdge's ACOs are composed solely of primary care physicians who serve as medical homes for their patients. "But that doesn't mean they are an island," she says. "They identify specialists in their areas who are good communicators and provide cost-effective and quality care. Preferred urgent care centers help them offer after-hours care, and independent hospitalists manage care in the inpatient setting. Around all of this is a group of care coordinators who help with care transition and checking in on patients between office visits."

Josh Seidman, managing director, Avalere, says that some large practices already include a number of specialists, while others contract with a select set of specialists for particular issues that commonly arise among their patients. Such specialists, e.g., cardiologists or psychiatrists, might spend one or two days a week in the practice, or are just a telehealth visit away, says Seidman, who advises clients on value-based care models with a focus on information technology. Some ACOs form relationships with hospitalists to oversee the care of patients when they are in an inpatient facility or to stay in touch with emergency department physicians when patients are in hospital EDs. The success of these systems rests on good data exchange between the hospitalist and the ACO, including admission/discharge/transfer (ADT) data.

The long run

Culture change like this doesn't happen overnight.

Historically, physicians haven't been trained to proactively identify patients with needs and figure out how to address

those needs in advance of them flaring up, says Seidman. "It's a big shift in approach. Then there is this idea of physicians operating as a team. Even more important is each person understanding their role within that team.

"Physicians aren't necessarily the best-equipped people to figure out how to help people adopt more healthy behaviors or how to meet a wide array of their social or other needs that have an impact on health," he continues. "A social worker, health coach or community health worker might be in a better position to do so. Physicians are trained to deal with complex clinical matters, but they have to think about the overall needs of the patient, some of which can be addressed by other professionals."

'Physicians are trained to deal with complex clinical matters, but they have to think about the overall needs of the patient, some of which can be addressed by other professionals.'

Medicare data shows that experience matters, says Seidman. "Physician-led ACOs do better over time – not surprising for anything that requires significant effort."

Will ACOs, like many healthcare trends, such as HMOs – be relegated to the ash heap of history? How long can they deliver savings and improve quality of care?

"There definitely are things you might call low-hanging fruit in terms of reducing unnecessary hospitalizations and readmissions," says Seidman. "But shifting your approach in how care teams are organized and social needs are addressed is important for long-term improvements in efficiency and quality."

ACOs may very well succeed where HMOs didn't, says Muhlestein. Unlike HMOs, ACOs offer patients the flexibility to switch providers. Even more important, HMOs focused almost exclusively on reducing the cost of care, which meant gatekeepers, prior authorizations – in a nutshell, barriers to care. While ACOs share concerns about cutting costs, they also work to meet goals for quality-of-care and patient satisfaction.

"If you move away from shared savings models to full delegated risk capitated payment, you can perpetuate these programs," he says. "Physician groups are starting to accept risk. It's not for everyone; it's a dramatically different approach to care. For physicians, it's moving away from, 'I am taking care of this patient in front of me,' to 'I need to be aware of everything about this patient, and if he or she has needs I can't provide for, I need to create partnerships or arrangements with other providers.' It's management.

"Some have already been successful doing this – enough so that many others are now open to the idea." ■

Lessons learned

The Journal of Healthcare Contracting asked Kim Harmon, vice president for ACO services for TMA PracticeEdge, a subsidiary of the Texas Medical Association, about lessons the organization has learned – and the biggest surprises it has encountered – while forming and nurturing physician-led accountable care organizations. She listed three:

1. **Smart growth is important.** An ACO doesn't need every physician in the community to participate. Focus instead on those who are engaged and willing to learn from the data provided.

2. **Success in value-based care models takes times.** Physicians get frustrated when they don't see immediate results/rewards. Shared-savings contracts are paid out 6-8 months after the end of the performance year. The longer physicians participate, the better they become.

3. **The biggest surprise has been the number of emergency visits generated by conditions that could easily be treated in a primary care practice.** Many patients do not take the time to establish a medical home. When unexpected health issues arise, they feel compelled to visit hospital emergency departments for a quick (and expensive) fix.

BY MICHAEL BROOKSHIRE,
JOSHUA WEISBROD AND ERIN NEY, MD

Preparing for a Post-Pandemic Boom in Healthcare Consolidation

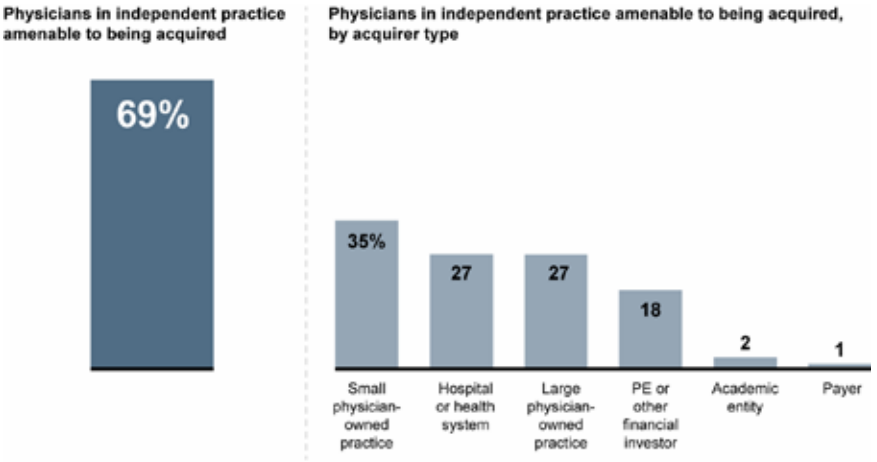
Strained finances are set to accelerate mergers and acquisitions in the wake of Covid-19.

Editor's note: This article is part of Bain's report *US Healthcare Trends 2020: Insights from the Front Line.* Explore more insights from the report here.

Providers have been consolidating over the last decade as organizations pursue economies of scale and expand vertically and horizontally. Post–Covid-19, we expect that larger healthcare groups and investors will accelerate their acquisitions of smaller hospitals, physician practices and alternative sites of care.

Strained finances and a sharp drop in procedure volumes have pushed organizations hard hit by the pandemic to entertain acquisition offers. Bain's 2020 US Front Line of Healthcare Survey showed 70% of physicians in independent practices were amenable to acquisition (see Figure 1). The findings were consistent across surgical specialties (74%), primary care physicians (69%) and other office-based practices (67%). Both surgeons and office-based physicians were willing to consider an acquisition.

Nearly 70% of independent physician practices are open to mergers and acquisitions



Source: Bain US Front Line of Healthcare Survey 2020, conducted with Dynata (n=109)

In 2019, 30% of physicians who owned practices reported that they would sell their practice in the next two years, according to Bain research. Today, physicians favor acquisition by organizations that would provide increased financial stability but still offer physician autonomy, namely by other physician practices. Nearly 30% of respondents were open to acquisition by a health system, and nearly 20% said they would agree to a private equity buyout.

As acquisitions pool physicians in larger groups, provider organizations will need to be mindful of professional satisfaction. That's particularly important when management-led organizations acquire independent physician-led practices. Although management-led groups offer economic security, physician-led groups enjoy a Net Promoter Score℠ that is 40 points higher, according to our research.

Large healthcare organizations, including hospital groups, expect to do more mergers and acquisitions. Fifty percent of hospital administrators said their organizations were highly likely to make one or more acquisitions over the next two years to pursue greater scale. Administrators

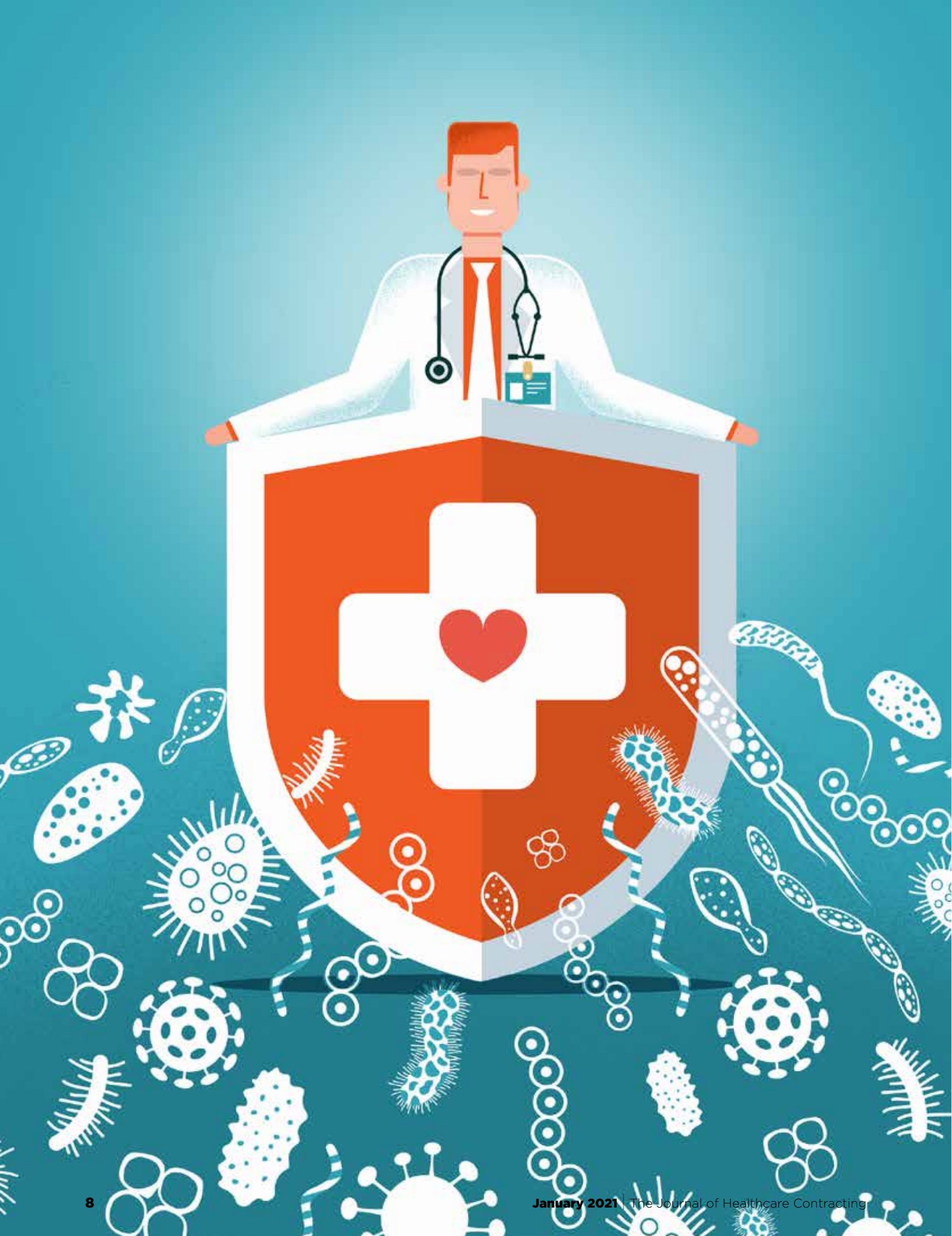
considering M&A were most interested in alternative care sites, including ambulatory surgery centers, urgent care clinics and pharmacy in-store clinics. The next most popular target was independent physician practices, followed by standalone hospitals. Home health businesses that provide care services in the home have continued to gain market share over the last few years, fueled by lower costs and patient convenience, and investors have taken advantage of this trend.

As healthcare providers consolidate, they are likely to invest in digital capabilities. That move is increasingly important as digital natives like Amazon and Google enter the fray. Leading providers are building digital capabilities, such as apps to message directly with patients, that enhance care delivery and strengthen patient loyalty. One large S provider group generated big returns by investing in a secure doctor-to-doctor messaging platform and integrated patient portal that allows physicians across the country to share records in real time. Several years after launch, 70% of members are registered for the patient portal, leading to greater medication adherence and improved patient outcomes. Member loyalty is three times higher for users of the group's digital tools.

Consolidation is likely to pick up in medtech, too. As provider systems consolidate vendors, medtech companies with category leadership positions will be in the best position to win in the ensuing flight to quality. Well-capitalized, larger medtech companies will be able to invest through the downturn to gain market share through organic and inorganic growth as demand returns.

Historically, M&A has been a critical part of a winning response to a crisis. Companies that made frequent acquisitions over the 10-year period from 2007 to 2017 – through the financial crisis and beyond – had on average 27% higher total shareholder returns than companies that made infrequent acquisitions, Bain analysis shows. Healthcare companies initiated several industry-defining deals during and after the last downturn, including Roche's acquisition of Genentech and Optum's purchase of Alere Health, Catamaran Corporation and DaVita Medical Group.

Both healthcare companies and outside investors have long sought to use vertical integration and horizontal expansion to better manage patient outcomes and financial risk. Sophisticated acquirers are evolving the way they structure deals, balancing cash and risk sharing. That approach, coupled with attractive valuations, is likely to make the next two to five years an active period for healthcare M&A. ■



Infection Prevention Practices

Providers adopt creative solutions to infection prevention

What *JHC* readers are witnessing in their alternate site offices during this pandemic may not be entirely new. The guidelines for infection prevention were agreed-upon by infection prevention professionals years ago. (See the Centers for Disease Control and Prevention's Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care.) But changes are afoot, and they already are affecting everyone associated with outpatient care, including physicians and office staff, patients and their families, and visitors, including sales reps.

From this point forward, infection prevention will be a matter of "more and less."

More:

- PPE
- Emphasis on hand hygiene.
- Wiping down hard surfaces.
- Patient screening.
- Attention paid to ventilation systems.
- Telehealth.

Less:

- Face-to-face visits of all kinds.
- Lunch-and-learns with vendors.
- Waiting room traffic.
- Breakroom camaraderie among staff.

Creative solutions

"Masks, handwashing and social distancing are important in communities, and they are important in doctors' offices as well," says Amy Mullins, M.D., medical director for quality and science for the American Academy of Family Physicians.

Some practices are scheduling visits through telemedicine/telehealth technology, she says. But if choosing to see the physician face-to-face, patients will be asked to alter the normal way they move through the office. Some offices have implemented temperature checks as well as questions to determine a patient's risk of exposure (e.g. recent travel or known exposures).

"Patients may be asked to wait in their car instead of the waiting room, or they may be asked to come alone or with only one other person," says Mullins. "But as the weather turns colder, asking patients to wait outside or in their cars instead of a warm waiting room will be challenging. Physicians may need to think creatively about solutions, such as calling patients in advance of their visit to let them know how long their wait will be."

The infection-prevention practices each healthcare organization takes depends a lot on where it is located, says Diane Cullen, MSN, RN, MBA, CIC, associate director, Standards Interpretation Group, The Joint Commission. State and county public health departments are taking varying approaches to directing facilities and issuing mandates, so sales reps should be aware of what is happening locally.

That aside, "there have been a lot of changes in ambulatory settings – many are similar to those that have taken place in hospitals," she says. Some healthcare

organizations are staggering the number of individuals in waiting rooms at one time, and even relocating chairs to facility hallways to lower the risk of inadvertent exposure. Others are labeling chairs with "Xs" to physically distance patients from one another.

Hand hygiene and disinfection of surfaces have always been important infection prevention strategies, but now they are receiving more attention than ever, says Cullen. Patients may be asked to clean their hands with alcohol sanitizer or have their temperature taken upon arrival.

"The patient's perception is reality. If the rugs are tattered or stained, or if things don't look like they've been well-taken-care-of, patients get the impression the office isn't safe."

Accessing personal protective equipment and cleaning supplies remains a challenge. "Products that healthcare organizations might have used previously may not be available from their distributor, because of high demand," says Cullen. The challenge for facilities is this: Staff has historically used, say, one brand of disinfectant, and now they must use another brand. Now, staff must be retrained, as contact time or considerations about exposure to skin may be different. "Providing that extra training can be significantly challenging for small organizations."

New protocols

At each of its two locations in Sarasota and Venice, Florida Cardiac Consultants has positioned screening nurses at folding tables to check the temperature and blood oxygen levels of patients. "We ask each patient about 15 questions, such as, 'Have you traveled lately?' or 'Have you been exposed to someone with COVID-19?'" says practice administrator Mark Spetsios. The protocol is new since COVID-19, and it is a way of protecting staff while giving patients a sense of safety, knowing the practice is taking the pandemic seriously. But it comes with a financial cost. "We have had to hire two additional people for the sole purpose of manning the screening tables," he says.

A year ago, 12 or 15 people might be seated in the waiting rooms of the practice's offices, but now the practice limits it to two. Patients wait in their cars until called to come in, and with some exceptions, they are not allowed to bring companions with them. "No one is permitted in the office unless they're a patient," says Spetsios. "Pharmaceutical reps can drop off samples or literature at the screening tables. And if a vendor wants to talk to me, I'll meet them outside, where we have a parking garage."

Silver linings

Ann Marie Pettis, RN, BSN, CIC, FAPIC, director of ambulatory infection prevention and control for Highland Hospital in Rochester, New York, says one thing is certain: "Because of COVID-19, the focus on infection prevention has escalated, and that's a good thing." Pettis is president-elect of the Association for Professionals in Infection Control and Epidemiology (APIC), and is responsible for infection prevention in all ambulatory settings at Highland Hospital and approximately 30 ambulatory locations.

"We have never taken our hands off the wheel" in terms of monitoring infection prevention practices at the health system's outpatient settings, she says. "This is not a one-and-done thing. We have been steadily auditing the practices." Because of COVID, Pettis has instituted weekly conference calls with the outpatient facilities to share knowledge and best practices.

"Since March, we have learned how to do things better than ever," says Pettis. Scheduling may be the most important one. "You have to be vigilant in how you schedule, so patients aren't sitting in waiting rooms." Having patients wait in their cars until called for their appointment works

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in warm weather, but is more difficult in cold-weather climates. "And telehealth will be much more important, probably in perpetuity."

As of November, sales reps were still discouraged from visiting Highland practices except in cases of emergency. But business is being conducted. One vendor – a maker of hand sanitizer –inserviced all the practices virtually on a new product. "Across the board, we recognize the importance of working with our vendors," says Pettis. "Thankfully, we have technology to help us do that."

Pettis says she tries to emphasize one more thing with the hospitals' practices: The patient's perception is their reality. "If the rugs are tattered or stained, or if things don't look like they've been well-taken-care-of, patients get the impression the office isn't safe." Some practices have gone the extra mile by displaying signage indicating if a stall is clean and ready for use.

The human factor

Financial, logistical and training issues aside, the biggest challenge to proper infection prevention might be human behavior.

"People get tired of social distancing and wearing face masks," says Spetsios. "And we get that. But it's going to be the reality for a while." Vendor lunches are on hold, and staff members no longer congregate in the breakroom. "You lose some of that collegial environment," he says.

"People like to gather," says Pettis. "It's who we are. But now is not the time to let our guard down. We remind staff that not only do we want to be safe for our patients, but for each other too. If one of them becomes sick or is quarantined, who will take care of their patients?" ■

PPE spending by physician practices

64% of practice owners said that summertime spending on PPE was up from pre-pandemic. Average increase in PPE spending was 57%.

- **13%** said PPE spending increased by 1-25%
- **12%** said PPE spending increased by 25-49%
- **14%** said PPE spending increased by 50-74%
- **25%** said PPE spending increased by at least 75%
- **15%** said PPE spending remained the same
- **2%** said PPE spending decreased
- **19%** said Don't know

Source: https://www.ama-assn.org/system/files/2020-10/covid-19-physician-practice-financial-impact-survey-results.pdf, American Medical Association. (Survey of 3,500 physicians administered from mid-July through end of August 2020.)

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References: 1. Centers for Disease Control and Prevention. Strategies to Prevent Hospital-onset *Staphylococcus aureus* Bloodstream Infections in Acute Care Facilities. https://www.cdc.gov/hai/prevent/staph-prevention-strategies.html. Published December 2019. Accessed December 10, 2020. **2.** PDI *in vivo* Study 0113-CTEVO
*Central line-associated bloodstream infections

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Checklist to Prepare Physician Offices for COVID-19

Editor's note: Below are some provisions of the American Academy of Family Physicians' Checklist to Prepare Physician Offices for COVID-19. Amy Mullins, M.D., medical director for quality and science for the AAFP, cautions that the use of the checklist and its implementation may vary among offices depending on their particular workflow and the level of virus spread in their community. Local public health offices are excellent resources for information on number of cases in the community as well as particulars on infection control practices in that community.

Office preparedness

- Design a COVID-19 office management plan that includes patient flow, triage, treatment and design.
- Consider designing and installing engineering controls to reduce or eliminate exposures by shielding staff and other patients from infected individuals.
- Provide hand sanitizer, approved respirators, face shields/goggles, surgical masks, gloves, and gowns for all caregivers and staff to use when within six feet of patients with suspected COVID-19 infection. Provide training for staff on respirators to ensure fit and appropriate use.
- Ensure adherence to standard precautions, including airborne precautions and use of eye protection. Assume that every patient is potentially infected or colonized with a pathogen that could be transmitted in a healthcare setting.
- Implement mechanisms and policies that promptly alert key facility staff – including infection control, healthcare epidemiology, facility leadership, occupational health, clinical laboratory, and frontline staff – about known suspected COVID-19 patients. Keep updated lists of staff and patients to identify those at risk in the event of an exposure.
- Staff should follow the CDC guidelines collecting, handling and testing clinical specimens from suspected COVID-19 patients.
- Prepare for office staff illness, absences, and/or quarantine.
- Cross-train staff for all essential office and medical functions.
- Review proper office and medical cleaning routines. Routine cleaning and disinfection procedures are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed. Products with emerging viral pathogens claims are recommended for use against SARS-CoV-2.

Triage and patient flow systems

- Develop a triage protocol for your practice based on patient and community outbreak.
- Recommend that patients with respiratory symptoms and fever call the office before arrival.
- Implement alternative patient flow systems.
- Distribute respiratory prevention packets consisting of a disposable surgical mask, facial tissues, and cleansing wipes to all symptomatic patients.
- Attempt to isolate all patients with suspected symptoms of any respiratory infection using doors, remote office areas, or negative-pressure rooms, if available.
- Evaluate patients with acute respiratory illness (ARI) promptly.
- After delivering care, exit the room as quickly and directly as possible (i.e., complete documentation in clean area).
- Clean room and all medical equipment completely with appropriate cleaning solutions.
- When possible, reorganize waiting areas to keep patients with respiratory symptoms a minimum of 6 feet away from others and/or have a separate waiting area for patients with respiratory illness.
- Consider arranging a separate entrance for symptomatic patients.
- Schedule patients with ARI for the end of a day or at another designated time.
- Provide no-touch waste containers with disposable liners in all reception, waiting, patient care, and restroom areas.
- Provide alcohol-based hand rub and masks in all reception, waiting, patient care, and restroom areas for patients with respiratory symptoms. Always keep soap dispensers stocked with handwashing signs.
- Discontinue the use of toys, magazines, and other shared items in waiting areas, as well as office items shared among patients, such as pens, clipboards, phones, etc.
- Dedicate equipment, such as stethoscopes and thermometers, to be used in ARI areas. This equipment should be cleaned with appropriate cleaning solutions for each patient. Consider the use of disposable equipment when possible (e.g., blood pressure cuffs).

Other topics covered in the Checklist are education of staff; additional options to prevent community transmission; referral or transfer of patients; waste disposal; and required equipment/supplies. ■

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Reference: 1. Report on the State of Pharmaceutical Quality https://www.fda.gov/media/125001/download May 13, 2019. Accessed July 3, 2019.

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Respiratory and flu season can be challenging during a normal year. This year is unlike any other year before it, providing unique challenges to supply chain leaders. Overcoming these challenges was the main topic of discussion at the Supply Chain Leadership Forum, led by McKesson Medical-Surgical.

"Every year, respiratory illnesses – including influenza, pneumonia, RSV and COPD – have been among the top three causes of death and disability among children and adults,"[1] said Greg Colizzi, vice president, health systems, McKesson. COVID-19 amplified the numbers, leading to shortages of medical products, equipment and ICU beds, as well as anxiety and fatigue among staff. Forecasting demand and procuring products tested the ingenuity and persistence of supply chain team members.

Lab

As a panoply of COVID-19 diagnostic tests hit the market throughout spring and summer of 2020, McKesson began working with core teams of clinical, financial and operational leaders to determine their

health systems' testing strategies, said John Harris, vice president, laboratory, McKesson. They asked questions like, "What performance characteristics are we seeking from COVID tests?" "Should we try to implement one testing platform for all acute and non-acute sites of care, or should we diversify?"

For SARS-CoV-2, the virus that causes COVID-19, they had three choices: molecular tests (which detect the virus's genetic material); viral antigen tests (which detect specific proteins on the virus); and serology or antibody tests (which help determine if the patient has developed immunity due to exposure).

The vast majority of SARS-CoV-2 diagnostic tests with FDA Emergency Use Authorizations (EUAs) were authorized for use in laboratories certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) to perform high or moderate complexity tests. However, several tests were authorized to be conducted entirely at the point-of-care without a sample being sent to a laboratory for analysis.[2] Point-of-care tests allow providers to learn the patient's status on the spot and to immediately prescribe a course of action.

Supply chain leaders became important participants in these discussions, said Harris. They visited providers at multiple sites and familiarized them with the logistical challenges of meeting the demand for tests. "This helped manage expectations," Harris said. They also made their distributors part of the process and relied on them to proactively inform supply chain of any concerns about product availability as well as new products coming into the market. With their distributors, supply chain leaders strategized on how to meet disruptions of core products, and prepared plans for acquiring alternative products.

Pharmaceuticals

At the pandemic's height, many people were reluctant to go to their primary care doctor to get vaccinated. Supply chain professionals were charged with stocking non-acute sites with respiratory and other preventative vaccines, so that when patients finally did visit their doctor, they could catch up on vaccines they had missed.

COVID-19 has reminded everyone in health systems of their common goal – to drive meaningful results in their organizations.

In November and December, clinical and supply chain teams faced a new challenge – how to prepare for a COVID-19 vaccine, said Patrick Baranek, senior manager, pharmaceuticals, McKesson. Vaccinations of all types – e.g., pneumonia, measles-mumps-rubella, influenza A & B, pertussis – are administered every year in thousands of sites across the country, he said. But COVID-19 brought with it a sense of urgency.

Post-acute care

The COVID-19 pandemic has reinforced for supply chain professionals the importance of engaging with the clinical leads in their post-acute-care settings, including skilled nursing facilities, home care and hospice, said Patti Baicy, RN, clinical director, post-acute care, McKesson. Each of those segments deal with a myriad of guidelines for PPE, testing and vaccinations, many with supply chain implications.

At the pandemic's height, many patients resisted being admitted to long-term-care facilities, opting for home health or even telemedicine when possible, she said. Patients in need of hospice care opted for home hospice rather than inpatient care. Consequently, the supply needs of home care providers changed. New products hit the market. More testing, such as PT/INR for people taking blood thinners, was performed in patients' homes. And as the acuity of home-based patients increased, so too did the need for hospital beds, oxygen concentrators, IV pumps and even ventilators. Health systems that lacked a DME supplier of their own aligned themselves with a reliable one on contract.

COVID-19 has reminded everyone in health systems of their common goal – to drive meaningful results in their organizations, said Colizzi. That means supporting improved operational efficiencies and financial outcomes, and building a clinical infrastructure to support patient care regardless of setting. "These are very dynamic times for everybody involved in supply chain," he said. ■

1 The Global Impact of Respiratory Disease, WHO, https://www.who.int/gard/publications/The_Global_Impact_of_Respiratory_Disease.pdf
2 A Closer Look at Coronavirus Disease 2019 (COVID-19) Diagnostic Testing, FDA, November 2020, https://www.fda.gov/media/143737/download

14 Thoughts About Building A Great Culture

1. Great leaders build and drive great cultures. They know it's their number one priority. They can't delegate it. They must lead and be engaged in the process.

2. Culture is the reason why great organizations have sustained success. Culture drives expectations and beliefs. Expectations and beliefs drive behavior. Behavior drives habits. Habits create the future.

3. Culture beats strategy. Strategy is important but it is your culture that will determine whether your strategy is successful.

4. If you focus on the fruit of the tree (outcomes and numbers) and ignore the root (culture) your tree will die. But if you focus on and nourish the root you always have a great supply of fruit.

5. When building a team and organization you must shape your culture before it shapes you. A culture is forming whether you like it or not. The key is to identify what you want your culture and organization to stand for. Once you know the values and principles that you stand for, every decision is easy to make; including the people you recruit and hire.

6. A culture of greatness doesn't happen by accident. It happens when a leader expects greatness and each person in the organization builds it, lives it, values it, reinforces it and fights for it.

7. Culture is dynamic, not static. Everyone in your organization creates your culture by what they think, say and do each day. Culture is led from the top down, but it comes to life from the bottom up.

8. "Your culture is not just your tradition. It is the people in your building who carry it on." – Brad Stevens, Head Coach, Boston Celtics

9. When leading a new team or organization, it will take longer to build a new culture if you allow negative people from the previous culture to contaminate the process.

10. When you build a strong, positive culture most of the energy vampires will leave by themselves because they don't fit in. But you may also have to let a few energy vampires off the bus.

11. Creating a culture where people are afraid to fail leads to failure. Allowing people to fail and learn from failure ultimately leads to success.

12. Change is a part of every culture and organization. Embracing change and innovating will ensure that your organization thrives.

13. Progress is important but when innovating and driving change make sure you honor your tradition, purpose and culture. This generates power from your past to create your future.

14. Culture is like a tree. It takes years to cultivate and grow and yet it can be chopped down in a minute. Protect your culture. ■

Jon Gordon's best-selling books and talks have inspired readers and audiences around the world. His principles have been put to the test by numerous Fortune 500 companies, professional and college sports teams, school districts, hospitals, and non-profits. He is the author of 20 books including 8 best-sellers: *The Energy Bus, The Carpenter, Training Camp, You Win in the Locker Room First, The Power of Positive Leadership, The Power of a Positive Team, The Coffee Bean* and his latest *Stay Positive*. His clients include The Los Angeles Dodgers, Campbell's Soup, Dell, Publix, Southwest Airlines, Miami Heat, The Los Angeles Rams, Snapchat, BB&T Bank, Clemson Football, Northwestern Mutual, West Point Academy and more.

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BY LISA EARLE MCLEOD

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Addressing the confidence gap

Organizations are filled with untapped potential, undermined by the thousands of small slights that erode the confidence of anyone who doesn't "fit in." This is costly to everyone because when people aren't confident, they're not fully present and they don't contribute as well as they could.

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Why confidence erodes over time

It's easy to say, "Be Confident!" Yet how confident would you feel if every day of your working life, someone told you, directly or subtly, you don't belong here? What if whenever you spoke in front of a group people, questioned your credentials or paid more attention to your appearance than your content? Sadly, this has often been the case for many women, and it's even worse for people of color.

Over time, it becomes harder and harder to rally yourself. Even if it's not happening right now, the baggage from past experiences puts you on guard. It's like a death by a thousand cuts. Several years of an insult here, second-guessing there, makes it hard to walk into a room as your best self.

How you can help people show up as their best selves

I'll never forget a meeting several years ago when I was presenting to an Executive team. They were all men, and all (seemingly) Type-A. The old drip, drip, you don't belong here, you're not good enough was ignited. Yet as I entered the room, the CEO stood up, shook my hand, gave me a big smile, and said, "I'm really intrigued by your work, and we're delighted you're here." That was all it took, I no longer had to pretend to be confident, I was confident!

This is something every single one of us can do. When someone walks into the room or joins the Zoom call, it may be just another agenda item for us, yet for them, it's a high stakes situation.

When someone who might be feeling less than confident enters a meeting, saying, "I'm glad you're here" can mean the world to them. Sitting back in judgment waiting for them to prove themselves, erodes their confidence, and it keeps you from getting their best ideas.

Avoid sitting back in judgment

When someone who might be feeling less than confident enters a meeting, saying, "I'm glad you're here" can mean the world to them. Sitting back in judgment waiting for them to prove themselves, erodes their confidence, and it keeps you from getting their best ideas. Even a seemingly confident exterior may be covering some inner fears. I was 45 years old and had already authored two books when that CEO's words gave me a boost. If they're the only "whatever" in the room, your words can help them put forth their best ideas.

Set people up for success (in advance)

Years ago, I adopted a technique to spotlight people who might not otherwise take center stage. It's something anyone can do. When I do a keynote or run a training program, I interact with the audience. It can be an opportunity for people to shine. Yet I consistently notice, when women and people of color are in the minority, as they typically are in a corporate setting, they rarely speak up. You can help people feel more confident by asking for their help in advance. I'll find someone who I think might not speak up, and say, "I'm going to ask a question about X during the session, if you're comfortable, could you raise your hand to answer?" This gives them time to think about their answer and the option to say no. They almost always say yes, because people don't want the speaker to experience an awkward silence. They're helping me get all the voices into the room, and in the process, they can shine in front of their peers.

Helping other people feel more confident is the nice thing to do. It's also the smart thing to do. When everyone feels seen and heard, you produce better results, and you have more fun. ■

Lisa Earle McLeod is a leading authority on sales leadership and the author of four provocative books including the bestseller, "Selling with Noble Purpose." Companies like Apple, Kimberly-Clark and Pfizer hire her to help them create passionate, purpose-driven sales organization. Her NSP is to help leaders drive revenue and do work that makes them proud.

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Association for Vascular Access and B. Braun Partner to Raise Standards and Enhance Training for IV Placement

New curriculum will be provided free of charge to medical, nursing, respiratory therapy, and other allied healthcare schools in the United States to improve instruction on peripheral IV access

On October 5, 2020 the Association for Vascular Access (AVA) and B. Braun Medical Inc. (B. Braun) announced a long-term collaboration to improve training on the placement of peripheral intravenous catheters (PIVCs). Together the organizations will develop and provide a new series of online courses free of charge to medical, nursing, respiratory therapist, and other allied healthcare schools – the first of which is being piloted at several leading nursing schools.

Vascular access is the most common invasive procedure performed in healthcare, with more than 380 million PIVCs placed in patients annually in the United States.[1] However, between 33-69% of PIVCs fail before the completion of treatment and more than 50% of adults describe insertion as moderately painful or worse. Collectively, this can lead to serious implications for patients, including increased costs and length of treatment.[2]

In addition to jointly developing the "Fundamentals of Peripheral IV Access" eLearning module series to increase the vascular access skills of healthcare professionals, AVA and B. Braun will create a certificate program for students who complete the courses that will attest to their foundational knowledge in PIVC placements with future employers.

"Studies have proven that current training programs are not consistent across schools in how or when they teach future clinicians about the insertion, care and maintenance of peripheral catheters.[3] Our intent is to offer a solution to standardize training in this area, which we believe will make long-term improvements in

healthcare in the years to come," said Judy Thompson, MSNEd, RN, VA-BC™, AVA director of clinical education. "We are proud to partner with B. Braun to offer free access to this best-in-class curriculum to students at hundreds of universities and medical schools. It is also fitting that this new curriculum – which helps advance AVA's mission to protect patients and improve lives by creating evidence-based innovations in vascular access – is being announced on the second annual Vascular Access Specialty Day."

The eLearning module will feature interactive graphics and hi-definition videos in addition to the necessary text critical to enhancing the PIVC education in healthcare. It will focus on key aspects like proper device placement, assessment, and insertion to instill confidence in students of all skill levels.

"In my early years of teaching, I worked with thousands of students to start their first PIVC. The manual dexterity required to navigate the equipment, patient emotions, and for that matter, the student's anxiety required a calm and keen eye for multiple physical and emotional cues," said Christine Vandenhouten, PhD, RN, chair and professor of nursing and health studies at the University of Wisconsin-Green Bay. "The PIV curriculum will elevate the knowledge and skill of nursing students and nurses across the U.S. and beyond. I am thrilled to incorporate this evidence-based curriculum into our pre-licensure BSN program."

The eLearning module will feature interactive graphics and hi-definition videos in addition to the necessary text critical to enhancing the PIVC education in healthcare.

"Our partnership with AVA and the academic institutions that are piloting the 'Fundamentals of Peripheral IV Access' curriculum gives us the opportunity to make a big impact on an area of patient care that is ripe for improvement," said Stephen Withers, RN, director, clinical support and services, B. Braun. "The failure rate of PIVC insertions is not acceptable. We believe this program is an important step to change that by increasing students' skill sets on a practice that for many will become a part of their daily care routine."

Several pilot studies of the curriculum will be conducted through the rest of the year, and the program is expected to be broadly released during the 2021 academic year. Additional information on the "Fundamentals of Peripheral IV Access" curriculum, including details about how to participate in the pilot program, is available at www.avainfo.org/PIVEducation. ■

ABOUT

The Association for Vascular Access (AVA) was founded in 1985 to promote the emerging vascular access specialty. Today, AVA stands at the forefront of protecting and saving lives via establishing best practices and promoting patient advocacy. AVA's multidisciplinary membership advances research, provides professional and public education to shape practice and enhance patient outcomes, and partners with the device manufacturing community to bring about evidence-based innovations in vascular access. To learn more or join, visit www.joinAVAnow.com.

B. Braun Medical Inc., a leader in infusion therapy and pain management, develops, manufactures, and markets innovative medical products and services to the healthcare industry. Other key product areas include nutrition pharmacy admixture and dialysis. The company is committed to eliminating preventable treatment errors and enhancing patient, clinician and environmental safety. B. Braun Medical is headquartered in Bethlehem, PA and is part of the B. Braun Group of Companies in the U.S., which includes B. Braun Interventional Systems, Aesculap® and CAPS®.

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1 iData Research. (2020). US Market Report Suite for Vascular Access Devices and Accessories.
2 Cooke, M., Ullman, A., Ray-Barruel, G., Wallis, M., Corley, A., Rickard, C. (2018). Not "just" an intravenous line: Consumer perspectives on peripheral intravenous cannulation (PIVC). An international cross-sectional survey of 25 countries. Plos One. https://doi.org/10.1371/journal.pone.0193436
3 Hunter, et al. (2018). Addressing the silence: A need for peripheral intravenous education in North America. JAVA. 23(3). pp 157-165. https://doi.org/10.1016/j.java.2018.06.001

BD to invest $1.2B in pre-fillable syringe manufacturing capacity over next 4 years

BD (Becton, Dickinson and Company) (Franklin Lakes, NJ) announced plans to invest approximately $1.2 billion over a 4-year period to expand and upgrade manufacturing capacity and technology for pre-fillable syringes (PFS) and advanced drug delivery systems (ADDS) across its six global manufacturing locations and add a new manufacturing facility in Europe.

The new manufacturing facility in Europe is expected to be operational by the end of 2023.

BD says that the investment will also fund capacity expansion, new product innovations, manufacturing technology enhancements and business continuity improvements across its existing network.

All of the investments are designed to maximize supply and reduce risks for pharmaceutical companies that rely on ready-to-fill syringes for their injectable drugs — including complex biologics, vaccines and small molecules.

The six current manufacturing facilities for BD Pharmaceutical Systems that will see a portion of this investment include facilities in:

- Columbus, Nebraska
- Cuautitlán, Mexico
- Fukushima, Japan
- Le Pont-de-Claix, France
- Swindon, United Kingdom
- Tatabánya, Hungary

"Since 2018, BD has added 350 million units of manufacturing capacity for glass barrel pre-fillable syringes, and this new commitment will invest in additional upgrades at all of our Pharmaceutical Systems manufacturing facilities and across multiple product categories, said Eric Borin, worldwide president of BD Pharmaceutical Systems. "In addition, this investment positions BD to have the needed surge capacity for increased pre-fillable syringe demand during times of pandemic response or periods of significant growth of new injectable drugs and vaccines."

Learn more here.

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1 B. Braun Data on File, 2020

Wearing Is Caring

Henry Schein Cares Foundation launches "Wearing Is Caring" campaign supported by The UPS Foundation

The Henry Schein Cares Foundation (HSCF), in partnership with The UPS Foundation, launched in October "Wearing is Caring," a public health awareness campaign designed to raise awareness of healthcare disparities in underserved communities, the need for social distancing, and the importance of wearing face coverings to help reduce the spread of COVID-19.

The campaign is aligned with guidance from the U.S. Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO) that encourages the use of cotton or cloth face coverings in public spaces to reduce community spread.

To help promote access to healthcare, HSCF and The UPS Foundation will provide financial support to longtime partners – the National Network for Oral Health Access (NNOHA), the National Association of Free and Charitable Clinics (NAFC), the CDC Foundation, National Urban League, and others. Funds will provide support to critically important health care programs in communities most in need.

In addition, Henry Schein, Inc. also will donate and distribute cloth face coverings to NNOHA and NAFC. The organizations will select community health clinics within COVID-19 hot spots as the recipients, helping to improve public health safety.

To help address the health disparities that have impacted communities of color, Henry Schein, Inc. will also donate face coverings to local safety-net health systems and other local partners in support of CDC Foundation's Crush COVID initiative, of which support of health equity and investing in communities disproportionately impacted by coronavirus is a key pillar.

"As we continue to support pandemic relief efforts, we're bringing our understanding of the people who are most impacted into action," said Eduardo Martinez, President of The UPS Foundation and UPS Chief Diversity and Inclusion Officer. "We're honored to collaborate with the Henry Schein Cares Foundation on their 'Wearing is Caring' campaign, as our collective efforts will help expand access to care in communities where help is urgently needed."

"Philanthropic and private sector support is critical for use alongside government funding to meet needs that arise in rapidly evolving situations where speed and flexibility are paramount to saving and protecting lives," said Dr. Judith Monroe, President and CEO, CDC Foundation. "Henry Schein Cares Foundation's 'Wearing is Caring' campaign showcases the supportive role that corporations can enhance health equity and help protect diverse communities during the COVID-19 pandemic."

"When the coronavirus pandemic first hit the U.S., the National Urban League sounded the alarm on racial disparities in terms of public health and economic consequences," said Marc Morial, President and CEO, National Urban League. "Public-private partnerships like this are urgently needed to bring support where it is most needed. Thanks to the foundations within Henry Schein, UPS and the CDC, that support is being delivered." ■

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