

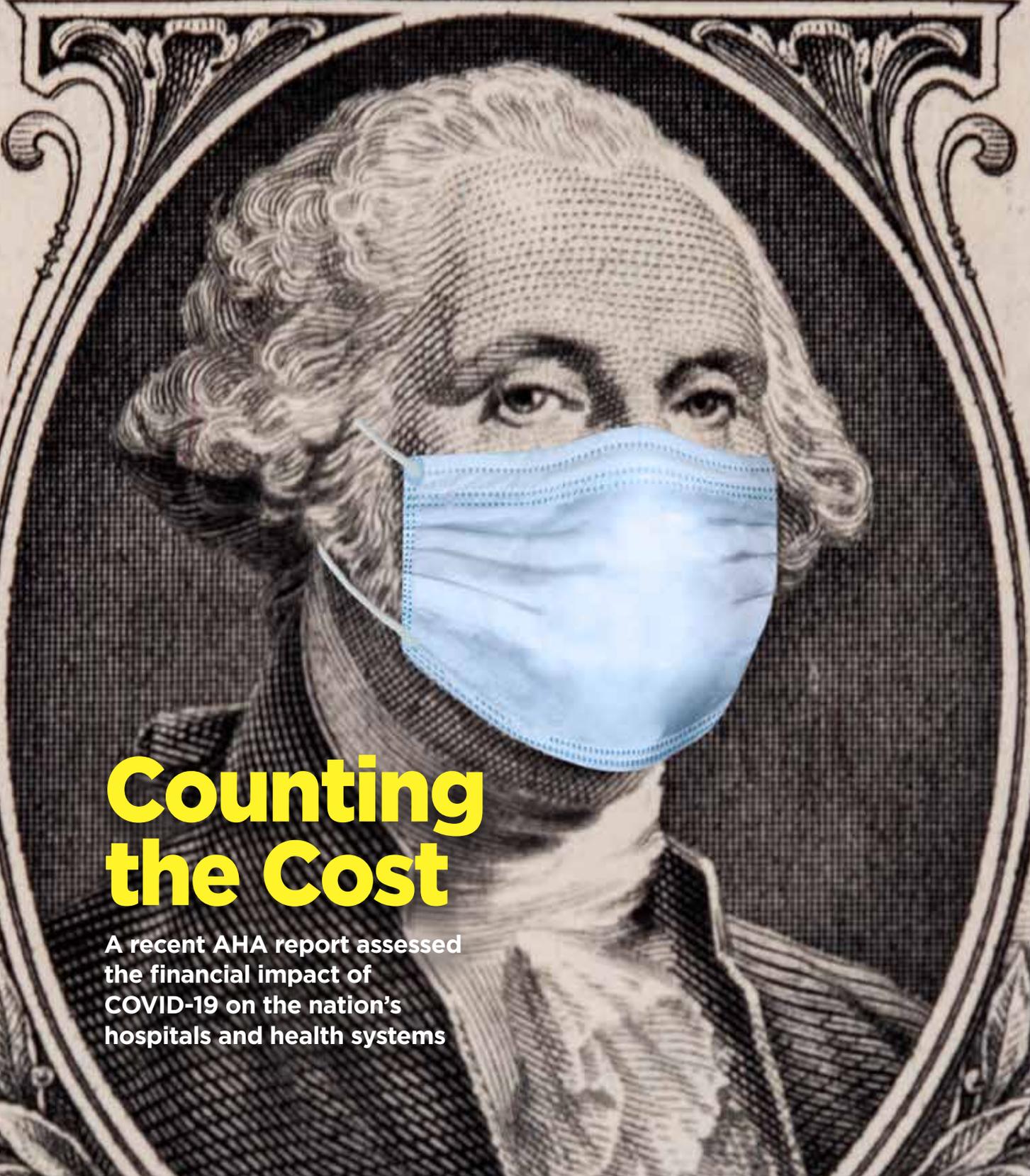
The Journal of

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C O N T R A C T I N G

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Counting the Cost

A recent AHA report assessed the financial impact of COVID-19 on the nation's hospitals and health systems



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2 Sense of Urgency

How one equipment distributor planned, procured and installed three alternate COVID-19 hospitals in a condensed timeframe.

6 Counting the Cost

A recent AHA report assessed the financial impact of COVID-19 on the nation's hospitals and health systems

14 Significant Volume

The ramp up, and contribution of molecular tests in the fight against COVID-19

22 Telemedicine

There was a massive uptick in telemedicine usage during COVID-19. But will it last?

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Sense of Urgency

How one equipment distributor planned, procured and installed three alternate COVID-19 hospitals in a condensed timeframe.

On March 30, 2020, CME Corp. (CME), a national full-service equipment distributor and NDC member, got a call from David Schnell, branch preparedness chief at the Rhode Island Emergency Management Agency, asking if CME would be interested in working with him on three different alternate hospitals treating COVID-19 patients in and around the Providence, Rhode Island area. The state needed to have properly equipped multiple alternate hospital sites up and running in a compressed timeframe.

“Even though CME was working hard on many other critical COVID-19 projects across the country, we could not refuse the chance to help our home state of Rhode Island with their COVID-19 preparedness plan,” said Normand Chevrette, president, CME.

The project involved planning, sourcing, receiving, staging, warehousing, assembling and delivering 15,893

items from 55 manufacturers to three sites in Providence, Cranston and North Kingston, Rhode Island. The entire project added 1,385 beds designated for low-acuity COVID-19 patients managed by two large IDNs. Over five government agencies, two hospital systems, a project management team, an equipment planning group, a construction company, Rhode Island Disaster Medical Assistance



Convention Center

Team (RIDMAT) and CME all collaborated in the planning and execution of the project. Government agencies included the National Guard, Office of the Governor, the Rhode Island Department of Health, the Rhode Island Emergency Management Agency, the Department of Defense and local municipalities

From March 30 to April 1, CME assessed sites with the National Guard and project management team. The CME government team then reviewed equipment lists with operations and clinic staff from two local hospitals responsible for operating the three new facilities. On April 2 and 3, CME sourced all items and began procurement. From April 6 to April 14, products were received at CME's Warwick warehouse where they were staged, assembled and prepared for

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delivery. By April 15, products began to be delivered to the three sites in 50-plus trucks by more than 20 CME installer and technical services teammates.

Obstacles to overcome

Challenges abounded. The most critical equipment needed for COVID-19 temporary facilities was in short supply or had long lead times, said Cindy Juhas, chief strategy officer, CME. The timeline was tight – CME was tasked to find equipment that could be delivered within a two-week timeframe. For example, the state needed 1,500 beds/mattresses, 1,200 commodes and 2,000 privacy curtains (3.6 miles of curtain). Equipment lists had to be created in a short timeframe.

Over 20 CME teammates loaded trucks and delivered product over two and a half days, including a weekend.

Logistics, too, posed a challenge. The state of Rhode Island could provide no storage space for new equipment and had insufficient human resources to provide staging, assembly, installation and delivery direct to the rooms. Two of the three facilities required the assembled equipment delivered in a three-day period, including a weekend.



And, having so many federal, state and local agencies trying to accomplish the same goals with different operating and management systems provided additional complications.

Fortunately, CME maintains an up-to-date quick ship list that was utilized to find much of the equipment needed. Certain items had to be sourced from multiple vendors to get the large numbers needed. “CME created a team focused specifically on this project, including our government sales team and several other key teammates who called to get confirmation of product availability and ship dates from over 50 manufacturers,” said Cindy Juhas, chief strategy officer, CME.

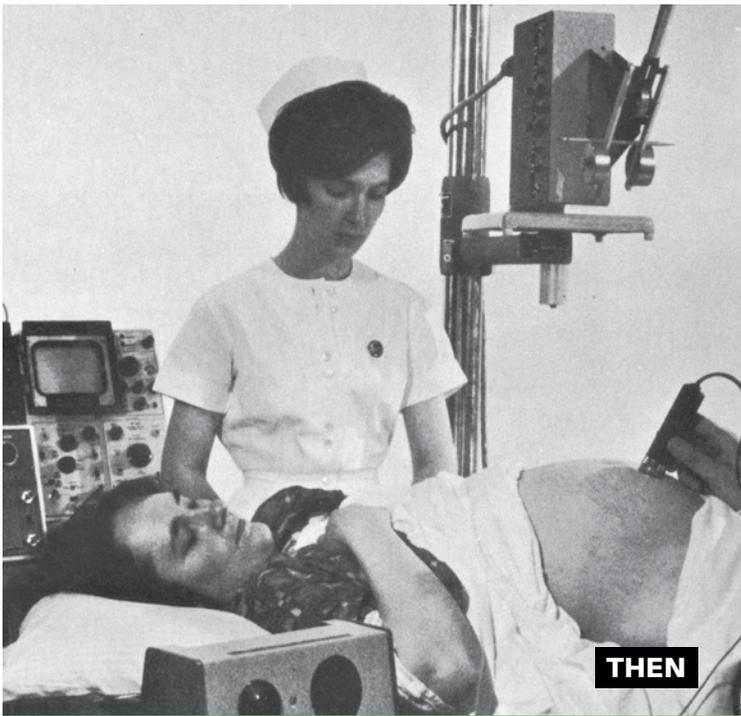
CME made available the warehouse space and provided necessary staff to receive, inspect, stage, assemble and prepare for delivery. CME also opened its warehouse on a Saturday for the National Guard Commander and the Branch Preparedness Chief of the Rhode Island Emergency Management Agency to

inspect portions of the received product. Over 20 CME teammates loaded trucks and delivered product over two and a half days, including a weekend.

Responsive and understanding

The project was primarily managed by an equipment planning group with direction from the Rhode Island Emergency Management Agency and the Rhode Island National Guard. “All parties involved had to be patient, flexible and timely in their response,” said Juhas.

The project was a success. Over 90% of the items were delivered within the timeframe presented. “Immediately upon being assigned the task of being on the Medical Surge Team, I thought about a local company in Warwick, CME Corp,” said Schnell. “Upon speaking to the CME staff, I knew I made the right call. They were responsive, understanding the urgency of the situation, and ready and willing to assist!” ■



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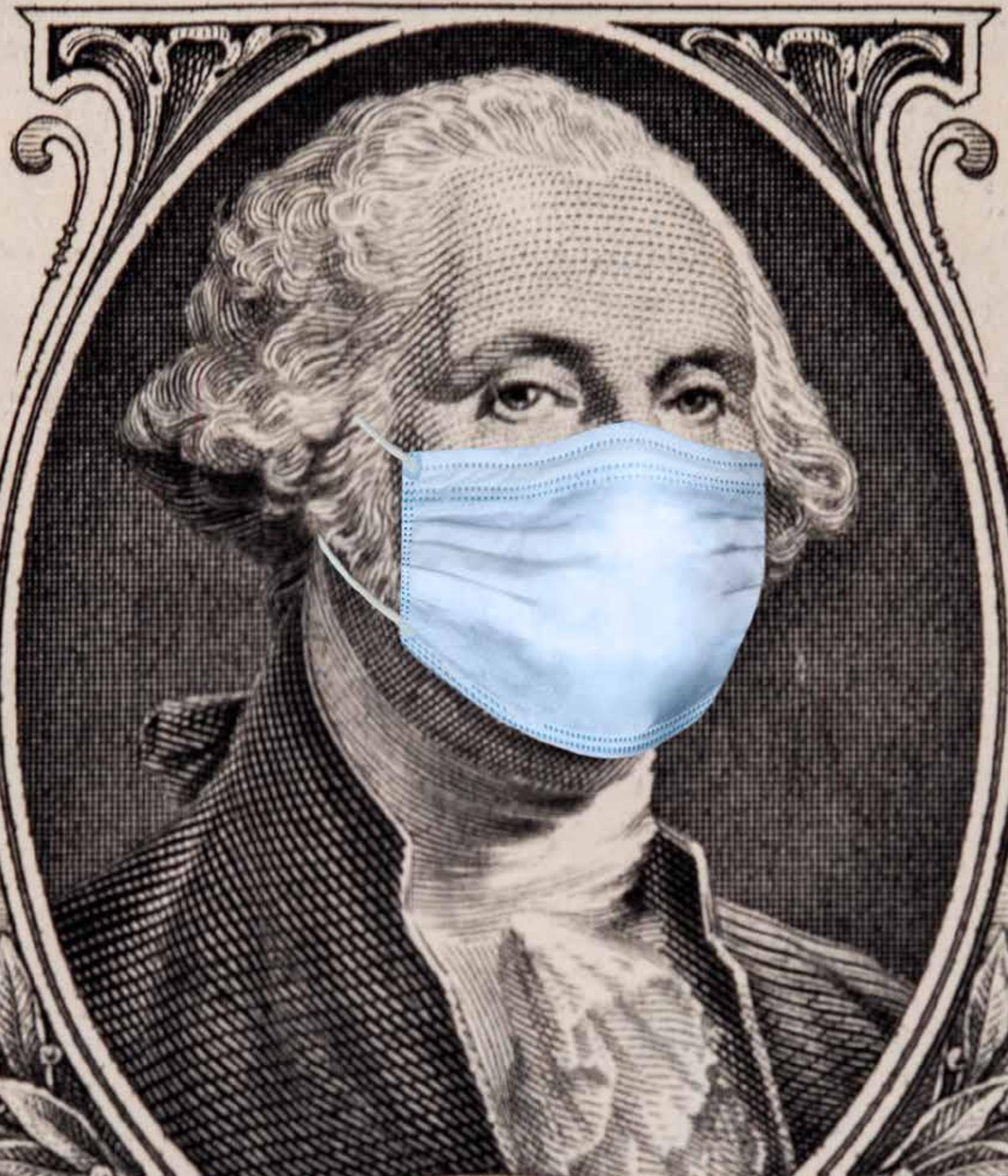


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Counting the Cost

A recent AHA report assessed the financial impact of COVID-19 on the nation's hospitals and health systems

Fighting COVID-19 has taken a toll on the nation's hospitals, especially financially, according to a report released in May by the American Hospital Association (AHA). In the report, the AHA estimated that the financial impact to hospitals and health systems from COVID-19 expenses and revenue losses over the four-month period from March 1 and June 30 totals \$202.6 billion, with losses averaging over \$50.7 billion per month.

The estimate includes the costs of COVID-19 hospitalizations, canceled and foregone services, purchasing needed personal protective equipment and providing additional support to hospital workers.

"America's hospitals and health systems have stepped up in heroic and unprecedented ways to meet the challenges caused by COVID-19," said AHA President and CEO Rick Pollack. "However, the fight against this virus has created the greatest financial crisis in history for hospitals and health systems. While we appreciate the support and resources from Congress and the Administration, many hospitals are still on the brink. We need further support and resources to ensure that we can continue to deliver the critical care that our patients and communities are depending on while also ensuring that we are prepared for the continuing challenges we face from this pandemic as well as other potential emergencies."

These challenges have created historic financial pressures for America's hospitals

and health systems, according to the AHA. Hospitals have canceled non-emergency procedures, and many Americans are postponing care as they shelter in place to stop the spread of the virus.

"Treatment for COVID-19 has created incredible demand for certain medical equipment and supplies as the virus has disrupted supply chains, increasing the costs that hospitals face to treat COVID-19 patients," the AHA said. "At the same time,

COVID-19 has led to unprecedented job losses, giving way to a rise in the number of uninsured. And while doctors, nurses, and other healthcare workers have met the COVID-19 challenge with heroic efforts, many hospitals and health systems, especially those located in hotspot areas of the pandemic, are supporting them by providing essentials like child care, transportation, and in some cases, housing."

The following are findings of the AHA report.

Net financial impact of COVID-19 hospitalizations

The AHA estimates the net financial impact of COVID-19 hospitalizations over

"America's hospitals and health systems have stepped up in heroic and unprecedented ways to meet the challenges caused by COVID-19. However, the fight against this virus has created the greatest financial crisis in history for hospitals and health systems."

– Rick Pollack, AHA President and CEO

a four-month period will be \$36.6 billion. “In other words, the nation’s hospitals and health systems will collectively lose \$36.6 billion, including payments for COVID-19 patients, from March to June 2020 treating COVID-19 patients alone.”

Total revenue losses from canceled surgeries and other services

The AHA estimates that, because of canceled hospital services due to the COVID-19 pandemic, U.S. nonfederal hospitals stand to lose approximately \$161.4 billion in revenue over a period of four months, from March to June 2020. This includes canceled surgeries, various levels of canceled non-elective surgeries and outpatient treatment, and reduced emergency department services.

Additional costs associated with purchasing needed PPE

The AHA estimates the non-treatment costs for hospitals and health systems

The AHA estimates that, because of canceled hospital services due to the COVID-19 pandemic, U.S. nonfederal hospitals stand to lose approximately \$161.4 billion in revenue over a period of four months, from March to June 2020.

to be \$2.4 billion over a period of four months, from March to June 2020, or roughly \$600 million per month.

Demand for equipment and supplies, such as PPE, has increased as a result of the COVID-19 pandemic. “Hospitals have incurred additional costs as they struggle to acquire additional supplies to meet the needs of their patients and staff,” the AHA said. “Moreover, current guidelines require all hospital workers to wear some PPE, regardless of whether they are in direct contact with COVID-19 patients. These guidelines

increase the need and expense for PPE relative to normal operations.”

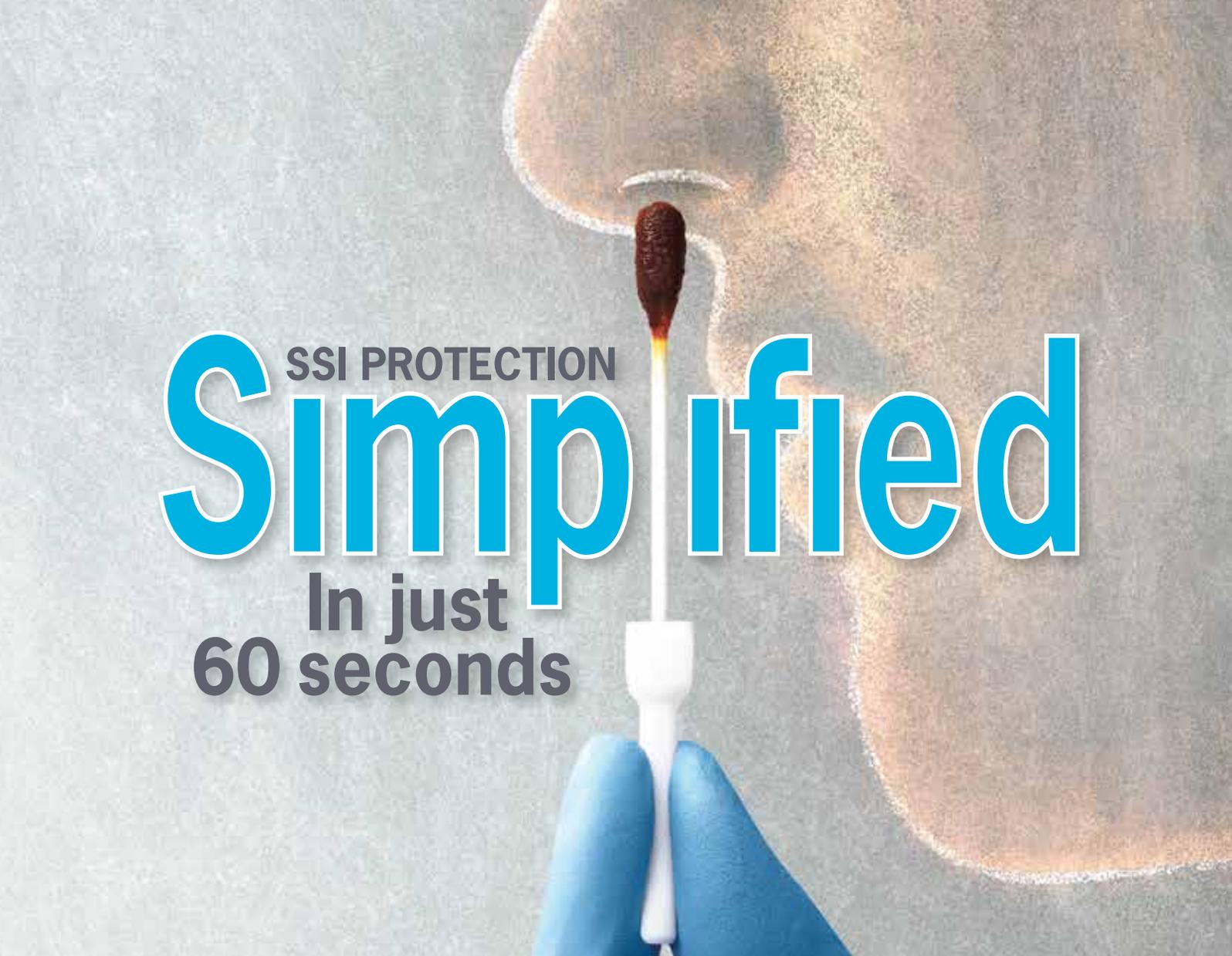
Costs of additional support some hospitals are providing to their front-line workers

The AHA estimates the cost of support for front-line hospital workers in COVID-19 hotspots to be \$2.2 billion through the end of June, or just under \$550 million per month. This includes the costs of providing childcare, housing, transportation, and medical screening and treatment for COVID-19 for front-line workers. This estimate could increase as more outbreaks of COVID-19 occur, or if the policy decision were made to extend these benefits to all healthcare workers during the pandemic.

Other costs that hospitals and health systems face include drug shortage costs, wage and labor costs, non-PPE medical supplies and equipment costs and capital costs. “The totality of these costs combined with the uncertainty of the pandemic’s duration is certain to imperil hospital finances,” the AHA said. ■



TO READ THE FULL REPORT, VISIT: WWW.AHA.ORG/SYSTEM/FILES/MEDIA/FILE/2020/05/AHA-COVID19-FINANCIAL-IMPACT-0520-FINAL.PDF



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*PDI user acceptance study.

[†]99.7% at 1 hour and 99.9% at 12 hours in healthy volunteers: PDI Study 0113-CTEVO.

[‡]>5-log reduction in methicillin-resistant *Staphylococcus aureus* (MRSA) clinical isolates *in vitro* at 1, 3, and 5 minutes: PDI Study PDI-0113-KT1.

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The power of point-of-care testing



Lab results weigh heavily into the medical decisions made by today's providers.

According to the Centers for Disease Control & Prevention (CDC), 14 billion lab tests are ordered annually, and by one industry estimate nearly 70% of medical decisions depend on laboratory results.

But what happens if the clinician is forced to wait days, or weeks, for results?

At best, the clinician may start a treatment plan without a complete picture of what the patient needs. Some clinicians may prescribe medication and courses of treatment based on symptoms alone, with the goal of providing their patients immediate relief.

However, this practice puts patients at risk of taking unnecessary medication, which can contribute to antibiotic resistance causing longer hospital stays, higher medical costs and increased mortality. The World Health Organization has identified antibiotic resistance as “one

of the biggest threats to global health ... today.” In a fact sheet on antibiotic resistance, the World Health Organization explained that when infections aren't cured with first-line antibiotics, more expensive medications may need to be used, increasing both the number of appointments and expense for the patient.

New abilities, greater efficiencies

Time matters now more than ever. Medical practices utilizing point-of-care testing (POCT) platforms may be able to deliver results within minutes, depending upon the test, rather than hours or even days.

Time is essential, but it's just one of several reasons for medical providers to consider POCT. Benefits include:

- › **Accuracy.** POCT gives the clinician the ability to not only draw patient samples in the office, but also receive the results in the office, which can help accelerate the development of an informed, accurate treatment plan.
- › **Reducing follow-up.** In an article, Lab Tests Online notes that POCT can reduce follow-up visits or calls, and reports that delivering the routine tests hemoglobin A1c, hemoglobin, and lipids at the point-of-care resulted in a 21% decrease in tests ordered for each patient, 89% reduction in follow-up calls, and 61% reduction in patient follow-up visits. Accurate results help clinicians



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confidently treat their patients with a plan that may reduce the need for additional testing and limit unnecessary patient follow-up.

- › **Cost.** Developing your POCT portfolio is an innovative way to cut costs related to the patient visit. The quick turnaround time improves the entire patient flow, and cuts laboratory costs such as specimen packaging and transportation.
- › **Convenience.** Customer experience is important to all generations, but none more so than to millennials, now the largest generation in the United States, according to the Pew Research Center. According to *Forbes*, this generation has grown up in a technology-powered consumer environment where transparency, rapid delivery, and convenience are the norm. Reports and Data states that the estimated 71 million millennials (ages 20–35) are driving the need for immediate and reliable results.

Discovering the possibilities

As POCT continues to expand and manufacturers continue to innovate, clinicians are looking for support outside of a standard product transaction. There are new lab products and solutions being introduced into the market on a regular basis, making it difficult for clinicians and laboratory professionals to have awareness on the latest technology that can drive optimum outcomes

for the patient. Clinicians will need training and knowledge on compliance and connectivity, as well as a grasp on what adding POCT testing will mean to current staff and whether additional staff will be needed to have a successful POCT program.

Having a POC Specialist that understands guidance around compliance, training and the reimbursement landscape is critical to long-term success.

There are new lab products and solutions being introduced into the market on a regular basis, making it difficult for clinicians and laboratory professionals to have awareness on the latest technology that can drive optimum outcomes for the patient.

Whether it is a new or existing customer, Henry Schein approaches the POCT consultation around a discovery process with an emphasis on collaboration.

- › What are your goals for lab testing in office?
- › What tests are you currently performing today and are these tests meeting your expectations?
- › How important is turnaround time in your laboratory?
- › Are you looking to improve workflow efficiencies by running tests at the point of care vs sending out?

“Point-of-Care Specialists at Henry Schein are vested in understanding product and technology advancements in the Point-of-Care segment and support our customers in modeling the financial and operational benefits and challenges with adding new testing to their practice,” said Gary Dennis, Director of Sales, Point of Care Group US, Henry Schein. “We work alongside the customer to understand their goals and develop a lab strategy that delivers value to their practice and the patients they serve.” ■

COVID-19 and POCT

The COVID-19 pandemic only amplified the critical importance of POCT for the nation's frontline caregivers. Through its POCT portfolio and industry partnerships, Henry Schein has played a key role in providing point-of-care testing to health care professionals and responded to the urgent need for wide availability of rapid point-of-care testing for COVID-19.

To learn more about how to drive operation and clinical efficiency with Point-of-Care Testing, visit henryschein.com/POCT

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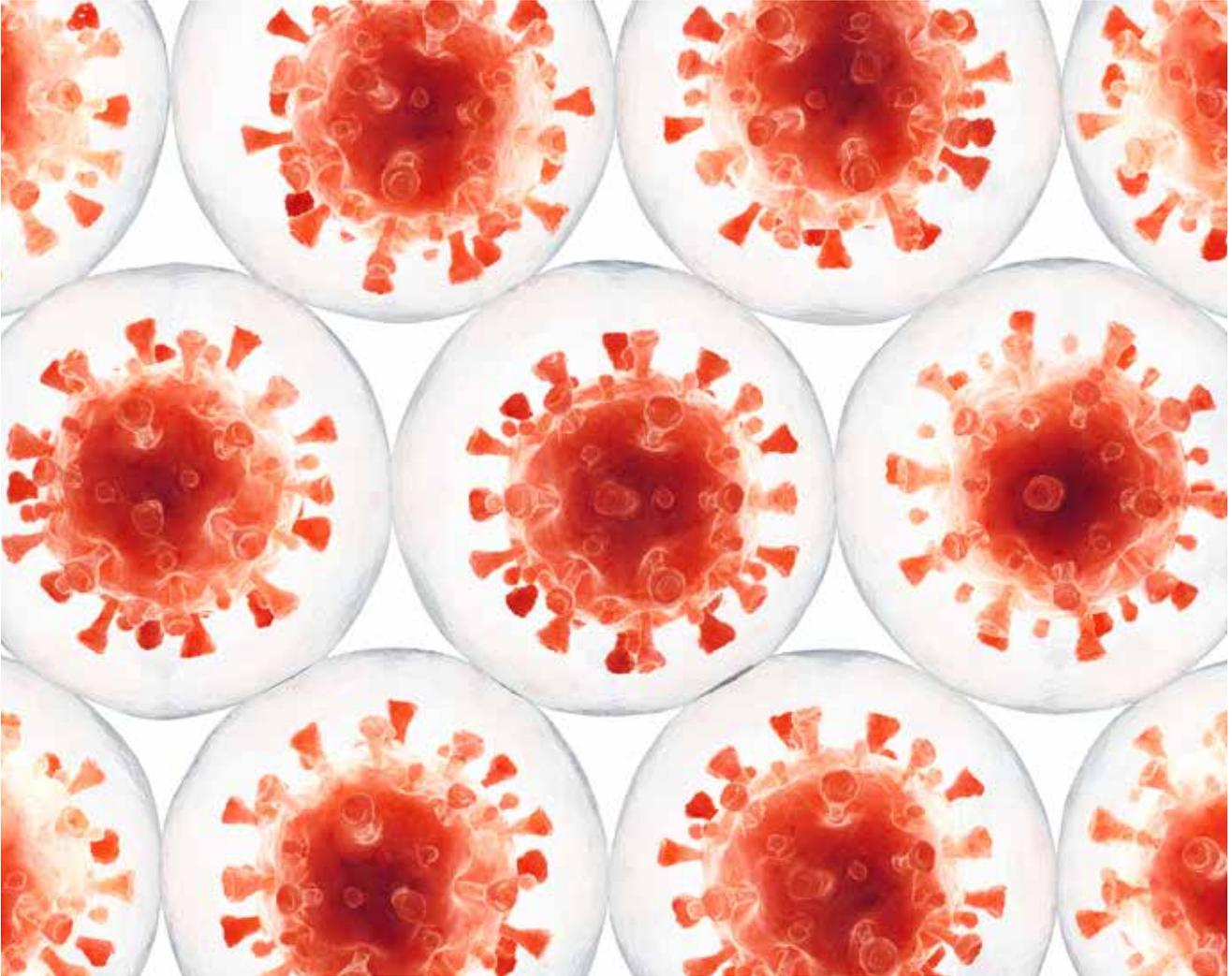


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Significant Volume

The ramp up, and contribution of molecular tests in the fight against COVID-19

The challenge was monumental, and crucial, to the frontline caregivers battling COVID-19. Almost overnight, demand for Quidel's SARs COV-2 assays skyrocketed as hospital labs scrambled to have the appropriate testing in place at their facilities.

Quidel responded by adding a significant volume of SARs COV-2 assays across the United States and did so in a significantly short window of time.

Working around the clock

Getting in a position to ship out the SARs COV-2 molecular tests first involved a combination of studies and approvals,

said Mike Abney, senior vice president of distribution, Quidel. "We had to perform the quickest set of studies that we've ever attempted," said Abney. "And we had work with the FDA to gain EUA approval with a highly accurate assay."

Then came the massive ramp up in production. Quidel's supply chain went from 0 to 1 million tests produced in the



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first 30 days, and then to 1 million per week going forward, Abney said. “We also enlisted Cardinal to help us with distribution, and to inform the hospital laboratory market about the assay and to pre-qualify customers who needed tests. So, the last step was getting all of the item details and pricing set up in two systems.”

The most unique challenge involved the increase of Quidel’s buying level on swabs, and transport media by 10-20 times the normal rate. “This has been a big challenge for all diagnostic test manufacturers in 2020, but was especially important for Quidel because we aim to provide everything the customer needs to perform the test in every kit we ship out, swabs and transport media included,” said Abney. “The fact that we have been able to hold up against that standard thus far during the pandemic is something that we are very pleased with. This will remain an issue for our industry in some form for the rest of the year.”

The project turned out to be the largest ever tackled at Quidel from a demand perspective, said Abney. “The first quarter of 2020 completed a record U.S. respiratory season, and the COVID-19 pandemic started while Influenza A was still at its peak. While our teams were in the middle of working overtime and weekends to meet the highest demand ever for our line of flu assays, we threw this project at them with the shortest timeline imaginable.”

Quidel’s Jon Dailey, associate director, Supply Chain; Nate Chapman, associate director, Molecular Manufacturing; and Ron Lollar, senior director, Clinical, Regulatory & Scientific Affairs worked around the clock to launch, secure the supply chain, and agree with the regulatory agencies for our Lyra SARs COV-2 assay. Due to the work of these three



individuals and their teams, Quidel took the brand over the 1 million test mark in less than 30 days.

“Every team at Quidel has people that have been working around the clock, seven days a week for the last couple of months,” said Abney. “In some cases, the entire team has been doing so. Outside of the essential teams to manufacture the

product, we had to do a lot of this on the phone and through video conference, which we had to adapt to quickly. We’re used to getting in a room in San Diego face to face and hashing things out. Many people on the team have commented ‘this is the hardest I’ve ever worked,’ but it’s been thrilling and motivating and we’re all happy to be a part of it.” ■

Lessons learned

The most obvious lesson from the COVID-19 pandemic? We have all learned “you can’t be too ready for the unexpected,” said Mike Abney, senior vice president of distribution, Quidel. “Our CEO, Doug Bryant, pushed us to hire a few more talented people than we thought we needed, and to beef up manufacturing capacity beyond the level we thought we needed, and suddenly we required all of it and more to answer the call to produce more tests for the pandemic.”

Also, the value of Quidel’s distribution partnerships has never been higher than it is today, Abney said. “We could not achieve the level of customer communication and logistics required to execute what we are trying to accomplish over the next year without them.”

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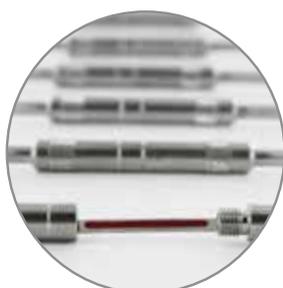
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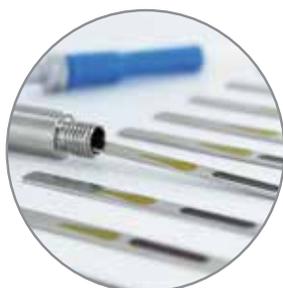
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Tackling the challenges and complexities of elective surgeries and hospital inventories in a reopening world



COVID-19 has definitely presented industry-wide challenges in supply chain

management, and as health systems and hospitals prepare for the restart of elective procedures, new challenges will continue to emerge. *The Journal of Healthcare Contracting* (JHC) recently hosted two podcasts with Owens & Minor and Tampa General Hospital to discuss how their solutions around people, processes, and technology can help providers overcome potential supply chain issues before they become problems.

Being Prepared for Elective Surgeries and Procedures

As healthcare providers transition back to the world of elective procedures, there are four key steps to ensuring adequate staffing and supply:

- › Identify procedures you will focus on
- › Determine overall volume levels for procedures
- › Determine inventory levels needed
- › Evaluate staffing needs

Identify procedures:

Identify those procedures you intend to ramp up first as elective surgeries return. The procedures you identify might be based on existing backlogs, historical data or even the time a procedure takes.

“The type of surgery, the length of the procedure and the exact list of products needed will vary from patient to patient. In this restart period, there may be a natural tendency to over-order, rather than being short or running out,” said John Raab, Director, Performance Delivery for Owens & Minor.

“Certain procedures will have higher volumes than others,” he added. “One way to identify these is to look at your historical volume and which procedures were performed most over a given time. Also consult with your surgeons and other clinical staff to understand their priorities by procedure and what backlogs they might have as elective surgeries ramp up.”

Determine overall volumes:

Once you have identified the procedures you will focus on, you can begin determining the overall volume levels of elective surgeries.

“If you plan to expand the days and hours that elective surgeries are being performed or focus on a select few procedures, then historical volume will not be the only factor to forecast future volume,” said Angela McNally, Vice President, Provider Solutions for Owens & Minor. “Determine how many days per week and hours per day you’ll be performing surgeries. Next, look at historical data on how long it takes you to turn over a procedure from case to case. It’s important to review room turnover times by procedure since different procedures take longer than others.”

The next step is determining the number of procedure rooms in use. You can then take that information and combine with the procedures being done and the hours they are being performed to determine overall surgical volumes. According to McNally, based on these projected surgical volumes, health systems should:

- › Evaluate preference card validation and value analysis for product substitutions
- › Identify support needed – product, manpower, data analysis and/or physical inventory
- › Connect with partners in the supply chain for services and distribution

Determine inventory needs:

Hospitals were forced to quickly sourced supplies during the peak of the pandemic. Now, they’re tackling the remaining inventory to make sure the right products will be available when they are needed. “Some providers may experience a need to right size their inventory levels,” said McNally. “It’s really important to understand what you have and then you have to define the processes for how you’re going to use it.”

Managing the complexities of a hospital’s inventory requires a dynamic process. Clinicians need more time than ever to focus on patient care and quality outcomes during the restart, and inefficient inventory management diverts their attention and devours staff hours while eroding profit.

PANDAC helps hospital administrators immediately gain access to all the information needed to check inventory status. These reports allow Owens & Minor to make recommendations for controlling inventory costs and saving money.

Evaluate staffing needs:

Efficiency is paramount as elective surgeries come back online and having the right amount of staff is probably one of the hardest aspects to plan for, according to Raab, but also one of the most critical. “Hospitals will need all hands on deck to focus on patients and the new protocols in place to continue to handle COVID-19 concerns,” said Raab. “Your supply chain experts need to be working closely with their supply and distribution partners to focus on the up-stream supply chain and services that will help drive efficiency while managing cost, labor and waste.”

Owens & Minor can help!

As you prepare your health system for the return of elective procedures while continuing to navigate COVID-19, Owens & Minor offers comprehensive services and solutions that combine people, process and technology to empower our customers.

People: Leveraging Visibility into the Supply Chain

Visibility into supply chain has always been important. But the need for that visibility has never been greater as providers seek to return to elective surgeries. McMahon stated, “when you talk about the unpredictable product or amount of product that the hospitals are carrying, it’s

not just unpredictable, it’s a different mix of product as well.” But providers have to be able to see that product in order to manage that product.

Going forward, “visibility is going to be key into this process and then truly understanding how do you take that visibility, use the data and the historical trend, but then also make a forecast of making sure that you have the right product, the right mix of product, that you will be able to, continue to service the needs of your patients,” McMahon said. That’s a challenge for a number of providers who either lack a solution that provides visibility

into the supply chain or if they have one, it provides only partial visibility.

Physical Inventory Service

Physical inventory services can provide an accurate cost-effective alternative to completing a full, financially auditable physical inventory at this time. “You don’t have to pull your clinical teams, or your supply chain teams to focus on this,” said McNally. “It allows you to focus efforts on restarts and elective surgeries while still maintaining COVID safety protocols, whether it’s a single department like a cath lab or it’s your PPE inventory.”

Owens & Minor physical inventory service is more than a count of your product on hand. “We also help you identify what you need to maintain to have those optimal inventory levels. We provide you visibility so you can see where you’d need to make recommendations and how you can move stock around to critical areas, remove out of date items and just look for opportunities to manage your space,” stated McNally.

PANDAC

Owens & Minor also has a solution called PANDAC that helps customers control purchases of wound closures and eliminate excess while maintaining supply levels. It includes on-site service, in-depth reporting and integration with materials management, business reviews and the ability to expand management to other product categories. Owens & Minor taps into patented technology to routinely monitor purchases and utilization, adjust stocking levels and provide continuous reporting on all aspects of purchasing and inventory.

PANDAC helps hospital administrators immediately gain access to all the

information needed to check inventory status. These reports allow Owens & Minor to make recommendations for controlling inventory costs and saving money.

“When we see a supply chain that has the ability to use predictive analytics to make decisions and use historical trends and then future trends, this is where QSight comes in and plays a critical role in the process.”

– Patrick McMahon, vice president, service of sales for Owens & Minor

“It’s really all about the data,” said Mark Campbell, Vice President of Supply Chain for Tampa General Hospital, an Owens & Minor customer. “Prospectively, we know who has block time scheduled. We know that procedures are scheduled one to four weeks out. It’s looking at that data, but also looking at historical data, what has actually been done, how that block time has been utilized and on what days of the week.”

Campbell added that PANDAC has helped because it has provided a laser focus on a key supply item, surgical closure or wound closure that the hospital doesn’t have to worry about. “When we have a dedicated resource to managing that critical resource, it frees us up to worry about other things,” he said. “That resource can expand and look at other products, but

also take into account what’s going on with our surgery schedule and flex as appropriate with that critical asset.”

Cost management around non-labor expense is a priority for many hospitals as they restart. McMahon said suture and mechanical spend provide potential big-ticket cost savings opportunities. “Traditionally, suture and mechanical spend represents about 10% of the spend for distribution,” said Patrick McMahon, vice president, service of sales for Owens & Minor. “Often, there are a lot of SKUs within these products. There are short expiration dates. It can be difficult to manage these products.”

“We create a process of making sure that we manage these products efficiently and effectively for your organization,” said McMahon. “We’ve been able to reduce inventory and support it with data and analytics to make actionable decisions on how to support these products.”

Process: Driving efficiencies and reducing waste

SurgiTrack

A product like Owens & Minor’s SurgiTrack can help streamline the surgical process. It is an industry-leading unitized delivery system that combines lean methodologies, technology, surgical products and physician preference products into one process. SurgiTrack provides an advanced clinical supply process, grouped by procedure and customized by surgeon preference. It helps reduce spend, decrease waste and improve processes in the internal supply chain.

SurgiTrack includes a platform that lets hospitals track key performance indicators and transform information into actionable intelligence. It relates the

supplies purchased to the contract pricing system and to the surgeon preference card, bringing greater supply chain efficiency and savings.

“In the past, we relied on simple things like product bundles, custom packs and standard packs, that seemed to drive the entire business of surgery,” John Raab, National Director of Preoperative Solutions for Owens & Minor, explained. “Today with the complexity of the product demands that are needed and the technology used for surgery, SurgiTrack is a method of pulling all the data needed together to both identify what products are needed for surgery and how to make best use of your clinical and your supply chain staff to support the business elements of surgery.”

SurgiTrack brings together the two worlds of surgery: the performance of the surgery by the clinical staff and the hospital’s supply chain duties. “SurgiTrack really bridges the gap between those two groups of people and makes their job easier,” said Raab. “It’s truly a business approach to a clinical need in the supply chain today – the supplies, all the products they need and also the information necessary to make sound business decisions.”

Technology: Transforming inventory management

Providers can leverage the power of a technology solution like QSight to make better, smarter decisions about inventory and supplies as elective surgeries resume. Owens & Minor’s QSight is the industry’s leading cloud-based solution

for procedure rooms. It uses state-of-the-art technology to transform how providers manage their inventory, simplifying clinical workflows and providing them the data to make better, smarter decisions.

“One of the problems providers are facing as elective surgeries resume, but especially longer term is the lack of visibility and transparency into critical pieces of inventory data, such as inventory counts by products, products on back-order, products below PAR and other important information,” McMahon stated. “And when they lack that information or even if they have it but don’t trust the validity of it, making the right decisions on what, when and how much to order of a product can be challenging.”

“When we see a supply chain that has the ability to use predictive analytics to make decisions and use historical trends and then future trends, this is where

QSight comes in and plays a critical role in the process,” McMahon said. “QSight provides that visibility within the supply chain that most hospitals don’t have access to if they’re not using a clinical inventory management tool today.”

With QSight, providers worry less about stocking out a product. “They can use the data within QSight to make critical inventory decisions based on the historical usage of that product instead of gut instinct,” McMahon stated. Providers can also use QSight as the tool to making sure there is no expired products. “QSight enables users to right to that department with expired product and pull that product off. And what’s critical about that too, is that it doesn’t only, help with labor optimization but also helps with that risk mitigation. Making sure that you never implant a product or a recalled product into a patient.” ■



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Telemedicine

There was a massive uptick in telemedicine usage during COVID-19. But will it last?



It's clear that COVID-19 has accelerated the adoption of telemedicine by physicians and their patients. But will it last? If so, how will it affect physician practices? What impact will it have on the types and volume of medical products and equipment they need?

As with just about anything COVID-19-related, no one knows for sure.

The evidence

Already before the pandemic, virtual office visits were on the rise. In February 2020, for example, the American Medical Association reported that physician adoption of televisits doubled from 14% in 2016 to 28% in 2019.

Then came COVID-19.

In April, Merritt Hawkins – a health-care search and consulting firm – reported that almost one half of approximately 840 physicians surveyed between April 11 and April 15 reported seeing patients via telemedicine. The firm contrasted that

result with The Physicians Foundation's 2018 Survey of America's Physicians, also conducted by Merritt Hawkins, which indicated that two years earlier, only 18% of physicians were treating patients through telemedicine. "The emergence of the virus has clearly accelerated the use of technological platforms used to treat patients remotely," noted the company in its most recent report.

Signs of increasing usage were widely reported during the pandemic. For example, NYU Langone Health, an academic health system in New York City, reported that between March 2 and April 14, telemedicine visits increased from 369.1 daily to 866.8 daily (135% increase) in urgent care, and from 94.7 daily to 4,209.3 (4,345% increase) in non-urgent care. NYU Langone Health comprises four hospitals and more than 500 ambulatory locations, and 8,077 healthcare providers.

"From Henry Schein's vantage point, we're seeing an uptick in the adoption of telemedicine by entire health systems, as well as solo practitioners, urgent cares, and ER departments," says Michael Casamassa, vice president of solutions and planning, Henry Schein Medical.

Greg Dean, vice president, technology and services, McKesson Medical-Surgical, points out that "COVID-19 has driven – and the relaxed regulations have allowed – many more providers and patients to use telehealth. Only time will tell, but the current general feeling is this will advance telehealth."



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¹ <https://go.forrester.com/press-newsroom/us-virtual-care-visits-to-soar-to-more-than-1-billion/>

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The government responds

In response to the increased demand for virtual visits during the pandemic, the Centers for Medicare & Medicaid Services (CMS) broadened access to Medicare telehealth services. Effective March 6, beneficiaries could receive a wider range of services from doctors without visiting a healthcare facility. (Prior to this, Medicare would only pay for telehealth on a limited basis, when the person receiving the service was in a designated rural area, and when they visited a clinic, hospital or other medical facility.)

‘By understanding the impact telehealth will have on the traditional delivery models of healthcare, distributors will be better positioned to expand their portfolios and support their customers with new solutions.’

On April 30, CMS waived the video requirement for interactive conferences, thus allowing Medicare beneficiaries to use audio-only telephone to receive services. In addition, CMS waived limitations on the types of clinical practitioners who could furnish Medicare telehealth services, including physical therapists, occupational therapists and speech language pathologists.

After COVID-19

Some of these waivers may expire when the public health emergency has ended. But what happens after that?

“Providers who were on the fence prior to COVID-19 are looking for a more robust solution to fit the changing needs of their practice,” says Dean. “Others will retreat after the pandemic. There is a basic wait-and-see attitude concerning which regulation and reimbursement changes remain in place post-COVID-19.

“The federal government has invested greatly in telehealth during the crisis and

may grow in-person visits. By directing patients who do not need an office visit to telehealth, a provider has time to see more of the critical patients – reducing wait times to get an appointment. Telehealth, or virtual care, also makes it easier to follow up with patients – these are often missed visits. And, with the ability to connect easily to a provider, it may reverse the trend and reconnect patients to their primary care provider.”

Telemedicine alone isn’t primary care

Steven Waldren, M.D., vice president and chief medical informatics officer for the American Academy of Family Physicians, predicts a significant increase in the utilization of telemedicine in the years ahead. “That assumes that reimbursement for telehealth remains post-public-health emergency and we continue the move toward value-based payment.”

But stand-up “virtual primary care” options are not the answer, he says. That’s because the cost-effectiveness and high quality of primary care rest on four things: contact, continuity, coordination and comprehensive care. A virtual-only model could deliver first contact, but not the other three. “That is not primary care.”

Stand-alone telehealth presents some questions insofar as diagnostics are concerned, adds Waldren. “Broad adoption of telehealth could create a significant market for patient-administered testing, particularly if services similar to UberEats and DoorDash deliver testing supplies quickly,” he says. “But without the option to step up a virtual visit to in-person, it may drive the utilization of more diagnostics/point-of-care testing and more referrals to subspecialties.

paved the way for future adoption. Looking five years or more down the road, we may see virtual care integrated into the workflow for providers as part of specialist consults, follow-up and monitoring.”

But telemedicine won’t replace all in-person visits, he says. In fact, quite the opposite.

“As providers learn how to leverage this tool and balance their patients, it

“If a telehealth provider can only deliver care virtually, they may decide to do more testing than a physician who has the option to see the patient in person.”

What’s more, not all issues can be addressed via virtual technology, such as administering vaccines or palpating a patient’s abdomen, says Waldren. “However, telehealth and telemedicine technology can facilitate distanced communication between patient and physician on qualitative questions and discussion.”

And although some patients might opt to substitute telehealth for at least some office visits, others may end up having a very similar number of in-person visits, he says. Those with chronic conditions, for example, might use telemedicine to engage more intensively with their physician and the care plan between in-person visits.

Protocols needed for virtual care

Growing acceptance of telemedicine may force providers to take a closer look at which visits lend themselves to virtual appointments, and which ones demand face-to-face visits, says Chris Smedley, vice president of physician enterprise solutions for Premier.

“This is such a critical question that medical groups across the country are contemplating, and there is no perfect answer. However, clinical necessity should and has to be a key driver in making these decisions.

“The severity of the condition and ability to move quickly from diagnosis to treatment will likely be key factors in determining these protocols. Providers are now being asked to inform new scheduling protocols that triage patients based on clinical guidelines and pathways for either

‘The cost-effectiveness and high quality of primary care rest on four things: contact, continuity, coordination and comprehensive care.’

an in-person visit or a virtual one. Key to success will be the physicians and staff working together to come up with models that are easy to implement and sustain.

“It will be important for providers and the clinical staff to work together to carefully construct questionnaires to identify which visits qualify for an in-office appointment versus virtual care. Central to all of this is ensuring patient comfort, safety and wellbeing.”

Practices must also consider that following the pandemic, patients may be skittish about seeking on-site care due to concerns of potential virus transmission, adds Smedley. “Many patients will opt for convenience and safety, which means they may choose not to visit a provider in-person if they can avoid it.”

Even without post-COVID-19 concerns about virus transmission, however, societal trends point toward a greater acceptance of telemedicine, he says.

“We’ve already seen a rapid shift in patient values where, oftentimes, their preference for a virtual visit drives how they choose to interact with a practice. ... Furthermore, due to the economic impacts of COVID-19, such as unemployment and the potential for lost or reduced wages, people are going to be more selective about when they choose to see a healthcare provider.” The proliferation of high-deductible health plans

over the last decade has already made people more selective about seeing a healthcare provider.

“There will be a downshift in in-person visits, and health systems will have to reevaluate both the use of the physical space as well as care delivery models if volumes don’t return,” says Smedley.

Convenience and safety

Mike Casamassa of Henry Schein believes that the adoption of telemedicine post-COVID-19 depends on many variables, including how quickly states reopen, how quickly clinicians get back to work, and how fast treatments or a vaccine are available.

But patients value convenience and safety and will likely demand telehealth where and when it is appropriate, such as for low-acuity conditions like minor scrapes, bumps and bruises, and respiratory illness, he adds. Furthermore, as technology advances, the use of telehealth may expand to dental, ophthalmology, and remote patient monitoring, specifically, for high-acuity, at-risk patients with two or more chronic diseases. Behavioral health issues are also appropriate for telehealth.

“Additionally, the patient intake process of telehealth, which is automated and touchless, will likely cross over to all physical visits,” he adds. “If the collection

of information prior to a virtual visit can be done in an automated and touchless manner, we can expect physical visits to be conducted the same, and more candidly, demanded by patients.”

Supply chain ramifications

By understanding the impact telehealth will have on the traditional delivery models of healthcare, distributors will be better positioned to expand their portfolios and support their customers with new solutions, says Casamassa.

Henry Schein did just that years ago by partnering with telediagnostic company Medpod Inc., he points out. Last summer, the distributor announced the availability of Medpod MobileDoc 2, and entered in a new agreement with Uber Health, which enables healthcare professionals to deliver telediagnostic examinations in non-traditional care settings, including the home or workplace.

McKesson Medical-Surgical’s Greg Dean believes that the growing usage of telemedicine could lead to more diagnostic testing. “Being able to connect quickly with a patient through telehealth or remote monitoring, doctors can initiate more timely visits for needed care and testing,” he says. “It may also drive the development for more home testing.” As for medical supplies, telemedicine may drive down the demand for some, but increase the demand for others, as the complexity of visits changes, he adds.

Says Premier’s Smedley, even if telemedicine leads to a dip in office visits, physician practices will always need personal protective equipment. “In many cases, organizations will seek alternative strategies to offset potential supply shortages through sterilization, conservation

and reuse practices where applicable.” In addition, because providers had to ramp up their telemedicine services so rapidly during the pandemic, they may reevaluate their longer-term strategy with these tools and solutions, he adds.

“There will be an economic impact on ancillary revenue, although it’s unclear today the degree to which these services will change,” he adds. “With more visits shifting to virtual care, health systems and medical groups are going to need to be

‘With more visits shifting to virtual care, health systems and medical groups are going to need to be creative and proactive to mitigate declining volumes for labs, X-rays, point-of-care testing and other procedures that are often administered during an appointment.’

Physician preference

“We won’t fully understand the long-term impact of virtual care on providers for some time,” says Smedley. “Some clinicians love providing care through telemedicine portals, while for others it exacerbates the symptoms of burnout because of the perceived distance from their patients and the lack of connection.

“As health systems adopt care delivery models to understand what patients need, they will also have to account for the effect on their clinicians and doctors. They’ll need to strategically attend to those clinicians and physicians who may gravitate toward virtual care versus those who prefer providing care in an office setting.

creative and proactive to mitigate declining volumes for labs, X-rays, point-of-care testing and other procedures that are often administered during an appointment.

“Coming out of the pandemic, there is a sense of urgency to recoup lost visits and ancillary revenue. In the fee-for-service model, volume is an important leading indicator relative to revenue. The pandemic has spotlighted how value-based care models can help stabilize providers’ revenue compared to volume-based payment models.

“This may provide a tipping point in order to further motivate medical groups to participate in more risk-based contracting efforts.” ■

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