

# *The Journal of* **Healthcare**

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**C O N T R A C T I N G**

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## Top Non-Acute Supply Chain Leaders



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Karla J. Butts, Providence St. Joseph Health



Darrick Adams, AdventHealth



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Tyler Ross, Novant Health

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Supply  
Chain  
Leaders**

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Director, non-acute,  
supply chain, AdventHealth

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# Closer to Normal



**One year ago this week, my son graduated from high school. It was the weirdest** event I've ever attended. We drove around the school as teachers lined the roads and waved, then went into the school 10 families at a time – very social distanced – as he received his diploma. There were no parties last year. Yet last week, I went to a party for a graduate and it was as if the pandemic never happened. No masks, hugs, buffet line – it was unbelievable.

Personally, things seem closer to what life used to be like, but professionally it seems much more behind. I haven't been on a plane for work in 15 months, nor have we had any clients visit. When I speak to Supply Chain leaders, many are still working remote but going into the office occasionally. Supplier representatives seem to be completely remote too, and very few are going into IDNs or hospitals. From what I can gather in these conversations, most IDNs will have a plan by the end of June as to what work setting expectations will be. I for one hope we are back together sooner rather than later.

In early June I look forward to attending the Federation of American Hospitals meeting in Nashville. This will be the first in-person industry event I've attended since the beginning of the pandemic. Ironically, the Federation meeting in 2020 was the last event I attended before the virus shut the world down. I look forward to seeing people in person again!

Recently I was chatting with a good friend of mine that's a national accounts representative for a large medical supplier. He has the kind of job that used to keep him in hotel rooms over 100 nights per year. This Road Warrior lamented how bad his cabin fever has been and quipped "Heck, I'm so desperate to get out of the house, I'm willing to go on a business trip with my own money."

I'm very curious what the interactions will look like in the future between Supply Chain leaders and Supplier representatives. Some questions I'd love to know are:

- › Will they meet in person as often as they used to?
- › Will it be harder for new vendors to be seen, heard and evaluated?
- › Will providers patronize and attend industry meetings and events?

In the coming years, it will be fascinating to learn the answers to these questions. In the meantime, enjoy this issue of *The Journal of Healthcare Contracting*.

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# New Ways of Thinking

Health systems across the country and their supply chains acted quickly to procure supplies amid the early stages of COVID-19 cases.

What was learned during that time will help health systems for future planning.

## As recommendations from the

Centers for Disease Control and Prevention (CDC) constantly changed during the height of the pandemic, healthcare facilities developed policies and procedures ensuring that the changing recommendations were appropriately applied in their setting. Healthcare personnel adhered to standard and transmission-based precautions when caring for patients with SARS-CoV-2 infection and donned recommended personal protective equipment (PPE) gear.

They identified and gathered the proper PPE to don, performed hand hygiene including hand sanitizer, and put on isolation gowns, N95 or higher filtering masks, face shields or goggles, and gloves. After all of that, they entered the patient room.

So how has supply and procurement changed for these PPE products? And how are healthcare organizations working to maintain supply continuity for these categories and for new infection prevention (IP) categories? Finally, how has future planning changed for IP categories and the supply chain? *The Journal of Healthcare Contracting* reached out to several supply chain leaders to get their insights. ■



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# Rapid Response

Parkview Health's supply chain team deployed a self-distribution system to help quell issues during the height of the pandemic.



## The process for evaluating IP-related products hasn't changed for Fort

Wayne, Indiana-based Parkview Health, which includes seven acute care hospitals across three states. However, the speed increased due to demand and availability of products during the height of the pandemic. What would typically take a few months in reviews and committees took one week.

"Aligning the evaluation process to market availability was a transformational shift for our organization," said Jesse Stanton, director of supply chain integration for Parkview Health. "Fortunately, our IP team was integrated into our incident command center and that allowed for evaluation to occur in a timely fashion."

"Every disaster or pandemic, whether realized or feared, has been on our radar for years," Stanton added. "We are constantly conducting risk assessments on every type of disaster and strategizing on how best to stock, procure and evaluate to place our



Jesse Stanton

health system in the best position to provide excellent care to all in need."

## Masks, gloves, surface disinfectants and hand sanitizers

Supply and procurement for gloves, masks, surface disinfectant, and hand-washing soap and sanitizers were critical. Masks saw utilization in areas that otherwise didn't use them, in part due the changing CDC guidelines. "Mask demand in some cases increased by 1,000% and restrictions were placed on ordering through our normal supply lines and primary distributor," Stanton said. "Allocations from primary procurement vendors were put in place based on usage in the fourth quarter of 2019."

This caused Parkview Health's procurement team to reach out to nontraditional

vendors. “Our strategy was to obtain in bulk purchases of substitute procedural masks that were set for delivery during the middle of 2020, while still procuring and building stock of our standard products,” Stanton said. “We were able to procure the appropriate masks needed for source control and the N95 masks needed for high-risk areas.”

Though Parkview has an adequate supply of masks and shields, it’s partnering with Hospital Laundry Service to create a stockpile of cloth masks, which can be used as backup to the main supply.

Gloves weren’t as big of a procurement issue as masks for Parkview Health. “Our infection prevention and control guidelines and compliance for glove utilization were robust prior to COVID-19,” Stanton said. “So, we had an increase in demand when COVID-19 numbers increased, but it was manageable.”

Manufacturing and raw material issues led to shortages for nitrile gloves earlier this year, after there was a demand increase nationwide due to larger vaccination efforts. “These disruptors have caused our organization to diversify our glove product and procurement activities, like incorporating vinyl into certain areas of use,” Stanton said. “Our supply chain team collaborated with our IP team to vet and determine which areas could be transitioned to other gloves.”

On the disinfectant side, the demand for surface wipes increased the most during the pandemic. It was also immediately placed on allocation by primary procurement sources and forced Parkview’s teams to source alternate products to meet use requirements. “We transitioned to locally sourced, infection prevention approved surface disinfectants made available in appropriate quantities,” Stanton said. “The

initiative was coined as the ‘bottles and buckets brigade’ and much of the product line was provided in spray format.”

Hand sanitizers were among the most requested and variable in the availability of standard products. “Our procurement teams sourced multiple hand sanitizer substitutes,” Stanton said. “Like most health systems, we turned to local alternate sources, including distilleries, for hand sanitizers that were used in limited areas to protect our standard stock.”

**“For supply continuity, we implemented a strategic stocking initiative in early summer 2020 that enabled our health system to weather the surge in fall 2020,” Stanton said. This strategy included establishing aggressive hard limits, committed buys, alternate procurement from multiple distributors and bulk buys when available.**

Most of Parkview’s PPE-related products, including cleaners and disinfectants, were on rolling backorders during the height of the pandemic. “Even other areas that would not necessarily be considered related to COVID-19 went on backorder due to shifts in manufacturing,” Stanton said. “Vaccination supplies were hit hard by backorders from last December to March due to ramped up vaccination efforts.”

### **Parkview’s self-distribution system and new product categories**

Parkview Health deploys a self-distribution system that includes an off-site distribution center. It was able to expand into adjoining space to accommodate the increase in supply needs. “For supply continuity, we

implemented a strategic stocking initiative in early summer 2020 that enabled our health system to weather the surge in fall 2020,” Stanton said. According to Stanton, this strategy included establishing aggressive hard limits, committed buys, alternate procurement from multiple distributors and bulk buys when available.

One of the unique categories that arrived for evaluation and procurement was laboratory specimen collection tubes. “These plastic lab collection tubes were

an unintended casualty of raw material disruptions in plastics and polypropylene from manufacturing PPE-related products,” Stanton said. These PPE-related products included isolation gowns, masks and face shields.

“Switching collection tubes requires an enormous amount of work related to validation studies and instrument calibration,” Stanton said. “Evaluating and procuring these items has only occurred by the excellent collaboration between our laboratory professionals and our supply chain analysts.”

Stanton said the common backorder pattern has spilled over to other plastic composed categories such as catheters, blood collection holders and suction tubing. ■

# Meeting Patients Where They Live

The Increasing Relevance of “Mini Hospitals,” ASCs, and Remote Support; and the Keys to Ensuring Facility Success



**In the not-so-distant past, the move to outpatient settings was driven by** advances in technology and procedures that enabled more minimally invasive procedures to address conditions once destined for the OR. Most in the industry agreed that there were benefits to moving certain procedures to the ambulatory surgery center (ASC), including shortened recovery time and a reduction in infrastructure requirements.

Today other factors are at play, such as an ASC-friendly reimbursement environment, consumer choice often driven by pricing considerations, and opportunities for physicians to have financial stakes in ASCs are continuing to fuel ASC growth,<sup>1</sup> even as they've taken a hit from the pandemic's non-essential procedure shut down. It's backlog time, and as ASCs catch up to the caseloads, they are becoming more agile all the time. At the same time, remote care, in terms of telemedicine, remote consults, even specialists attending surgeries, is becoming more common.

Although these changes have required great agility of healthcare systems, as well as some growing pains, patients stand to realize benefits. For some, travel will be reduced for certain types of treatment. For others who feel anxiety about a hospital visit during a pandemic, the smaller and more controlled setting may bring peace of mind. Still others may appreciate the less-expensive impact to their deductibles, as ASCs may at times provide comparable treatments to hospitals but at lower costs.

On the provider and supplier side, most agree that at least some of this “new normal” is here to stay.

## ASCs Looking for Ways to Do More

ASCs tend to be focused on specific procedures that are high volume and elective in nature, including screening colonoscopies, outpatient ureteroscopies, orthopedics, and ophthalmology. Pandemic restrictions meant a complete shutdown for many and extreme limitations for most. As a result, ASCs have been hard hit and are looking for ways to make up lost revenue.

Access to the proper equipment is one of the biggest challenges for ASCs looking to fill newly emerging gaps in the care available to communities. As they plan for expansion, ASCs will need to be able to finance new equipment and they'll need to consider how to add new procedures while also remaining profitable in relation to those procedures.

Recognizing these needs from the pandemic's start, Olympus created a task force specifically focused on the growth of ASCs for the emerging new healthcare landscape, and determined that the most important value for facilities would be in the form of 1) Flexible Financing to address the realities of new and changing market conditions and 2) Robust Customer Service. Combining these with an already deep product portfolio is key to meeting a range of ASC needs.

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## Flexible Financing

To optimize purchasing, ASCs will benefit from working with companies that offer flexible funding options, to minimize the impact of equipment purchases and a rebuilding of revenue streams.

Some financing options ASCs should consider are:

- › **Disposable purchasing power:** Some programs allow ASCs to leverage their disposable purchasing power across specialties. For example, some companies allow the ASC to fund capital equipment through an ongoing purchase of disposable devices on a pay-as-you-go basis. In this arrangement, there is no large upfront capital outlay. The ASC is able to order what they need, when they need it.
- › **Cost per Procedure:** A good partner might also offer an arrangement that allows the ASC access to the equipment and service needed, financed and paid via a per-procedure payment, based on the valuation of everything provided. For instance, \$500,000 worth of equipment and \$1 million worth of turnkey financing may result in less than a \$100 per-procedure payment. A CPP program obligates the ASC to perform a specific number of procedures within a specified time limit, such as 16,000 flexible endoscopy procedures in 36 months, but also eliminates a large upfront expenditure.

- › **Leasing and Financing:** Equipment lease structures, master lease/financing arrangements, vendor-agnostic financing, turnkey project financing are all options available for agile and productive product fulfillment. A good partner will be able to offer favorable repayment terms with minimal interest. It's also important for an ASC to choose a supplier that is not going to resell a loan, because ASCs will want to maintain flexibility in their repayment plans.
- › **Creative Contracting:** The most important element in the financing relationship may be flexibility. As an example, the Total Partnership Program by Olympus gives ASCs access to competitive pricing and streamlines purchasing and leasing through one monthly invoice, saving time and money for long-term stability and predictability in business planning.

## Robust & Versatile Customer Support

A recent survey by the Strategic Marketplace Initiatives consortium showed that both suppliers and providers believe that only the most important or clinically-focused meetings will be in person. Accurate immunization records may be required of support staff and more control of vendor access – ASCs should make their requirements clear and medical device companies should also state clearly their expectations regarding the safety of their support staff.

Most agree that, now that a greater swath of healthcare professionals are accustomed to video conferencing, there

is potential for more efficiency, more representation of multiple functions and even better outcomes as a result of remote meetings. As meetings are scheduled, there will be increased scrutiny over the meeting format decision, as to which makes more sense: fully virtual with broad attendance, or in-person with limited attendance.

Remote support, where possible, will continue being used because of its benefits. Virtual consults and telecollaboration are on the rise, as Olympus has witnessed with increased interest in our MedPresence offering. The ASC and the supplier should discuss options for keeping support quality high, whether it happens in person or online.

## Deep Product Portfolio

In building for the future, ASCs should consider standardizing their capital equipment so that it can support multiple specialties, which ensures the best return on investment. Imaging platforms, for example, can serve multiple purposes, from endoscopy to surgical to gynecology to urology. A vendor-neutral capital platform with room to grow may ready the ASC for a changing healthcare landscape and may be a way to attract the best talent.

Ultimately the move of more procedures to ASCs will be good for the healthcare industry and patients, as procedures conducted in ASCs are known for keeping healthcare costs down while providing great access for patients.

The good news is that these are changes and relationships that we expect to be positive, lasting ones. ■

For more information about Olympus and how they partner with ASCs, [click here](#).

<sup>1</sup> <https://www.advisory.com/en/daily-briefing/2019/03/05/asc-shift>

Corinne Janetski, Director of Marketing, Imaging, Surgical Endoscopy, Olympus

# Good Working Relationships

Piedmont Healthcare's supply chain and IP teams relied on relationships for quick approvals and supply opportunities.

## Atlanta-based Piedmont Healthcare's supply chain team has always had a

good working relationship with its IP team, according to Pam Esper, executive director of strategic sourcing and contracting for Piedmont Healthcare. That relationship was very important during the past year.

"When we had to deviate from our standard products, we had a process for quick approvals so that we didn't miss a supply opportunity," said Esper.

Piedmont, with 11 hospitals and over 550 locations, secured additional warehouse space during the early stages of the pandemic that it still uses today. "We are still using it as we build permanent resiliency into our stocking methodology," Esper said. "We have also committed to supply assurance programs that have been working out very well for us."

Procedural and surgical masks were a challenge to procure for Piedmont Healthcare early last year, but it was able to find stock from several secondary suppliers until its distributors recovered. "Supply chain obtained samples that were then approved by IP," Esper said. "Masks are a part of our PPE Assurance program."

Like many hospitals, Piedmont used 3M's N95 masks that were hard to find. "Working closely with our employee health and IP teams, we sourced two other makers of FDA-certified masks, fit tested employees to these new masks and now have three manufacturers available for the clinical staff," Esper said.

Piedmont also received many donations of PPE and other supplies throughout

the pandemic. "We accepted them and then IP was asked to approve," Esper explained. "If they didn't meet the clinical specs, we tried to find another use – like facemasks for visitors."

**"We've been able to make it through by having approved substitutes or moving product between hospitals until stock arrives."**

– Pam Esper, executive director of strategic sourcing and contracting, Piedmont Healthcare

The health system purchased gloves through a standard distributor and an IP-approved secondary supplier. When gloves were restrained during the height of the pandemic, Esper said Piedmont purchased from a few smaller distributors that its supply chain team obtained samples from and were approved by its IP team.

## IP team created its own solution

Piedmont's IP and facilities teams designed an approved spray-on solution for

surface disinfectant when disinfectant wipes were out of supply. "IP created the educational training on how to mix it and other key pieces of information, and supply chain provided the materials," Esper said.

Piedmont's IP team created a running list of all nontraditional items to be reviewed, according to Esper. "What was and wasn't approved was listed by category in case we needed to purchase more. That list kept us from repeating the same steps over again," Esper said. "As we move back to more normal operations, we'll continue to find the best products to ensure our patients' safety."

As the health system moves back to those normal operations, the majority of PPE supply is getting back to a healthy status, according to Esper. "But what we're finding is random products are being delayed mostly due to transportation and shipping issues," she said. "We've been able to make it through by having approved substitutes or moving product between hospitals until stock arrives."

Meanwhile, Piedmont's IP team has been busy with its vaccine clinics and reloading a pipeline of initiatives. "We started planning for the future last May," Esper said. "Knowing that we were expecting fall and winter surges, we worked with our operations team on building key supply stockpiles."

"We feel good about what we've put in place," Esper concluded. ■

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# Creating Momentum

Ochsner Health's Régine Honoré Villain and her supply chain team acted quickly to procure supplies amid the early surge of COVID-19 cases in New Orleans. What she learned during that time will help Louisiana's largest healthcare provider for future planning.



**For Régine Honoré Villain, MPH, senior vice president**

supply chain network, chief supply chain officer of New Orleans, Louisiana-based Ochsner Health, the squeeze on supplies started in early March 2020. “Almost overnight, we started to see a pinch on supplies,” she said.

COVID-19 cases were first being reported in the United States in Washington State, and then the next big surge that made the news was New York. “We were two or three days behind New York, so we were surging at basically same time,” she said. “We experienced a pinch that perhaps others did not experience because of that timeline.”

Very early on, Villain said she and her team realized that they needed to shift focus on the way that they were procuring supplies. “I knew that the only way to sustain the kind of demand was to make sure that we secured additional inventory, perhaps from places that we hadn’t before,” she said. “So, it changed the way that we did procurement.” In the past, the supply chain team was somewhat regimented by going through regular channels with distribution, the GPO and trusted partners. “It became very apparent that we needed to break from that because everybody was flocking to the same people.”

The Ochsner team thought a little bit more globally. Direct sourcing became a thing that they latched onto right away, Villain said. “No longer did we have the luxury of time to wait for somebody – a distributor, third party or middle person – to get to us; We basically jumped the line and went straight to manufacturing entities,” she said. “We started to transact with them at a level that we hadn’t before.”

Then came the idea of thinking about alternate sourcing. Not only sources used in the past, but in different ways. For instance, Ochsner went to people like plumbers, because plumbers had access to certain bags that they couldn’t find in other places. Ochsner went to people who manufacture plastics in order to get containers in order to get bottles, because they were now making hand sanitizer. “All of a sudden, we started to integrate supply chain operations in a way that we hadn’t before.”

Essentially, Ochsner became its own entity within all of those areas, along with other areas like 3PL, Villain said. They started to do third-party logistics because they couldn’t wait for couriers

or for distribution. Ochsner established a warehouse in the course of 24 to 48 hours and decided on how to run a fleet of vehicles. They rented trucks and then started driving.

The entire supply chain was disrupted in a way that they hadn’t thought about before, Villain said. “But frankly, when I think back about it, I really appreciated the fact that this event was forcing us to think outside the box.”



Régine Honoré Villain

One of the biggest revelations was when the supply chain team reached out to local purveyors to get products. The response was very positive. The local breweries became de facto hand sanitizer producers. At the time of the surge, the local couture dressmakers and stores that produced clothing for Mardi Gras were idle, because it was right after Mardi Gras. They were going to be in a lull for a while. “But we found out a way to partner with them,” Villain said. “They challenged themselves to create masks, and then they started making gowns. Meanwhile, we started making face shields and goggles.

It was absolutely amazing. Everything that was traditional was no longer, and everything that could have been perceived as a taboo or questionable in supply chain became mainstream.”

### Maintaining supply continuity

Villain said the warehouse built for the pandemic isn’t a full-fledged warehouse, “but it’s definitely an operation that will

**“We’re asking ourselves a question in the morning,” she said. “But we need to be able to process it that same day, so that we have a plan to execute, because every day was the equivalent of losing a week.”**

allow us to decompress the supply chain,” she said. “In the past, just-in-time was something that everybody aspired to. You wanted to be lean, mean and efficient. Well, there’s something to be said for having redundancies in a way that actually balances your availability to have supply on hand, because anybody who was truly entering into the pandemic saw themselves having difficulties riding through the waves.”

Fortunately, Ochsner was able to enter into the pandemic at a place of strength because they had started to ramp up before 2020. “We anticipated that there

could be an issue based on the chatter that I was hearing out of China,” she said.

In October-November of 2019 the industry was dealing with disruptions to the supply of surgical packs. Then Villain said they began to hear chatter about a sickness in China. “My thought process went to ‘Well, if these people are getting sick, that means they’re not going to work. That means a factory is not producing.’ So if those factories are not producing, it’s likely going to be a while before they start ramping up. And then generally every year, it’s known that factories will close for the last two weeks of the year.”

## “[F]rankly, when I think back about it, I really appreciated the fact that this event was forcing us to think outside the box.”

Villain said she had a feeling that they needed to get their hands on as much as possible so that they wouldn’t be struggling at the beginning of the following year. “I call it a Spidey sense,” she said, like Spiderman. “My Spidey senses were tingling. I just had a feeling, an inkling that I needed to act quickly and make sure that I had people on board, and I needed to understand chain of custody. I started formulating the questions and forcing the issue with some of my suppliers. I would ask them ‘Where are you getting your supplies? If you’re getting your goods from China, I want to know, because if that’s the case, I want to ramp up and make sure that I have enough to keep me level for at least a couple of weeks.’”

When COVID-19 started to hit, Ochsner was in a position of relative strength, because of the early accumulation. “It was almost unintentional, but

the foreshadowing really helped us. It allowed us to create momentum in order to continue to supply the hospital and take care of our patients and caregivers.”

### Future planning in the “almost” post-pandemic era

The future for supply chain will be centered around creating resiliency and redundancy, Villain said. “It may sound like those two concepts are the same, but they’re not.”

You want to make sure that you have options as a supply chain, she said. Strict

standardization is gone. “We need to make sure that we have options, because if one line of products is compromised, then the entirety of the chain is compromised,” she said. “That’s why the future is also stronger collaboration with internal stakeholders, folks like our infection control specialists and our physicians. When it comes to technology and biomed, we have to make sure that we’re partnering with external stakeholders, so that we can understand how can we come together differently, and be able to execute quickly on decisions.”

But the speed to execution is paramount for the future. “You don’t have the luxury of time; you cannot wait to make a decision for a week.”

At the at the height of the pandemic, Villain was telling her team that when they entered the day with a question mark, needing to make a decision, she

wanted them to exit the day with an exclamation point. “We’re asking ourselves a question in the morning,” she said. “But we need to be able to process it that same day, so that we have a plan to execute, because every day was the equivalent of losing a week. So, the speed to execution has to be there. The resiliency has to be part of the narrative, and ensuring you have redundancy is also important.”

As an industry, nearshoring needs to be explored, Villain said. “How do we make sure that as an industry, we don’t allow ourselves to be subject to the rigors of distance?”

Amid the height of the pandemic, Villain said at some point when you wanted to procure something, whether or not you were willing to pay for it, you couldn’t get it because it couldn’t get to you in time. Things were being shipped over the water because of the way they were bought – tons and tons of heavy items like gloves. “The quantities that we were buying you couldn’t put on a plane; You had to put them on a boat,” Villain said. “You’re waiting 4,5,6 days. Then custom issues arise. We cannot afford to be in a situation where we’re depending on that process much. Well over 75% of everything that we were getting was coming from overseas. So now we’re thinking about, what do we need to do in order to create opportunities to make sure that nearshoring is a reality?”

There’s a lot of things that go into nearshoring, Villain said. “But certainly, it is something we’re thinking about as an industry. We just need to understand it better. We need to lean on each other a little bit more intentionally, and create those connections, so we can truly create a network of support, so that we can have the redundancy and resiliency.” ■

# UVC Disinfection

A smart addition to a multi-faceted infection prevention program

**With the ongoing COVID-19 pandemic, the UVC disinfection industry has** grown exponentially. Now, more than ever, hospitals realize the importance of providing peace of mind to both patients and staff that the facility is as clean and germ-free as possible.

UVC disinfection technology has been shown to be a chemical-free method of providing enhanced disinfection in the health care space. While UVC can be a useful complement to an existing disinfection program, no one single approach to pathogen reduction can fully eliminate germs in a health care environment. This is why it is critical to deploy a layered or multi-faceted approach to cleaning and disinfection.



## The importance of a layered approach

Even with the best cleaning protocols in place, it is challenging to achieve 100% compliance. In fact, studies show that more than 50% of health care surfaces are not properly disinfected. Moreover, a study by Weber, et al showed a dramatic increase in infection risk by 39-353%<sup>1</sup> upon admission to a room that previously housed a patient with a multidrug-resistant organism.

**UVC disinfection technology not only helps to provide the cleanest health care environment possible, but it also reinforces that the facility is committed to protecting patients and destroying germs.**

Studies show that an integrated, bundled approach is an effective and efficient means for comprehensive pathogen reduction within a health care facility. For best results, as reported in the *American Journal of Infection Control*, health care facilities should establish strict cleaning protocols, including both manual cleaning and automated, total room decontamination technology,



combined with extensive training and monitoring of staff<sup>2</sup>.

Montrose Memorial Hospital is one of hundreds of health care facilities that have implemented the **Tru-D** UVC disinfection device. The technology does not replace the hospital's award-winning environmental services staff but supplements them – adding an extra layer of protection against harmful germs and pathogens. Four staff members are trained to take the **Tru-D** robot to patient rooms and initiate the disinfection process, which is completed in all four operating rooms.

“We are committed to providing the safest and cleanest environment

possible through manual cleaning, hand hygiene, antibiotic stewardship and now with innovative disinfection technology,” said James Kiser, CEO of Montrose Memorial Hospital. “We continue to remain on the leading edge of technology and provide innovative care for our friends and family.”

By combining manual cleaning with enhanced terminal room disinfection, hospitals can help stop the spread of harmful germs. UVC disinfection technology not only helps to provide the cleanest health care environment possible, but it also reinforces that the facility is committed to protecting patients and destroying germs. ■

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# COVID Fatigue and the Infection Preventionist

The need for infection preventionists has never been greater.

What can hospitals and healthcare systems do to appropriately staff those positions?

**Linda Dickey, RN, MPH, CIC, FAPIC, Dickey Consulting LLC, has been an infection preventionist for more than 25 years. In that time, “we’ve never been in a situation where we have either reused or extended the use of personal protective equipment, certainly on the scale that we’ve had to do with COVID,” she said. Dickey is president-elect of the Association for Professionals in Infection Control and Prevention (APIC).**



Linda Dickey



Robin Carver

In the past, that reuse or extended use was simply not done as a fundamental tenant of infection prevention. Single-use items were used once and thrown away. Yet reuse and extended use was a situation that nearly every healthcare provider found themselves in amid the early days of the pandemic.

“We all realized when we ran into the supply chain issues that it made us think differently about how reserves are handled,” she said. “And it made us think more about the cost of that, because, obviously, there was warehouse space and holding a lot of supplies to consider, versus

just-in-time inventory. COVID taught us all that we can’t always expect to have something readily available.”

Because there were so many interruptions in the supply chain, infection preventionists had to be nimble and work closely with supply chain partners. “We probably worked more closely with them than we ever did before,” Dickey said, whether it was examining personal protective equipment options, cleaning and disinfection options, or even options related to some types of services. “Not that we didn’t work closely with our supply chain partners before, but it made it

abundantly clear that we are joined at the hip to try to solve these problems because they are quite vexing. COVID has been extremely challenging to our supply chain partners. It put them front and center in terms of trying to manage the availability of various types of products, hand in hand with maintaining safety.”

The beginning of the pandemic was extremely difficult for infection preventionists, Dickey said, because the guidance coming out was so fast, and so evolving. “Not only were people involved in epidemiology and infection prevention trying to calm fears and maintain patient care and answer questions, but we were doing it in the context of not necessarily having all the information that we would have known had the pandemic been further down the road. So, I think everyone in the whole world literally was working somewhat in a vacuum, learning about COVID-19, its transmission, what the options were for safe and effective care, and what the options were for actual treatment for these patients.”

Many infection preventionists worked around the clock, either extending workweek hours or fielding calls on the weekend. Dickey said for her, those extended hours started in late January and continued throughout the year. She didn’t have her first day off until Mother’s Day. “Our leadership was phenomenal, and our supply chain leader

was over-the-top phenomenal and still is,” she said. “But we constantly had to find time to communicate with each other and develop communications that went out to the organization and make sure that we were all on the same page. That takes time, and thoughtfulness. And so, I think a lot of infection preventionists probably experienced that level of intensity for quite some time.”

Even off the clock, infection preventionists were still fielding questions from family or friends about COVID-19. “They were reaching out and asking, ‘Can you give us any more information?’ ‘What does this mean?’ ‘What should we be able to do that’s safe?’ So, you not only experienced the stress on the professional side of your life, but your personal side as well,” Dickey said. “It’s been a marathon.”

### Extended fatigue

Infection preventionists have been planning and preparing for pandemics for years, said Robin Carver, RN, MSN, CIC, vice president, member engagement at Premier Inc. “I don’t think anybody could have been fully prepared for what we experienced, because even as we wrote plans, and participated in drills, you never know truly what’s going to hit you.”

Now with COVID cases on the decline, many infection preventionists are admitting that they are exhausted. Fatigue has set in.

“The impact to infection preventionists as a profession has been pretty profound over the last year,” said Carver. “We talk a lot about the front-line care providers, because they were the ones there day in and day out. But the IPs were also right there, day in and day out. And many of the IPs that I work with on a consistent basis have

said, ‘I’m so exhausted. I have to be on call, or I have to be at the hospital 24 hours a day, seven days a week, because there are so many questions.’”

Indeed, hospitals and health systems have relied on their infection preventionists to answer an onslaught of questions. How do we isolate patients? Can we reuse this medical equipment? Can we co-room patients together, and what’s the risk associated with that? How do we get the right air filtration in place?

Infection preventionists have oversight into all those things in a hospital system, said Carver. “We think about them often as just the people that report hospital acquired infections or do hand hygiene policing. But they have to be experts across the board in things like ventilation, sterilization and disinfection of the environment and of medical devices. And the impact of the various organisms on different body systems.”

Infection preventionists as a profession are very close to retirement age. “The last survey that I saw indicated 55% of infection preventionists were at retirement age, which will leave us a huge gap,” Carver said.

In fact, Carver has worked with several health systems over the last few months who have said they need help finding an infection preventionist because they can’t adequately staff the position. “The reality is they’re just not out there. So, as we see people that have decided at the end of this pandemic that they can’t do this again, and don’t want to do this anymore, they’re either leaving the profession for other options or they’re retiring.”

### Filling the gaps

The role of infection preventionist, and who has filled that role, is evolving. In the

past, most infection preventionists started as nurses. They may have transferred from some other role into the infection prevention role. “For a long time, I think that was a qualifier of industry hiring practices,” Carver said.

Over the last decade, infection prevention has been moving into different disciplines. More people entering the role of infection preventionist may have an epidemiology, public health or a laboratory background. “I know a few IPs that are respiratory therapists by training,” Carver said. “We’re really trying to broaden what is the definition of an infection preventionist.”

A lot of health systems are also trying to tier their approach to infection prevention, Carver said. “If you think about it, just one part of what we do is surveillance – looking at lab results and determining in the clinical presentation, do they meet the definition of an infection? A lot of health systems are saying they can use a less experienced staff member for that.”

As a result, some health systems have created a role called an epi tech, which might be someone that’s not a nurse or does not have a higher-level clinical background, to fill the role of surveillance. The epi tech may transition up to an infection preventionist. “They’ve created tiers in their departments,” Carver said. “It also helps anytime you have that ladder of progression for people in our profession, certainly helps capture their attention.”

Salary is another lever for infection prevention. When hiring infection preventionists, infection prevention department leaders are competing against things like case management positions, where the employee can work 7 a.m. to 3 p.m., or they can work on the weekend and

grab a weekend differential. But in today's environment, infection preventionists have almost a 24/7 role. There are days they will have to be on call, late hours if an incident happens. They're constantly having to figure out how to protect the staff or patients.

"So, if you're going to choose, you're probably going to choose the role that pays a little bit more, and you're there 7 a.m. to 3 p.m. and then turn around and go home. The other factor a lot of organizations have been looking at is market salary. What do we need to do to really compete and get good talent in infection prevention roles?"

## Many infection preventionists worked around the clock, either extending workweek hours or fielding calls on the weekend. Dickey said for her, those extended hours started in late January and continued throughout the year.

Infection prevention is a very specialized discipline. There is a lot of education and preparation that goes into it, Carver said. "When you have a shortage of infection preventionists, that means if you have an IP or two that's left in your department, they of course have to pick up more. It means that they have to be pretty dedicated to the regulatory reporting that has to happen."

CMS takes data from NHSN and calculates payments or penalties based on that in the value-based purchasing program. So, if a hospital is limited in the number of infection preventionists it has available, that means the reporting has to be their focus. "You have to make sure that the data gets in so you're not penalized."

A shortage of infection preventionists means the hospital may lose the monitoring that needs to happen in the clinical

area. "You lose the expertise of that person being able to guide practice changes at the bedside," Carver said. "You lose that person monitoring the environment to make sure that you know things are being cleaned appropriately, that operating rooms are being turned over correctly. You lose that oversight when you're very limited and the only thing they can do is pay attention to the regulatory reporting programs. And how long are they going to stay in that position, if all they do is sit in the office and go through data and report it to the government?"

### A pathway to more IPs

In late March, APIC announced their intention to create an infection prevention and control curriculum for colleges and universities. APIC's IP Academic Pathway marks the first national effort to link undergraduate and graduate programs to the field of infection prevention and control, ultimately leading to certification in infection prevention and control.

"The pandemic has brought to light the tremendous need for trained infection preventionists in our nation's healthcare facilities," said APIC CEO Devin Jopp, EdD, MS. "While APIC has a robust competency model and other resources to support professionals already practicing in the field, a clear pathway into infection prevention and control careers does not currently exist for college and university students. Through IP

Academic Pathway, APIC plans to create an intentional track for infection prevention certification and degree programs. This will help not only the healthcare field, but also industries like entertainment, hospitality, and travel, which are increasingly hiring infection preventionists."

An APIC task force will develop the IP Academic Pathway core concepts, which will detail competencies needed to work successfully in infection prevention and control as outlined by the Certification Board of Infection Control and Epidemiology (CBIC). Once developed, the curriculum can be integrated into a higher education institution's course of study through their undergraduate, graduate, and continuing education programs.

"Creating the IP Academic Pathway is a national imperative," said Jopp. "As the leading organization in infection prevention and control, APIC is uniquely positioned to lead this initiative. APIC will be soliciting input from both the infection prevention and higher education communities and seeking university partners that are willing to help design and pilot the new program."

Dickey said they are seeing the need for infection prevention expertise well beyond the acute healthcare setting. "COVID has shown very clearly that there's a need for individuals who have this expertise in long-term care, home care and in other types of settings, even if it's just to advise," she said.

"There are even industries outside of healthcare that have asked, 'How do you operationalize some of these infection prevention measures, and what does that look like for my business?'" Dickey continued. APIC wants to help educate people on the role of infection preventionists. "So, I think that there's actually quite a bright future and a strong future for people that are attracted to infection prevention." ■



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# COVID Repercussions

Infection preventionists were monitoring for rising cases of HAIs amid the pandemic.



**While the U.S. healthcare system has been so focused on combatting COVID-19,** infection preventionists have been worried of a rise in cases of other infectious diseases or hospital-acquired infections.

“We are still looking at the data, but the most concerning is bloodstream infections,” said Linda Dickey, RN, MPH, CIC, FAPIC, Dickey Consulting LLC and president-elect of the Association for Professionals in Infection Control and Prevention (APIC). “It’s too early to know what the correlation might be specifically related to COVID care. Initially in the pandemic we saw a real drop in the volume of patients because they were afraid to come in for care, and you can blame that on COVID. But it does nobody any good if they need emergency care and they are scared to come in.”

In fact, according to a recent study published in *Infection Control & Hospital*

*Epidemiology*, HAIs in hospitals may have increased after several years of declining cases.

From 2015 to 2019, there was a sizable decline (31%) in the national standardized infection ratio (SIR) for central-line–associated bloodstream infections (CLABSIs). To understand the impact of the early months of the COVID-19 pandemic on central-line–associated bloodstream infections (CLABSIs) nationally, Prachi R. Patel, M.P.H., from the U.S. Centers for Disease Control and Prevention, and industry colleagues studied SIRs for the second quarter of 2020 (2020 Q2: April, May, June) were compared to those from 2019 Q2.

From the analysis, which included 13,136 inpatient units from 2,986 acute-care hospitals, a 28% increase was observed in the national SIR, from 0.68 in 2019 Q2 to 0.87 in 2020 Q2.

Critical care units had the greatest percentage increase (39%) in SIR, while ward locations experienced the second highest increase (13%). Critical care locations had the highest number of CLABSIs in 2020 Q2, with 1,911 events. Hospitals in all bed-size categories exhibited an increase in SIR, according to the authors.

“Infection control practices changed in many healthcare settings during the pandemic to accommodate increasing numbers of patients and to mitigate shortages of personal protective equipment, supplies, and staffing,” the study authors wrote. “Reducing the frequency of contacts with patients and of maintenance activities for central venous catheters (eg, chlorhexidine bathing, scrubbing the hub, site examinations) as well as alterations to processes of care (eg, risking disrupting catheter dressings when placing patients in a prone position) all have the potential to contribute to an increase in CLABSIs.”

For more on the study, visit: [www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/impact-of-covid19-pandemic-on-central-line-associated-bloodstream-infections-during-the-early-months-of-2020-national-healthcare-safety-network/F4FBF17FE70FED931B54097A2AC400C9](https://www.cambridge.org/core/journals/infection-control-and-hospital-epidemiology/article/impact-of-covid19-pandemic-on-central-line-associated-bloodstream-infections-during-the-early-months-of-2020-national-healthcare-safety-network/F4FBF17FE70FED931B54097A2AC400C9). ■

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# Lessons Learned: New Realities of Non-acute Supply Chain

5 best practices from U.S. Supply Chain leaders to carry healthcare forward



**While the role of supply chain leaders had been steadily extending beyond the hospital and into the non-acute care (e.g., clinics, physician offices, long-term care facilities), COVID-19 forced a sudden and significant leap in responsibility.**

Non-acute facilities found themselves on the frontlines of the pandemic, facing patient surges and significant demand for personal protective equipment (PPE) and other supplies as they perform testing, provide treatment and administer vaccinations. Support from supply chain has been critical to the success of the non-acute continuum.

What has supply chain learned from this experience and what best practices will they carry forward?

McKesson recently hosted two virtual forums with U.S. healthcare supply chain leaders to learn how they have

been managing the new realities of the non-acute supply chain. The forums featured three panelists: Sean Poellnitz, vice president of supply chain at Mosaic Life Care in St. Joseph, Mo.; Darrick Adams, director of non-acute supply chain at AdventHealth in Altamonte Springs, Fla.; and Tyler Ross, director of supply chain operations at Novant Health in Charlotte, N.C.

They collectively explored what's worked/hasn't worked for their organizations, and what lasting changes must be made to strengthen non-acute supply chain resiliency in the future.

Here are five key learnings from the sessions.

## 1 Care is shifting, and skills must shift with it

The pandemic has placed a significant burden on non-acute, but it has also presented a unique opportunity to accelerate the expansion of care beyond the hospital – something the industry has been working to achieve for quite some time.

As supply chain leaders have been increasingly called upon to support the non-acute, it has brought to light how the role must evolve: the need for new strategies, talent and skills to support the expansion of care. A growing number of organizations are appointing dedicated non-acute supply chain leaders. Among forum participants, 50% said yes, this role existed before COVID; 10% said yes, new as a result of COVID; and 40% said no.

Poellnitz described the need for supply chain talent that can support shifting care models:

“Do I have the business case to invest in the right talent to support new and emerging healthcare models? The seeds are planted and they're growing. We need to ask the right questions to support long-term growth. What are the partnerships and technologies that will fuel that growth?”

Forum participants pointed to specific skills required of non-acute supply chain leaders: strategic sourcing abilities, lab/diagnostic testing support, and

capabilities to manage products/services to support new care models, such as hospital at home.

Several participants described their shift to support hospital at home programs and more assisted living and independent spaces/services to meet growing community needs. From contracting with home mobile imaging providers, to converting skilled nursing facility bed licenses for assisted/independent living use, the mix of products/services to support both of these areas are much different than hospital/SNFs.

Poellnitz, who worked in transportation and defense supply chain before entering healthcare, says the profession needs people with real world experience regardless of the industry.

“The question is no longer, ‘do you have healthcare experience?’ but rather ‘can you source products?’ If you can source, we need you. It doesn’t matter what industry you come from. It’s more about finding talent who can get things done.”

## 2 Trusted relationships serve as a safety net

Traditionally relationships in healthcare have been wrought with competition and distrust. Suppliers are seen as trying to get the most money out of providers, while providers are seen as trying to squeeze every last penny out of prices. Among healthcare organizations there is competition for patients and a reluctance to share information, let alone resources.

When the pandemic hit everyone had to put aside their differences for the greater good. As panelist Tyler Ross stated: “It wasn’t provider versus supplier but rather everyone coming together to help America win.”

Forum participants agreed that the industry must maintain and even strengthen these relationships long-term and not fall into old ways of thinking and operating.

Panelist Darrick Adams described how his organization is opening its first physician offices for patients aged 65+. They worked with their distribution partner to establish a standard list of items they need to open those sites. Now, anytime a new site opens, he can bring up that “shopping list”, adjust quantities based on the individual site and have the products shipped to the facility.

“Our organization has been active with thinking ahead to what the care landscape will look like,” said Adams. “We already have better processes in place through our work with our distribution partner that will help carry us forward.”

## 3 Preparedness takes visibility and data

As we have all witnessed, the shift from just in case to just in time inventory management backfired in the face of pandemic supply shortages.

“Overnight it wasn’t about us being this lean supply chain anymore because lean is risky,” said Poellnitz.

Adams explained how one of his system’s 14 medical groups bought huge amounts of a product when COVID hit, leaving the other groups with a drained allocation.

Participants stressed the need for real time visibility into supply chain and business intelligence, including dashboards to make informed decisions. Those teams that already had this type of capability were more successful in acquiring needed supplies.

Poellnitz’s team experienced frustration when trying to perform predictive

analytics finding there was “no hard science to it.” When he was asked, “do we have supplies?,” he realized the real question should be “can we create the right business models to forecast risk?” He is currently working with finance to develop dashboards to address this need.

Ross said his team is developing robust planning and redundancies to future address shortages as they arise:

“I hope coming out of this we move from traditional just in time methodology for inventory management and product availability. Just in time is important but again we’re not retail, so we need some sort of safety valve to absorb disruption.”

To better prepare supply chains to weather future challenges, the participants agreed that supply chain leaders must have a seat at the table to help develop and implement preparedness plans.

## 4 Safely expanding the scope of suppliers

The leaning of inventories and standardization of supplies positioned the U.S. healthcare industry for disaster in the time of crisis.

When traditional supply sources dried up early on in the pandemic, providers began searching for alternatives. There are countless stories of supply chain leaders desperately ordering N95 respirators from unknown companies never to get the products or receiving products that were unusable/unsafe.

Those in the forum described the challenges they faced and how they turned to distributor partners and other healthcare organizations for guidance on sourcing.

Because manufacturing in the world’s central supply hub, China, had come to a halt, many providers also turned to suppliers

on-shore/nearshore to the U.S. as a more reliable channel. Participants shared stories of local distilleries that produced hand sanitizer, and textile companies shifting production to face masks and gowns. As one participant stated: “The label ‘Made in the U.S.A.’ has never been so sought after.”

Forum participants felt the trend toward supplier network expansion and a broader domestic supplier portfolio will continue. They called for greater industry collaboration among providers, suppliers and distributors where they share sourcing guidance with one another.

### 5 Clinical collaboration required throughout the continuum

There has been growing talk in healthcare about the need for a clinically integrated supply chain where clinicians and supply chain professionals work more closely to make informed product decisions.

The pandemic has driven greater clinical/supplier integration as these parties have been required to work together to address supply shortages, inventory management, substitutions, etc. Forum participants believe this is a positive move and one that should expand.

Supply chain leaders have found themselves engaging with clinicians in offices, clinics and other non-acute sites where they previously had never set foot, offering their expertise, knowledge and connections.

The importance of clinical collaboration, beyond product selection, but also product usage, was discussed as a vital component in helping to conserve supplies and prevent future shortages. Having these parties work together to develop guidelines for PPE usage, for example, could reduce shortages and demand through changing clinical practices.

### Conclusion

The COVID-19 pandemic forced many changes in healthcare, some that had been in slower progress for quite some time.

The greater reliance on non-acute settings for diagnosis and treatment of virus patients highlighted the critical role these facilities play in the broader care continuum. It is clear that the attention on non-acute will continue as health systems invest in care sites outside of the hospital, including the allocation of supply chain resources to support their needs.

“Non-acute has been stressed with a lot of change but it is a major growth area

for health systems,” said Greg Colizzi, vice president of health systems marketing, McKesson, who led the forum. “The pandemic has provided the opportunity for supply chain leaders to identify proven practices throughout the continuum that will help carry us forward.”

McKesson is focused on helping supply chain leaders navigate the new realities of managing the non-acute supply chain. The company’s mission is to be a solution to support a “care-anywhere” approach as the delivery of care continues to evolve – one patient, one product and one partner at a time. ■

## Top 11 considerations for supplier sourcing

Supply shortages during the COVID-19 pandemic left healthcare supply chain teams scrambling to identify alternative suppliers with safe and effective product substitutions. Some healthcare organizations found themselves at the mercy of fraudulent suppliers that failed to deliver products or sent unusable/unsafe items.

Here are 11 questions to ask when vetting a supplier and its products:

1. Does the company have proper FDA registration (e.g., proper product code, certifications, etc.)?
2. Can a quality assurance audit of the factory be conducted?
3. What are the options in the event of poor product quality, recall, etc.?
4. What is the company's level of product liability insurance and indemnification?
5. Is there a clear and clean chain of custody (factory direct or broker chain)?
6. Will product be inspected before shipment? If so, by whom?
7. Are samples – not pictures – available for immediate review?
8. Who will the financial transaction be with? Is this a different entity than the stated factory?
9. Are there pre-payment requirements?
10. What recourse is available if there are product issues or if product is never shipped?
11. Who will manage logistics, customs clearance and statewide transportation?

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# *The Journal of* **Healthcare** C O N T R A C T I N G

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# Pandemic pushed IPs to the forefront as subject matter experts

IPs have served as the clearing house for new products during the COVID-19 crisis.

**Editor's Note:** *The participation of those in the following article does not constitute an endorsement of the sponsor's products or services.*

**As the COVID-19 pandemic raged, infection prevention information constantly** changed. The Centers for Disease and Control and Prevention's (CDC) interim guidance was continuously updated based on available information about COVID-19 and the situation in the U.S. All recommendations were organized into recommended infection prevention and control (IPC) practices for routine healthcare delivery during the pandemic and recommended IPC practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection.



Despite the previous best efforts of infection preventionists (IPs), if you asked some other healthcare professionals their opinions of infection prevention before the COVID-19 crisis, you might have heard the word hinderance. Yet when a worldwide pandemic arrived few judgments were made without the input of IPs. Decisions around personal protective equipment (PPE) use and reuse, visitors, cleaning and disinfection all demanded the expertise of IPs.

Patients with suspected SARS-CoV-2 infection were seen under nurse-directed triage protocols to determine if an appointment was necessary or if the patient could be managed from home. In some settings, patients opted to wait in a personal vehicle or outside the healthcare facility where they were contacted by mobile phone when it was their turn to be evaluated. Other facilities identified a separate, well-ventilated space that allowed waiting patients to be separated by six feet or more.

Because of this, the public also became much more aware of standard precautions in infection prevention. Patients became more involved in their own care and were more apt to remind healthcare staff about prevention practices like hand hygiene.

"The most striking change was infection prevention moving out of the healthcare setting," said Ivan Gowe, an infection preventionist at Pardee UNC Health Care in Hendersonville, N.C.

Patients can also bring unrealistic and non-evidence based expectations into their care through their elevated recognition. But that's a side effect IPs are willing to live with if it means patients are more informed.

"The lack of knowledge surrounding SARS-CoV-2 was disconcerting to the public and many people were looking for ways to protect themselves," said Nancy Kerr, a registered nurse (RN) and manager of infection prevention at Hackensack Meridian Health in New Jersey. "As healthcare workers, we knew what to do but the general population wasn't so sure."

And just like that, the pandemic put the spotlight on infection prevention programs and the role of IPs.

"I've seen more emphasis on infection prevention in communities and hospitals in one year than I've seen in my 30 years

in this profession,” said Eileen Sherman, system director of infection prevention at Main Line Health in Philadelphia.

Many tenets of infection prevention, such as hand hygiene, were not taken seriously by the public before the pandemic. But as the crisis intensified, communities sought knowledge on hygiene, masking, social distancing and vaccinations.

IPs were viewed as subject matter experts within and outside of the hospital walls.

“It’s nice when I tell people what I do and they have an idea what that means and they express gratitude,” Gowe said.

### Shifting roles of IPs

Daily leadership decisions persist more than a year after the pandemic’s beginning.

“I continue to support an active system COVID-19 command center,” Sherman said. “The IP team makes rounds daily to provide support to the clinical team in applying isolation precautions and assessing exposure risks.”

New guidelines from the CDC and state health departments are constantly reviewed and toolkits are updated to support clinical teams on compliance with the latest guidelines.

“We got a glimpse into guideline developments and learned how to develop safe practice measures for ourselves,” Gowe said.

IPs wanted to ensure that their clinical staffs were protected. “PPE was probably the most significant concern,” Kerr said. “We vetted substitute products to ensure they were in line with NIOSH, OSHA, FDA and CDC guidelines. In addition, we looked to reprocessing or sterilizing other PPE such as N95 masks if we couldn’t get supplies.”

IPs played many different roles as subject matter experts. “I felt partially

responsible for quelling fears in the staff,” Gowe said. “We have been professional coaches and repositories of evidence.

Many conversations with healthcare workers surrounded concern for their families rather than how to don and doff PPE. That created a camaraderie with the staff.”

Rapid changes became the norm. “Our partnership with our process improvement team became critical to responding and operationalizing workflows that changed frequently with each new challenge the pandemic presented. Senior leadership support empowered the team,” Sherman said.

### Supply chain partnerships

Supply chains increased production of PPE within the existing domestic manufacturing environment and using the Defense Production Act. Reliance on nontraditional manufacturers and suppliers as an alternate sourcing channel has been successful. Plus, traditional suppliers and sourcing channels are now meeting PPE needs and the larger health systems have sufficient PPE inventory levels.

“Our supply chain team have been tremendous partners in supporting the COVID-19 response,” Sherman added. “Sourcing for alternate products such as N95 respirators has been a labor of love.” Sherman said the IP team partners closely with the supply chain team at Main Line Health to evaluate all PPE and disinfection products before they are purchased. The two teams collaborate to communicate with staff regarding new products and to ensure education is provided to the end user.

Similarly, Kerr said the IP team at Hackensack Meridian Health continually cooperated with supply chain and clinical teams. “My role has always been

in a leadership capacity, but the pandemic catapulted it into the prime resource and clearing house,” Kerr added.

“IPs were sought after by many vendors of new IP products during this pandemic,” Sherman said. “It was a difficult time to evaluate some innovative ideas while being solely focused on keeping patients and staff safe. We reviewed various disinfection options for the reuse of N95 respirators and considered various disinfecting products on different surfaces.”

As long as the FDA emergency use authorizations (EUAs) remain in effect and as more alternate sourcing channels emerge, the healthcare field must remain vigilant in vendor vetting programs. Hospitals utilizing nontraditional suppliers must follow their own formal vendor approval policies.

### Preparedness

That vigilance and preparedness is vital for the future of healthcare planning. IPs must be embedded in emergency preparedness activities in a robust manner. Evaluation of PPE and other IP-related products to identify alternatives will continue to be an important activity for IP and supply chain teams.

“The development of an IP professional’s competency in leadership during a pandemic or crisis response should be included in all good IP programs,” Sherman said.

Kerr added that educational awareness on emerging infectious diseases and more prevention initiatives should be promoted. “People need to understand how outbreaks and clusters are mitigated and that we all have a responsibility to do our part, even if it means personal restrictions and inconveniences,” Kerr said. ■

# How Premier Has Ensured Access to Shortage Drugs During COVID-19

**Drug shortages have long plagued U.S. healthcare providers with more than 250 shortages** over the past few years.

Today, waves of pandemic-induced [supply chain challenges](#) are compounding the issue, at times leaving providers struggling to secure therapies for patients.



Through pioneering models that create market stability and security, Premier, a leading healthcare improvement and technology company, has been a long-time leader in addressing shortages and building greater drug supply chain resiliency – a commitment we've continued through COVID-19.

## Remedies to Cure an Unhealthy Market

While shortages are triggered in a number of ways, a 2019 [Food and Drug Administration \(FDA\) report](#) points to economics as a main driver. For example:

- › About 40% of generic drugs are supplied by a single manufacturer.

- › Almost all shortage drugs are older, low-cost generics costing less than \$9/dose and some as little as \$1/dose.
- › Because these products don't generate blockbuster profits, manufacturers are less willing to invest capital to improve quality, build redundant capacity or source safety stock.

It's this dynamic between lack of profitability and lack of suppliers that leads to a fragile market not strong enough to handle fluctuating demand – especially during a pandemic or other crisis.

Through [innovative programs](#) that target these root causes, Premier members bring supply and price stabilization to the

market by identifying priority shortage medications and engaging suppliers in aggregated buying contracts over the long term. This creates a positive ripple effect, giving manufacturers proper demand signaling, predictable revenue and the surety needed to increase production or move into new markets.

Overall, Premier's drug shortage programs aggregate \$684 million in total generics spend from 2,700 hospitals across the nation.

As of April 2021:

- › We've created the industry's only comprehensive, multi-faceted drug shortage program with more than 330 high-risk products protected through the [ProvideGx](#) and [PremierProRx](#) programs.
- › Our members have weathered demand spikes of [150% or more](#) since March 2020 – with limited interruptions in supply.
- › Efforts have paid off as six products added to [ProvideGx](#), including [metoprolol](#) and [cysteine](#), have since been delisted from the [FDA drug shortage list](#).

Yet alongside case spikes, resumption of elective procedures and ongoing stockpiling efforts, our nation's drug supply remains precarious. As a result, Premier is continuously monitoring weekly fill rates for more than 250 drugs necessary for COVID-19 care

and requiring contracted manufacturers to retain sufficient safety stock of both active pharmaceutical ingredients (APIs) and finished medicines.

## Bringing Shortage Drugs Back to Market in 2020

Many of the drugs in shortage we saw in 2020 were impacted by COVID-19 therapeutic demands – including demand for anesthetics and other medicines used to ease intubation.

According to a November 2020 Premier analysis, the top 10 drugs that experienced the biggest demand spikes were those used to support mechanical ventilation. Fentanyl, for instance, a controlled substance often used to provide pain relief to COVID-19 ventilated patients, saw a 7.5X demand surge during peak periods.

Together with our members, Premier is building a more robust and resilient supply chain by ensuring that vital medications supplied through our programs are available to save the lives of critical COVID-19 patients:

- › Through a partnership with Pfizer, ProvideGx added fentanyl and four other drugs that are not only essential during the pandemic, but are also vital for routine and elective care longer term.
- › Diprivan® (propofol), another critical sedation drug, experienced a 5X demand spike in the spring of 2020 per Premier data. Stock available through prime wholesalers was gone in less than two weeks, and many

providers were stuck scrambling for this product. In July 2020, ProvideGx introduced Diprivan to its portfolio.

- › Dexmedetomidine was added to the program, stabilizing the long-term supply of yet another medication needed to care for the most acute COVID-19 cases. According to Premier data, dexmedetomidine demand in April 2020 increased more than 360 percent when compared to the same period in 2019, and providers typically only received about 62 percent of what they ordered.
- › The program gives members access to sterile water, which has seen average daily usage increase by 350% from May 2020 to early 2021, due to its use in COVID-19 patient ventilation and a variety of other patient care settings.
- › Prior to the pandemic, Premier added a line of emergency syringe products, which have proven vital for providers administering COVID-19 vaccines.
- › Beyond essential COVID-19 products, ProvideGx brought in three cephalosporin antibiotics, creating sustainable supply of these medicines commonly used for routine patient care and treating bacterial infections.

Premier's drug shortage programs are proving their ability to more effectively deliver product to members and patients in and out of a pandemic.

In addition to shared commitments from our members, program requirements include supply source visibility and sourcing diversity, including reporting

criteria on both finished dose manufacturing sites as well as APIs sources. Leveraging AI and machine learning, Premier also offers technology to aggregate pharmacy spend data – enabling health systems to better manage costs, generate efficiencies and improve inventory stability.

This greater transparency yields a diverse and balanced approach. It allows for better contingency planning, helping our members and patients get supply of the basic, lifesaving medications they need, when they need them.

Protecting patient care and the health of our communities is at the heart of our mission.

This past year has unquestionably placed unprecedented demand on the pharmaceutical supply chain.

While drug shortages continue to be a pervasive problem for patients and their providers, Premier and its member hospitals are taking a leadership role, stepping up to systematically address the root causes and provide the right economic models that incent manufacturers to increase supplies, invest in redundancies, enter or re-enter markets and explore new therapeutic categories for innovation.

Through our programs, Premier members have experienced exclusive supply protection with access to a broader range of shortage products than anyone else in the market. Although there is still much to do to fix global shortages, we'll continue to fight for resolving medications on the shortage list and protecting patients from drug supply disruption.

Learn more about Premier's pharmacy solutions. ■

Jessica Daley, Vice President, Strategic Supplier Engagement, Premier and Wayne Russell, Vice President, Pharmacy, Premier



# A Reset for Infection Prevention Protocols

Infection prevention took a hit this past year, but rebuilding is already taking place

**Is it fair for Medicare to penalize the bottom 25% of hospitals because of patient infections or other avoidable medical complications?** Fair or not, in February, the Centers for Medicare & Medicaid Services did just that, announcing that 774 hospitals would lose 1% of their Medicare payments over the next 12 months (based on pre-COVID performance, from mid-2017 to 2019.) It's part of Medicare's Hospital Acquired Condition Reduction Program.

The American Hospital Association believes the six-year-old program is flawed, for a number of reasons: Some quality measures are inaccurate, and the program fails to take into account patient safety improvements that hospitals have made, says AHA. What's more, it unfairly penalizes teaching hospitals, large hospitals and small hospitals.

Even the Medicare Payment Advisory Commission, which provides the U.S. Congress with analysis and policy advice on the Medicare program, has criticized the so-called "tournament model" penalty system, in which providers are scored relative to one another, "despite the potential availability of clear, absolute and prospectively set performance criteria."

The HAC Reduction program is just one of several government programs that are intended to reduce healthcare-associated infections. Others include the National Action Plan to Prevent Health Care Associated Infections, the Agency for Healthcare Research and Quality (AHRQ) Safety Program for Improving Antibiotic Use, and CDC's U.S. National Action Plan for Combating Antibiotic-Resistant Bacteria.

Do we need so many programs to monitor and (it is hoped) reduce healthcare-acquired infections? Do they work? And even if they did, how has COVID-19 affected them?

"Each of these programs provides a framework for the infection control and



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

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- ✓ THERMOMETERS
- ✓ KN95 AND N95 MASKS

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\* While supplies last

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

epidemiology communities in hospitals and other settings,” says Lynne Batshon, director of policy and practice for the Society for Healthcare Epidemiology of America (SHEA). “Adoption of new measures is a key component toward progress, [but] the measures have to be the right measures, they must be reliable, and they must be properly risk-adjusted.”

### Progress

The CDC’s 2019 National and State Healthcare-Associated Infections Progress Report offers some evidence of progress. At the national level, acute care hospitals achieved:

- › About 7% decrease in central-line-associated bloodstream infections (CLABSIs) between 2018 and 2019. (Largest decrease: 13% in NICUs.)
- › About 8% decrease in catheter-associated urinary tract infections (CAUTIs) between 2018 and 2019. (Largest decrease in ICUs: 12%.)
- › A 2% increase in ventilator-associated events (VAEs) between 2018 and 2019. (Increase observed in ICUs.)
- › No significant change in hospital onset Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremias between 2018 and 2019.
- › About 18% decrease in hospital onset *C. difficile* infections between 2018 and 2019.

In addition, a study published in February 2021 found that hospitals using the AHRQ Safety Program for Improving Antibiotic Use decreased usage of antibiotics and reduced *C. difficile* infections, a potentially deadly condition of the colon and digestive system. More than 150 million antibiotic prescriptions are written annually in the United States, according to AHRQ. If antibiotics are overused, they can become less powerful over time as some bacteria grow resistant. (The Centers for Disease Control and Prevention estimates that at least 2.8 million infections and 35,000 deaths

**‘This won’t be our last healthcare crisis. Healthcare systems need to be prepared to maintain and sustain their existing infection prevention programs and techniques.’**

## COVID collides with safe protocols

In a case report, CDC researchers and the New Jersey Department of Health described an outbreak of carbapenem-resistant *Acinetobacter baumannii* (CRAB) at an unnamed New Jersey hospital, which affected 34 patients and was linked to 10 deaths. Investigation of the outbreak, which occurred during a COVID-19 surge that lasted from March through June 2020, found that pandemic-related resource challenges severely limited the hospital’s infection prevention and control policies:

- › To conserve equipment during the surge, the hospital’s respiratory therapy unit instituted a policy to extend the use of ventilator circuits and suctioning catheters for individual patients, replacing them only if they were visibly soiled or malfunctioning. (Prior to March 2020, ventilator circuits and suctioning catheters were changed at specified intervals of every 14 days and every three days, respectively, unless malfunctioning or visibly soiled.)
- › To conserve PPE, gown use was suspended for care of patients with vancomycin-resistant *Enterococcus* spp. and MRSA.
- › Anticipating shortages, the hospital adopted an extended-use PPE protocol for N95 respirators and face shields.
- › To prioritize personnel resources, activities of the multidrug-resistant-organisms (MDRO) workgroup were suspended, along with biweekly bedside central venous catheter and indwelling urinary catheter maintenance rounds.
- › Routine audits of appropriate PPE use, hand hygiene compliance, and environmental cleaning were temporarily discontinued.
- › Responding to COVID-19-related care needs also resulted in unintentional changes in standard practices, including less frequent patient bathing with chlorhexidine gluconate and a 43% reduction in ICU CRAB screening tests.

a year are caused by antibiotic-resistant bacteria in the United States.)

### The COVID impact

Perhaps not surprisingly, COVID has had a dramatic impact on providers' ability to prevent healthcare-associated infections, says Batshon. Particularly in facilities and locales that experienced surges in the coronavirus, professionals who had been responsible for overseeing infection prevention protocols had to turn their attention to caring for COVID-19-positive patients. "We learned that without sustained infection prevention programs, even in places where programs had been effective, quite frankly, you're going to see slippage," she says. In addition:

- › Some hospitals had to staff provisional ICU units with people who weren't familiar with the ICU or its infection prevention protocols.
- › Staff were overworked, exhausted, and forced to care for more patients than they normally would.
- › Many hospitals experienced shortages of personal protective equipment.

The COVID-19 pandemic has required hospitals to take unprecedented measures to maintain continuity of patient care and protect healthcare personnel from infection, the CDC noted in December. Yet "[t]his outbreak highlights that multidrug-resistant organisms can spread rapidly in hospitals experiencing surges in COVID-19 cases and cause serious infections in this setting"

"What I'm hearing from experts is that a lot of ground was lost since 2020, when a lot of energy was directed toward patient safety," says Batshon. "And this won't be our last healthcare crisis. Health-

care systems need to be prepared to maintain and sustain their existing infection prevention programs and techniques."

In December 2020, SHEA joined the Association for Professionals in Infection Control and Epidemiology and the Society for Infectious Diseases Pharmacists in requesting that CMS refrain from using 2020 quality data for the HAC Reduction Program for payment determination. In a letter to the deputy secretary of the Department of Health and Human Services, representatives from the three organizations wrote, "As the number of COVID-19 cases surge,

hospitals are becoming overwhelmed with more patients than can be managed with typical care standards. Requiring reporting and enforcing penalties on hospitals related to quality measures during the pandemic will only shift critical resources to non-essential surveillance activities and result in reduction of resources and funding available to support necessary patient care and staffing."

A CMS spokesperson told *The Journal of Healthcare Contracting* that CMS will make an announcement on the HAC Reduction Program for the fiscal year 2022 program year later this year. ■



## Counting the cost of infections

According to a CDC report, more than 2.8 million antibiotic-resistant infections occur in the U.S. each year, and more than 35,000 people die as a result. In addition, 223,900 cases of *Clostridioides difficile* occurred in 2017 and at least 12,800 people died.

Additionally, according to a collaborative CDC study, the estimated national cost to treat infections caused by six multidrug-resistant germs identified in the report and frequently found in health care can be substantial – more than \$4.6 billion annually.

"Dedicated prevention and infection control efforts in the U.S. reduced deaths from antibiotic-resistant infections by 18% overall and by nearly 30% in hospitals. However, the number of people facing antibiotic resistance is still too high," the CDC said. "More action is needed to fully protect people."





# Top Non-Acute Supply Chain Leaders

**More than ever before, non-acute facilities play a critical** role in delivering care and reaching today's patient population. With those non-acute facilities comes a host of unique challenges, and opportunities.

In the following article, *The Journal of Healthcare Contracting* would like to recognize some of the leading supply chain leaders in the non-acute space, either for exclusive roles in a non-acute specific supply chain team, or bridging non-acute with traditional acute care supply chain.

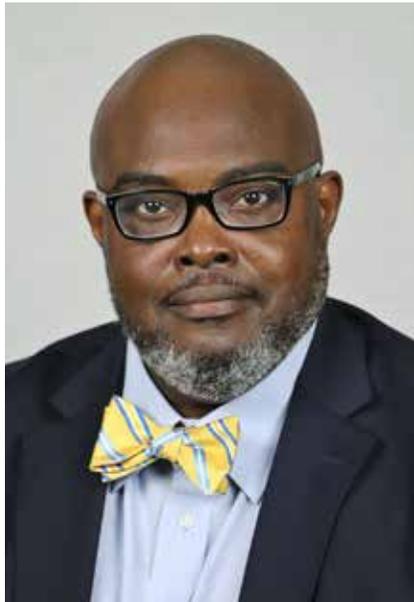
- › **Darrick Adams**, director, non-acute, supply chain, AdventHealth
- › **Karla J. Butts**, MA, executive director, client executive team, The Resource, Engineering, and Hospitality Group, Providence St. Joseph Health, Renton, Washington
- › **Steve Faup**, divisional director, supply chain, for Capital Health, Trenton, New Jersey
- › **Tyler Ross**, MS, director, supply chain operations, Novant Health, Kannapolis, North Carolina
- › **Ruvini DeFonseka Schultz**, manager ambulatory supply chain & pharmacy operations, Centura Health, Centennial, Colorado

*A special thank you to McKesson for sponsoring The Journal of Healthcare Contracting's 2021 class of Top 5 Health System Alternate Site Executives.*

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# Darrick Adams

Director, non-acute, supply chain, AdventHealth



**By removing PPE from our formulary, we ensured that only medical group directors were able to place orders.**

***JHC:* The Journal of Healthcare Consulting:**

**Why do you believe non-acute, alternate site locations are vital to not only a health system or IDN, but U.S. healthcare in general?**

**Darrick Adams:** I believe that non-acute is vital to U.S. healthcare in general because of the access it has created for patients. Patients can schedule appointments, provide symptoms, and be called when it's time to see the doctor. This makes healthcare easy and efficient, which should lead to better overall outcomes.

***JHC:* What are some keys to success for supply chain teams that may be unique to non-acute?**

**Adams:** I believe the keys to success for supply chain teams are: There are several ways that supply chain teams can find success. By understanding the category of your shipment, you can do quick product turnaround with a low unit of measure. Additionally, understanding the people you work with on a daily basis is a great way to drive success. You can cultivate internal and external relationships with others in the industry to leverage for tools and best practices. We also leverage distributor partners to drive business. With partners, you both need to be equally invested to get the benefits.

***JHC:* How was your department affected by COVID-19? What type of disruptions did you see?**

**How were you able to navigate?**

**Adams:** Our department was affected adversely by COVID-19. We experienced

a lot of the same disruptions you saw across the board in healthcare. Hoarding, supply shortages, and bad suppliers just to name a few. We were able to navigate those disruptions with several methods. First, we limited ordering access. By removing PPE from our formulary, we ensured that only medical group directors were able to place orders. We also sourced alternative suppliers, developing relationships with new suppliers to get access to additional PPE outside of our contracted sources. Then, we created a bad supplier list. We worked with peer health systems to create and refine a list of fraudulent suppliers to avoid in the future.

***JHC:* Has the perception/integration by executive leadership of alternate sites within a health system or IDN changed in the last few years?**

**If so, could you explain?**

**Adams:** I would say that it has been the same. We are fortunate because I feel our leadership has always been forward-thinking about this space. Non-acute figures prominently in our growth plans for the future.

***JHC:* What project or initiative are you looking forward to implementing now or in the near future?**

**Adams:** The project that I'm looking forward to implementing is our Senior Care concept Well 65+. It launched in April and is off to a great start. I am looking forward to this being the next successful concept in our portfolio.

# Congratulations to the Top Non-Acute Supply Chain Leaders

- Darrick Adams, AdventHealth
- Karla J. Butts, Providence St. Joseph Health
- Steve Faup, Capital Health
- Tyler Ross, Novant Health
- Ruvini DeFonseka Schultz, Centura Health

Patient care may look different now, but the impact you make does not go unnoticed. Your leadership in driving change, process improvements, clinical integration and innovation to support the non-acute supply chain is unmatched. We appreciate all that you do to care for the communities that we serve.

# Karla J. Butts

Executive director, client executive team, The Resource, Engineering, and Hospitality Group, Providence St. Joseph Health, Renton, Washington



***The Journal of Healthcare Contracting:* Why do you believe non-acute, alternate site locations are vital to not only a health system or IDN, but U.S. health care in general?**

**Karla Butts:** Health equity is a great concern for me personally and I believe non-acute/alternative locations help bridge the gap. These locations expand the clinical reach and support to communities where logistics alone may present a barrier to access care. By providing increased access, we build a coordinated care network for patients to ease their care planning and provide an opportunity to reach their full health potential.

At Providence, our promise is Know Me, Care for Me, Ease My Way. For our organization our non-acute/alternative locations are vital in delivering on this promise; delivering high quality care directly in the communities we serve, providing the right level of care for every event and stage of life.

**We created a pandemic forecasting tool to understand inbound and anticipated demand incorporating the patient volume data from our system to anticipate changes in volume trends.**

***JHC:* What are some keys to success for supply chain teams that may be unique to non-acute?**

**Butts:** Non-acute systems can be a large footprint, so pushing out uncontrolled variation and inefficiencies through modernized approaches in product standardization, single channel distribution models, and leveraging data and analytics are key to overall non-acute supply chain success. Having a cross-functional supply chain team that incorporates end to end service delivery – inclusive of all functions from procure to pay has proved to be successful as we expand our footprint within our own non-acute space.

Another key is understanding the inherent complexities of this space. Non-acute locations are often comprised of multiple groups and providers serving several locations, delivering diverse levels of care over large geographical footprints. Our organization

has over 1,000 combined locations covering seven states that include clinics, ASCs, and post-acute service lines. It is critical to understand the overall supply chain needs and potential barriers including logistical concerns for these locations. This level of understanding and familiarity with our locations drives how we design our overall non-acute strategy.

Understanding how vendors serve in this environment is another key factor. Recognizing not all vendors support or seek out non-acute footprints or if they do, they may have different pricing, distribution models, and service offerings that are separate from our acute agreements. This is an important consideration when shaping your strategy.

**JHC: How was your department affected by COVID-19? What type of disruptions did you see?**

**How were you able to navigate?**

**Butts:** As with all areas of healthcare we saw the largest disruption in PPE availability. To add to the challenge, we had to prepare to provide large volumes of PPE in a short period of time to sites that have historically not used full PPE including N95s as part of their day-to-day practice. The disruption also extended to items needed to properly sanitize locations to keep our patients and caregivers safe.

Another challenge was having real-time visibility to locations' on-hand inventory. Visibility is different from that of an acute setting; non-acute sites often do not have real-time inventory data feeds. To respond, we had to quickly gain an understanding of what the overall potential demand was going to be for established locations but also be fluid in planning for setting up

alternative testing sites as well as influxes in volumes that could shift within 24 hours in some markets.

To navigate these disruptions, we partnered with our strategic partners on a distribution model that was transparent and when needed we engaged in new relationships to source from new vendors (locally and globally) to bridge the gap. We created a pandemic forecasting tool to understand inbound and anticipated demand incorporating the patient volume data from our system to anticipate changes in volume trends. We also navigated demand planning by standing up processes to account for volumes needed in the non-acute space to navigate the increased demand due to little to no historical utilization of specific items.

## **Our standards model includes a multi-functional planning team, standardized formulary/product standards list, and a coordinated “white glove” site set up.**

**JHC: Has the perception/integration by executive leadership of alternate sites within a health system or IDN changed in the last few years?**

**If so, could you explain?**

**Butts:** I do believe the perception/integration has expanded over the last few years, understanding that the needs of our patients and communities are evolving and to meet that demand so must our delivery model. Historically care for patients has been centered at the acute facility level, but now we are seeing that model being deconstructed and remodeled around the patient and their needs by creating an overall delivery care model for our patients.

To meet that new model, we have added resources to our supply chain functional teams specifically to support non-acute service lines including client services, sourcing, procurement, operations and logistics just to name a few. We recognize the opportunity that presents for our customers and patients by building and supporting a holistic supply chain network.

**JHC: What project or initiative are you looking forward to implementing now or in the near future?**

**Butts:** We have a few exciting projects launching soon. One is launching a system formulary in our non-acute settings that will reduce variation, cost, and align to our continuum of care model.

We are also an expanding organization and have built an onboarding standards model that can be deployed for our express care and urgent care locations currently but will be expanding into other non-acute/alternative sites this year. Our standards model includes a multi-functional planning team, standardized formulary/product standards list, and a coordinated “white glove” site set up.

As we continue to expand our footprint, we are continually designing modernized processes and offerings to our network that connects them to our full portfolio available from within our supply chain functional teams.

# Steve Faup

Divisional director, supply chain, for Capital Health, Trenton, New Jersey

**Editor's Note:** *Steve Faup has responsibilities in both acute and non-acute supply chain for Capital Health.*



***The Journal of Healthcare Contracting:* Can you talk about how the non-acute side of the healthcare supply chain was affected by COVID-19? What kind of disruptions did you see, and then how were you able to navigate that?**

**Steve Faup:** We had the same problems other organizations did when it came to supply and availability. Sourcing alternative products was a large part of the focus. As a team, we vetted over 300 vendors that were new to our system, and most were new to healthcare supply. While the Medical Groups in person visits were reduced, excluding certain specialties, the need for the right product at the right time did not change. The biggest concern became the ability of hospitals and health systems that were not ready for telehealth, to become ready for telehealth in what felt like 15 minutes after the need arose.

**We feel very responsible to ensure that the healthcare system is supported, and can provide care for their patients. For us, our goal was to build a model to support the growth of our off site locations.**

***JHC:* Are you finding that supply chain is being invited into the conversations where care is going outside of the four walls of the hospital and into the community because of the disruptions?**

**Faup:** The simple answer is yes. A few years ago, there were 15 or so alternate site practices operating as part of this healthcare system. It was a smaller model, and something the Health Care System Leadership was talking about and building. Now we have over 60 practices spread out through two states and multiple counties. They continue to grow including Laboratory and Emergency Services.

We feel very responsible to ensure that the healthcare system is supported, and can provide care for their patients. For us, our

goal was to build a model to support the growth of our off site locations. For the non-acute and acute site services, we were working within a model focused on acute care service support. Prior to the pandemic, we began working to build a program dedicated to servicing the individual medical practices. During the pandemic, it was in everyone's best interests that we finalize and implement a plan to move forward.

In October 2020, we successfully transitioned to the new model for service, including regular business reviews to monitor performance and opportunities to enhance value. We certainly do not want to lose sight of our role outside the walls of the hospital. Our Supply Chain Team understands that we do not want to solely look at resolving issues by continuing an existing process. We have learned to ask, "How do we want to deal with this tomorrow?" The growth for us is certainly continuing. The engagement with physician practices, the rollouts, whether it's acquisitions or just building relationships, is a process that is now a step in our model. The Health Care System is very much focused on the communities we serve and providing a full scope of services for our clients. It is incumbent on us to ensure we are providing our practices with the supplies they need in order to continue to deliver quality patient care.

**JHC: From the overall health system, C-suite leadership, has the perception of alternate site changed at all?**

**Faup:** This is about a bigger picture. It spans multiple hospitals or health systems that I have worked for over the years. It's changed at different points. When we were first asked to engage the alternate sites, I thought, "This is different, I would love to help you out. We

will work it out. We will build formularies, delivery schedules, etc." There are some basic things that we do, the way our brains work in this role is, "Well, if we put this here, put this there, and this is in place, that should help. And then if it does not work, we will modify it and make it work."

## **Predicting and planning accurately when the demand model was fluctuating, was like opening an umbrella in a hurricane. Using a combination of data and "know how", we began buying for the future while providing supplies and services for today.**

I remember years ago while working at a different health system, the leadership told the Supply Chain, "Don't worry about [alternate sites]. We're not going to invest any resources with them." Where I am today, the message is 180 degrees different. The Leadership is very engaged; they are supportive. They look at it and the opportunity that it provides to the communities that they support. They want to send a clear message about the importance that our role extends outside our doors. If there is a need in our community, they want to find a way to provide it. It is a great approach and one that makes you smile and know there are people caring about people.

**JHC: What did you learn about yourself and your team in the last year with so many disruptions?**

**Faup:** Thank God, I have a sense of humor. I tend to laugh first, and then we work it out from there. I have had the

good fortune of working with people that are similar in their approach. It's something that has come in handy over the last year.

Within the first few months of COVID-19, while still adapting to the current needs, (high demand, low supply, new avenues, and new vendors) we recognized the problem wasn't going away in 30 or 60

days. Predicting and planning accurately when the demand model was fluctuating, was like opening an umbrella in a hurricane. Using a combination of data and "know how", we began buying for the future while providing supplies and services for today. It was and still is a team effort.

I think that we've always looked at ourselves as problem solvers. Just give us a problem and we'll figure it out. At any moment, you could look at what was going on and say, "This is so many problems wrapped into one. I'm not sure which one to address first." We found a way, and we worked through it together. The team is there ... leading a team of people that care is easy. When one person needed help, someone would quickly step in to support them. I think that ultimately, we thought we were indestructible. I also think that we came out of it saying this really was a big deal. We should be proud of ourselves and what we were able to do during an intense and stressful period.

# Tyler Ross

MS, director, supply chain operations, Novant Health, Kannapolis, North Carolina



***The Journal of Healthcare Contracting:* Why do you believe non-acute, alternate site locations are vital to not only a health system or IDN, but U.S. healthcare in general?**

**Tyler Ross:** Non-acute locations offer health systems the ability to reach patients where they are, in their own communities and on their own schedule. Our patients no longer have to travel long distances from potentially rural locations to receive care at a central (usually acute) facility; they are now able to tap into world-class healthcare from a trusted team of professionals in their own geographies. This is important not just as a tool to make care more accessible than ever, it also demonstrates a health system's commitment to its communities and the health of its citizens.

***JHC:* What are some keys to success for supply chain teams that may be unique to non-acute?**

**Ross:** Non-acute supply chain represents what I call a "high-volume, low-density" model that can feel contradictory to traditional lean, bulk-driven distribution systems. Clinics, individually, do not require as many items, or in as large quantities,

**Going into the pandemic, we had already spent two years building foundational relationships with our physicians and clinic leaders, allowing us the ability to be trusted partners in navigating the supply chain challenges of COVID.**

as hospitals do, but as a group of clinics they still represent significant volume and spend. This requires outside-of-the-box thinking to build a distribution network that is both cost-effective and operationally-efficient, while still providing a high service-level to the individual clinic. We have been fortunate to have a medical group that stresses a "sum is greater than its parts" mentality, where each clinic is not treated as a small business but rather as a franchise of the whole. This allows us to promote system-based solutions and implement them at an individual-clinic level.

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## **Certainly the fact that our leadership had created a non-acute team in 2018 is paramount to our success and indicative of forward-thinking on their part.**

**JHC: How was your department affected by COVID-19? What type of disruptions did you see? How were you able to navigate?**

**Ross:** We were fortunate to have already established a strong relationship with our 600+ clinic medical group after our non-acute team was created in 2018. Going into the pandemic, we had already spent two years building foundational relationships with our physicians and clinic leaders, allowing us the ability to be trusted partners in navigating the supply chain challenges of COVID. During the pandemic, we've had to consistently shift between different products (especially PPE), different suppliers and at different price points, but our clinics trusted us to be communicative and proactive in helping them sustain their operations despite these shortages. Like every healthcare supply chain team across the country, we had to become extremely nimble and creative in our approach to providing sustainment during the pandemic, and our relationship with our medical group was key in allowing us to be successful.

**JHC: Has the perception/integration by executive leadership of alternate sites within a health system or IDN changed in the last few years? If so, could you explain?**

**Ross:** Before the recent "boom" of non-acute sites in healthcare, clinics were definitely considered peripheral entities, always coming in second place

to hospital needs. Given the expansion of our non-acute footprint over the last few years, and the increased emphasis of adding clinics to our healthcare model, this perception has changed significantly. Clinics are now viewed as vital to our success as a health system, not just as a small subset. Our medical group operates over 600 clinics, as opposed to 15 acute care centers, and so the scope and breadth of influence from our non-acute sector has grown as well. Our medical group executive vice president is a member of Novant Health's executive team, and as such our non-acute sector has significant influence over the direction our health system takes today, and will take in the future.

our manager of non-acute supply chain, have been instrumental to our success. The Novant Health Medical Group (our clinic group) also accepted us with open arms in 2018, thus making relationship-building and strategy implementation fairly effortless and widely supported.

**JHC: What project or initiative are you looking forward to implementing now or in the near future?**

**Ross:** We have been extremely fortunate to be able to support the rollout of the COVID-19 vaccine, as our non-acute team has served as the lead department for establishing and operating vaccination centers. This work has been thoroughly rewarding, and my

## **We have helped establish over 50 vaccination sites since December 2020, and were able to integrate seamlessly in the workflow given our existing relationship with our medical group.**

Certainly the fact that our leadership had created a non-acute team in 2018 is paramount to our success and indicative of forward-thinking on their part. I was just the fortunate one to be given leadership of the team operationally. Mark Welch (SVP, supply chain), Mike Bianchin (VP, logistics operations), my leaders who created our team, as well as Stephanie Phipps, who is on my team as

team and I are thrilled to be a small part of the project. We have helped establish over 50 vaccination sites since December 2020, and were able to integrate seamlessly in the workflow given our existing relationship with our medical group. I look forward to continuing this work and to support the expansion of vaccine availability and administration to the communities we serve.



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# Ruvini DeFonseka Schultz

Manager ambulatory supply chain & pharmacy operations,  
Centura Health, Centennial, Colorado



**Preventive care management through primary care offices, specialist visits, and long-term care facilities is critical in lowering the cost of healthcare for patients and improving their daily quality of life.**

***The Journal of Healthcare Contracting:***

**Why do you believe non-acute, alternate site locations are vital to not only a health system or IDN, but U.S. health care in general?**

**Ruvini DeFonseka Schultz:** According to the American Hospital Association's 2019 Annual Survey published in 2021, there are on average 2.4 hospital beds in the U.S. healthcare system per 1,000 people, showing that the acute side is not meant to handle the day-to-day care needs for the U.S. population. Though healthcare system resources are often focused on the acute space where revenue from surgeries and other procedures are generated, for U.S. healthcare to improve long-term health outcomes and promote ongoing patient-centered care, there needs to be more of an investment in supporting non-acute clinicians and departments.

Preventive care management through primary care offices, specialist visits, and long-term care facilities is critical in lowering the cost of healthcare for patients and improving their daily quality of life. If we have more resources in the non-acute space to see patient's same day when they call with an issue, to follow up within a few hours about test results, or check in with high-risk patients, we can help avoid hospitalizations and emergency department visits, reducing the overall cost to treat. The plans providers create for their patients in the non-acute space help patients get back to doing what they love to do while managing their situation. As technology and medical knowledge advance, there are more

services that can be safely performed in the non-acute space, expanding access for care, reducing costs, and saving patient time.

***JHC:* What are some keys to success for supply chain teams that may be unique to non-acute?**

**Schultz:** Supply chain teams in the non-acute space are in constant transition: locations move addresses, new specialties are added, and associates turnover. The key to my team's success is collaboration and process improvement.

My small team supports supply chain operations for 330+ locations spanning Colorado and Kansas. We make sure we are included in meetings with non-acute clinical and operations leadership, patient safety, and acute supply chain so we can smoothly implement projects and brainstorm solutions. Participating in our non-acute daily safety huddle with practice managers, medical assistants, nurses, and physician leaders gives our team space to communicate changes to all sites in real time and hear trending issues we can proactively resolve.

Each month my team evaluates our processes, forms, and standards to determine areas that would benefit from process improvement both within our internal workflows and for our end users. We are currently undergoing testing of a new order form for non-formulary items that speeds up processing for our non-acute buyer and our clinic ordering associates. This form is owned by my team so we can update it as changes are requested. Our team is also creating a



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

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centralized website for non-acute supply chain, pharmacy, equipment, lab, and purchased services so that information regularly requested of us and by teams we collaborate with is available to all new and current associates. We are hopeful that access to this information will improve our end user experience and compliance.

As the number of clinics we support increase and services expand, our team continues to collaborate with our non-acute locations and supporting departments to improve operations, understanding of supply chain, and the savings we are able to provide.

**JHC: How was your department affected by COVID-19? What type of disruptions did you see? How were you able to navigate?**

**Schultz:** From March 2020 through now, COVID-19 has brought about backorders in manufacturing, materials, and product delivery that our teams have never experienced. In the span of a few days our sites went from hardly any need for masks to an extremely high demand. Because order history is what distributors and manufacturers use to determine monthly allocations for PPE and disinfectants on shortage, this caused major procurement issues for our non-acute team. Even where we had allocation, our suppliers didn't always have stock available. This forced all associates in supply chain to partner and find alternative sources for PPE supplies. There was a lot of filtering through the many scams or price gauging to find good quality, reasonably priced PPE for our associates.

We moved to heavy conservation of PPE, allotting associates in direct patient care only one procedural mask a day. At one point, our healthcare system started

manufacturing isolation gowns at our corporate office using trash bags to keep up with COVID floor and testing site demands. In April 2020, our team was tasked with coming up with processes to order and deliver COVID testing supplies for the system at our ambulatory urgent cares and free-standing emergency departments (FSEDs), and later primary care clinics. Early on during COVID, I was invited to participate in our Non-Acute Incident Command with other clinical and operations leaders for our system. This allowed our supply chain team to be a part of decisions that were being made and voice concerns or ideas so that our associates were protected and our patients could continue receiving care. Since January 2021, my team has been coordinating COVID vaccination supplies and supporting pharmacy sourcing of vaccine coolers, temperature monitors, and needles.

**JHC: Has the perception/integration by executive leadership of alternate sites within a health system or IDN changed in the last few years? If so, could you explain?**

**Schultz:** Integration for non-acute sites is more accessible than it was in past years because group purchasing organizations, manufacturers, and distributors are willing to support non-acute integration contracts and strategies. As our supply chain partners support integration, it is easier for executive leadership in our healthcare system to see the benefit of integration for non-acute sites. Non-acute supply chain operations at Centura began less than 8 years ago so we are still automating processes and creating strategies to support integration. Today our non-acute locations are in a place where they know

to reach out to our central inbox or phone line when they need support. By creating open access to a non-acute supply chain, we are able integrate our operations across our locations and showcase the value and savings of integration. The movement of suppliers and GPOs supporting integration of non-acute locations is a great step to opening conversations with healthcare leadership around the benefits of a dedicated non-acute supply chain team.

**JHC: What project or initiative are you looking forward to implementing now or in the near future?**

**Schultz:** A project we will complete this summer gives our non-acute patients access to purchase healthcare items online direct to their home through our distributor partner. This includes COVID-19 home monitoring items, wheelchairs, and other items providers recommend to support patients. We hope that this will benefit both patients and provider by saving time, providing options, and guaranteeing quality items.

We are starting an initiative with our distributor to highlight women or minority owned vendors on our formulary. We are also looking at opportunities available through our GPO for increased diversity in our vendor partners that recognize the communities that we provide care to.

Looking two years into the future, we are exploring what it would look like to have a dedicated non-acute warehouse space for both supply chain and pharmacy that could support cost savings initiatives and lowest unit of measure for slow moving items. This space would also serve as a central location for our team to stage new clinics. This initiative is exciting as it marks growth and increased strategy for our non-acute teams. ■

# Three Steps to Creating Your Own Strategic Stockpile



BY ELIZABETH HILLA,  
HIDA SENIOR VP

**As the nation begins to see the light at the end of the tunnel on COVID-19,** government and industry leaders are assessing the historic healthcare supply challenges presented during this pandemic. To better prepare for the future, federal and state officials are considering improvements to preparedness capabilities like the Strategic National Stockpile and regional stockpiles, but healthcare providers are taking proactive steps now to collaborate with their distributor partners.

From major systems to smaller providers, procurement professionals are engaging with their medical products distributors to discuss how to better manage future supply disruptions. Here are three steps providers can take to build and maintain their own strategic stockpile of critical medical supplies.

## Conduct a stockpile audit

As shortages of PPE begin to ease, it's an excellent time for providers and distributors to collaborate on an analysis of current supply levels of critical medical products and an updated reserve strategy. Providers can use the experience and data of the past year to answer important questions about their supply needs:

- › Does your definition of PPE align with your distributor?
- › Which critical medical supplies do you need?
- › How will your distributor provide it?
- › What is the most cost-effective way to store and maintain it?
- › How will you use it?

- › How will you replenish it?
- › How many days' inventory will you need during a non-pandemic year?
- › Can you fund it over multiple years?

A thorough exploration of these issues can help providers establish the foundation for a sound stockpiling plan with their distributor. Once that plan is established, it will be necessary to work together to identify the most efficient way to implement it.

## Utilize existing infrastructure

Healthcare providers that are establishing the physical space necessary to store and replenish stockpiled medical supplies could face high upfront costs and significant long-term expenses.

According to commercial real estate giant CBRE, "Warehouse vacancy rates are sinking and rents are soaring" due to historically high demand for storage space. That presents a major challenge given how much warehouse capacity a hospital or hospital system may need for a stockpile.

A single 350-bed hospital creating a 90-day stockpile of a typical mix of PPE would need to buy and maintain 13-15 tractor trailers of storage space. To meet the same obligation, a 5,000-bed hospital system of 10-12 hospitals would need the equivalent of 1½ football fields of space.

To prepare for future pandemics and to manage costs, many healthcare providers are contracting to use their distributor's available warehousing capabilities. Healthcare distributors currently operate 76 million square feet of warehouse space at 500 distribution centers across the country. Providers can work with distributors to access this capacity for their own dedicated supply of medical products, which can increase storage and delivery efficiencies.

## Create trusted partnerships

One vital lesson learned during this pandemic is how important it is for healthcare providers to have strong, established relationships with supply partners before an emergency occurs. For example, when COVID struck and supply was diminished, many providers turned to unknown brokers who often did not deliver promised products.

The time to establish those trusted partnerships with the full range of supply entities – from a provider's prime vendor distributor through relevant government agencies – is now. ■

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**Even with the challenges that have been met due to the COVID-19 pandemic,** Healthmark Industries has remained successful providing infection control solutions to healthcare facilities. Recently celebrating 50 years of business in 2019, Healthmark has experienced a great deal of growth with a variety of products and services. Known for providing innovative solutions for infection control to healthcare facilities, they are currently expanding their product line. The company has around 300 employees and has moved to their headquarters that is an overall size of around 100,000 square feet in Fraser, Mich.

Healthmark Industries was established in 1969 in Grosse Pointe, Michigan by Ralph A. Basile and his wife Suzanne. After a successful career in medical sales, Ralph decided to start his own company. In the early days, Healthmark was operated out of the family home, for their first generation products. From the beginning, Healthmark operated as a family business. Sons Ralph, Mark, and Steve were among Healthmark's first "employees," stamping literature with the company information on a pay-for-piece basis. As time went on, each of the sons, at different times and with different prior experiences, joined the family business and helped it grow. Healthmark's founder and patriarch, Ralph A. Basile, passed away in 2001 after a battle with cancer. Through the efforts of his wife, three sons, grandchildren, and many loyal employees, the company has continued to grow.

## An expanded product line

Over the years Healthmark has expanded their product line to fit the needs of healthcare facilities and one of the product lines that they added to is optical products. One of the newest products that just launched is the Flexible Inspection Scopes. It features a distal tip composed of a light source and camera lens at the end of a 110cm, flexible shaft. Designed for lumens 1.18 mm in diameter or larger or 2.0mm or larger. The camera and light are powered

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by the USB connection on a PC. Compatible with computers running Windows PC's, the included software allows viewing and recording.

Cleaning verification continues to be an important issue in healthcare across the country. News headlines often report about complications from surgeries caused by instruments and equipment that have not been properly cleaned. It has affected the healthcare field in recent years.

Healthmark added products to its ProFormance™ monitoring tools over the years to help ensure surgical instruments and other equipment are reprocessed correctly. AAMI<sup>1</sup> and AORN<sup>2</sup> recommend at least weekly testing of the cleaning process. These products are designed to help facilities comply with standards and ensure they are reprocessing equipment and cleaning surgical instruments properly.

“One of the ongoing challenges in the healthcare industry is to effectively reprocess surgical instruments on a consistent basis,” says Ralph Basile, Vice President. Healthmark has products designed to help hospitals and healthcare facilities provide safe environments and prevent infections.

Researchers have discovered that devices that haven't been reprocessed correctly can emerge from the cleaning process with bits of bone, blood and tissue from the previous operation. These contaminants can be reservoirs for some potentially lethal bacteria. Proper cleaning and sterilization are essential for ensuring that medical and surgical instruments do not transmit infectious pathogens to patients.

According to the Centers for Disease Control and Prevention (CDC), multiple studies in many countries have documented lack of compliance with established guidelines for disinfection and sterilization. Failure to comply with scientifically based guidelines has led to numerous outbreaks.

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## Researchers have discovered that devices that haven't been reprocessed correctly can emerge from the cleaning process with bits of bone, blood and tissue from the previous operation.

“Our ProFormance™ products are designed to help hospitals and healthcare facilities meet the challenge to regularly test their cleaning process in order to ensure their medical devices are being reprocessed properly. Once reprocessed, inspection will need to take place to ensure the surgical instructions are indeed clean,” Basile explained.

Healthmark also launched a new software application on the website, ProFormanceQA.com. This is a cloud-based database that Healthmark offers for free for their ProFormance™ product customers. It's a secure online database that allows you to record key statistics for the performance of your decontamination procedures, including the test results

call 800-521-6224 ext. 6657 or email [proformanceqa@hmark.com](mailto:proformanceqa@hmark.com) to schedule a call with the ProFormanceQA Help Desk.

If you are looking for industry news, helpful hints and other information, Healthmark produces a weekly newsletter that is distributed to thousands of readers. Each Healthmarket Digest features a story written by a member of the Healthmark team as well as a weekly coupon.



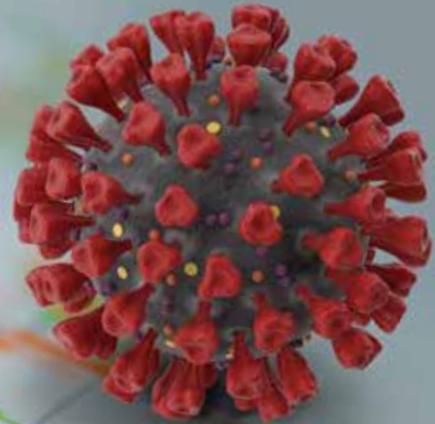
For more information about Healthmark Industries, visit [www.hmark.com](http://www.hmark.com) or call 800-521-6224. ■

1 AAMI (ST79 Comprehensive Guide to Steam Sterilization and Sterility Assurance in Health Care Facilities)

2 AORN Recommended Practices for Cleaning and Care of Surgical Instruments and Powered Equipment

# Mark Van Sumeren: The Number Cruncher

Meet the man behind one of the most widely-read COVID-19 reports among U.S. healthcare supply chain leaders.



**Mark Van Sumeren said three things prompted him to begin to dig into the data and analytics about COVID-19 case numbers.**

First, he was restless. Like most working professionals in March 2020, he was sitting in his home office wondering when he was going to get back out on the road either for client business or other purposes. “I don’t sit still very well.”

Second, he was curious. “We look back at how little we knew about this virus last March, and how we probably still don’t know a lot, but we know a whole lot more.”

Finally, and perhaps the most important, Van Sumeren was frustrated. Much of the reporting and narratives weren’t being given a lot of insight, “and I think part of that is, unfortunately, we got caught up in a political year,” he said. “Everything was reported with a political lens on it. So it was either, ‘The sky is falling,’ or, ‘There is nothing to this.’ Now, we know that the truth was in the middle.”



Mark Van Sumeren

Van Sumeren wanted to see if he could glean some insight from the mass of data that could better inform teams so that they could lead their organizations better, direct their people better, and live their lives a little bit better. Based off the industry’s response, he’s succeeded with the creation of his COVID-19 report.

*JHC* recently reached out to Mark Van Sumeren to discuss what prompted the creation of his widely read daily COVID-19 overviews and forecasts, as well as his thoughts on how the healthcare supply chain has handled the pandemic and what he sees for the industry going forward.

***JHC:* What goals did you have for the report?**

**Mark Van Sumeren:** I didn’t set out to do it. I didn’t set out for it to become what it’s become.

It does require a lot of time. It's probably three to five hours a day. What kept me going was feedback I got from people. There are a lot of people that I've had the pleasure of working with in this industry for 40 years. And to me, I had an opportunity to provide information that [my friends] found useful and that's pretty rewarding right there.

There were all these wonderful sources of data ... and being an engineer by training, I was curious about the data and if I could make my own insights or determination from it.

I started playing with the data for my own edification and found some things that weren't being told through the popular reporting, because it required some insight and analytics that [most people] don't have the time to do.

## I sat in on a meeting of medical device operational directors this week, and one of the takeaways from that, hearing from the provider side of the community, is that the providers' supply chain is now elevated in importance inside the four walls of the health system.

I was educating myself and I started sharing with a few friends and former colleagues and said, "Is this of any interest to you?"

Well, the response back universally was, "This is great, keep sending it. And by the way, here are seven other people I want you to send this to."

### **JHC: How did you sort through all the noise to deliver actionable insights?**

**Van Sumeren:** Early on – back in March and into April of last year – all eyes were on Italy, and Italy was on fire.

It was a disaster, and one of the insights I picked up early on is that the reports every day would be "How many more cases" and "How many more deaths?"

Well, the counts only go up, they never go down. So that's not very practical, or it's not actionable unless you know what direction it's heading. So I started to look for, "Can I tell when it starts to turn? When the number of new cases will start to diminish, the number of hospitalizations will diminish."

I was able to find that, without getting too engineering or technical, if you start to look at the derivative or the second derivative of the cases, I could predict when new cases would start to decline days or weeks ahead of time, because the rate of change would slow down.

### **JHC: What everybody really wants to know is, when do you think you'll get to wrap up the report?**

**Van Sumeren:** Well, as a self-confession, I've got all my models and spreadsheets where I pull the data together and I first set it up to run through May 15 of 2020. Obviously, we blew through that date pretty quickly.

I've got on my wall some metrics that I said, "I will be done with this when we hit all of these metrics."

If new cases are on a downward slope and they reach a point that they're lower

than they have been since we started in March 2020 (when they were doubling every day) ... if they drop below that and they're declining, and the same thing holds true with hospitalizations, and if we get to a 60% vaccination rate, I will say I'm pretty confident that I can wrap this up.

If I had to stake a bet, I would say it's going to be maybe just before – but probably a little bit after – Memorial Day that we will be at a good point.

I'm not suggesting that the virus will be done and over with, but I think we'll be at a point where it'll be contained and unless something unusual happens, it'll be more like the annual flu type of thing in terms of its level of impact.

So that's my bet right there.

### **JHC: How do you feel about the healthcare supply chain's response to the pandemic?**

**Van Sumeren:** When the demand for ventilators and gloves and protection equipment goes up by a factor of 10 or 20, or 50 – no one could have prepared for that.

So let's dispense with the finger-pointing, but let's learn from what we went through and ask, "How do we get better about this going forward?"

I sat in on a meeting of medical device operational directors this week, and one of the takeaways from that, hearing from the provider side of the community, is that the providers' supply chain is now elevated in importance inside the four walls of the health system.

And that was long overdue.

To many, that's great. To some people, that can be a little scary, but I think the value and role that supply chain plays has never been so obvious as it's been over the last year.

**JHC: Do you think that's going to stick?**

**Van Sumeren:** I do. As I said, I've spent the better part of my career advising senior management – I did a lot of operations of finance work and got engaged in the supply chain just before the middle of my career, if you will. But my 10 years as a partner with the E&Y I was advising CEOs, CFOs, COOs, and I was basically teaching them of the importance of supply chain.

Because back in the '90s, the early 2000s, it was not important and I got accused by one of my other partners of, "Why are you educating the client base? They won't need us."

So I said, "I'm educating so that they will need us." Because an informed executive suite is going to be more demanding, but going to need more from the supply chain organization and really, that's where I spent my time.

So I have great confidence that these senior leadership teams, now that they see the criticality of the supply chain, will not forget that lesson.

**JHC: Do you have any predictions about how the landscape of the industry is going to change as a result of lessons learned?**

**Van Sumeren:** I think there are some changes that are going to stay in place. [There's the] idea of the nearshoring or onshoring, dual-source versus sole source as being a way of minimizing risk, but also I think we're probably going to see higher utilization of certain things. Protective equipment, gloves, and things like that.

What this pandemic showed us is that we had gotten accustomed to operating within a rather narrow band of variability, and I think we've broken through those bands.

I don't expect that the future will return us to that same narrow band, so we're going to have to build in that flexibility to not simply reorder the amount that we reuse but start to think ahead.

We need to have better ways of syncing up inventories, or sharing, or better flexibility, resilience, if you will, in the supply chain to get it where it needs to be.

**JHC: How were you able to forecast the trends of the pandemic so accurately? Are there any methods that might have application for supply chain leaders?**

**Van Sumeren:** By spending enough time with the information, you could start to see patterns and get some insight to when the momentum was going to change. I think that has applicability to these supply chain leaders as they think about, "What are the triggers or the signals that something has changed, and

therefore, demand is going to go up or down and I need to react. What are those triggers inside our organization or in the local community or even globally, that might start to indicate something has changed, and I need to prepare myself for it."

The sourcing side of [supply chain] will be even more important going forward, but we under-invested in technology and the knowledge that we need to have about products, and location, and status, and that sort of thing and I think we got caught short by that under-investment.

We left ourselves with a lot of work to do now – not only to put it all back together, but now to learn the lessons that we've learned, and being able to make adjustments as we need.

*To sign up for the report and access the full past archive for free, visit [healthindustryadvisor.com/days.php](http://healthindustryadvisor.com/days.php). ■*

## About Mark Van Sumeren

Mark has 35 years of experience with strategy development and execution, business intelligence, industry insight and supply chains. He started out of undergraduate school working as an industrial engineer at what is now the Detroit Medical Center in the mid to late 1970s. He then went to work at Ernst and Young

(then Ernst and Whinney) in its healthcare consulting practice, and spent 20 years with the company, working for the latter half of that time as a partner.

In the late '90s, he helped start the company's healthcare supply chain consulting practice, successfully growing the practice into a sizeable firm. He then

joined Owens & Minor, where he spent 11 years as an officer with responsibility for strategy and business development.

Since going into "retirement" six years ago, he has continued to work with healthcare organizations in consulting roles, mostly working in longer-term relationships with a small group of organizations.

# Uniform Apparel for Healthcare Professionals Benefits More Than the Wearers

**Do you remember your first encounter** with a nurse or a doctor? Perhaps it was at an early check-up in your pediatrician's office, a visit to the school nurse, or an injury that sent you to the emergency room. It was probably easy for you and your parents to identify the medical professionals caring for you by their dress code. People of a certain age knew nurses dressed in white uniforms, and doctors wore white coats. Through the years, the workplace apparel of medical providers became less uniform, with many doctors leaving their white coats behind and opting for a more casual wardrobe. Nurses went from wearing all white to multiple plain colors to printed scrubs.

Today, for a number of reasons, the pendulum has swung back to embrace the idea of uniform apparel for healthcare professionals, particularly in hospitals and long-term post-acute care (LTPAC) facilities. These facilities have so many staff members interacting with patients or residents – from doctors and nurses to lab technicians, dietary and environmental services personnel – and need a way for everyone to distinguish between them. Providers also are realizing distinct benefits from a uniform apparel program including:

- › Stronger branding
- › Increased security
- › Better patient experiences
- › Greater employee satisfaction
- › Improved infection prevention and control

Let's take a closer look at the competitive advantages your facility or network can realize by adopting a uniform apparel program.

## Brand Awareness is Important to Healthcare Consumers Too

Many patients have a choice when they go to the hospital or post-acute facility, and you can help ensure they know and remember your name. When your employees wear color-coded uniforms bearing your custom-embroidered logo, they create and maintain a lasting professional image for your hospital, health system or post-acute facility. They

also reinforce your brand messages, whether they're related to care quality, convenience, longevity, or innovation. If you're a new organization, uniforms with your name and/or logo can contribute to your branding initiatives, both in your facility and when your employees are in the community.

## Does This Person Belong in My Room?

Security is one of those issues that medical professionals rarely discuss, yet it is increasingly at the forefront of business operations for healthcare decision-makers. You want your patients, residents and





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staff to feel as safe as possible, knowing that the right person is in the right place at the right time. Color-coded uniforms with a facility name or logo not only identify a care provider's role and reason for entering a room, but also assure patients, families and other providers that these individuals are indeed on your team. Providing and receiving care should be top of mind for your professionals and patients respectively; no one should wonder if the person entering the room just walked in off the street!

## **Patient and resident experience surveys have found that when these people can easily identify staff members and their roles, and thus find communication easier, they give higher ratings to the care they receive.**

### **Perception = Reality for Your Customers**

It seems like a minor detail, but when your staff looks professional, your patients or residents respond positively. A uniform apparel program reassures your customers, and eliminates confusion in often stressful circumstances, building on the goodwill factor – and perhaps your Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores, too. Patient and resident experience surveys have found that when these people can easily identify staff members and their roles, and thus find communication easier, they give higher ratings to the care they receive. Satisfied customers will always be some of your most vocal advocates.

### **Put Money Back in Your Employees' Pockets – and Yours**

Supplying your employees with color-coded uniform apparel in a variety of styles and sizes is an excellent boost to their morale – and their budget. For example, our GroupOne® program offers three well-known brands: the workhorse Fundamentals® scrubs and uniform line, the soft and comfortable Jockey® Scrubs, and Meta® Labwear coats. Many hospital and post-acute facilities are purchasing one or more of these brands for their

employees, so staff members don't have to. Knowing they'll be able to work in high-quality, stylish clothing gives them more stability (and one less expenditure) as care providers. This kind of program can help you recruit new staff, too. From a financial perspective, it enables you to better control costs by choosing the right ordering option for your facility, and tracking and managing your orders.

### **Infection Control has Moved to the Top of the List**

Sadly, the COVID-19 pandemic has shown us first-hand how rapidly dangerous infections can spread from person to person, facility to facility, and workplace

to home. It's been a difficult lesson to learn, but healthcare providers are now more dedicated than ever to improving infection prevention and control (IPC) in their facilities.

Rebecca Love, RN, MSN, FIEL, president and co-founder of SONSIEL, the Society of Nurse Scientists, Innovators, Entrepreneurs & Leaders, sees uniform apparel as a key component to IPC programs going forward. "Uniform apparel initiatives remove the burden of stopping infection spread from your staff. Employees worry much less about carrying disease to their families, or becoming infected themselves. When clothing is provided and laundered by a healthcare facility, the rate of healthcare acquired infections goes down. It's just smart public health policy, and contributes to our end goal of controlling infections of all kinds and stopping their spread."

### **You Can Make It Happen, with the Right Uniform Apparel Partner**

As the trend to adopt uniform apparel grows in hospitals and LTPAC facilities, it's worth being selective in contracting with a top-notch distributor. Look for a collaborative, community-minded company with experience, quick turnaround times, adequate inventories, and a range of product, ordering and shipping options. You also want a partner who listens to healthcare workers and brings the most relevant products to market. You'll be pleasantly surprised how a uniform apparel program will contribute to your success – and to a great experience for your patients or residents. ■

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



# Physician Leadership in Supply Chain

Now more important than ever

BY STACY A. BRETHAUER; PATRICK A. KENNEY, MD; MOLLY K. ZMUDA, MHA3; SIDNEY M. FLETCHER, MD4; BRUCE L. HALL, MD, PHD, MBA5; JIMMY CHUNG, MD, MBA6

**When COVID-19 began spreading across the United States in 2020, the role of physician leaders in supply chain at the nation's hospitals accelerated in importance.**

Physician leadership in supply chain helps bridge the gap to clinical staff through a model known as a clinically integrated supply chain. Clinical integration (CI) brings together two previously siloed (but equally important) entities within health care provider organizations: clinical care and resource management. A clinically-integrated supply chain helps establish a common vision and strategy for advancing quality through resource utilization, clarifying cost-effectiveness and justifications of new technology for clinical needs.

As the pandemic surged, providers quickly encountered supply constraints for routine commodities such as masks and gowns, forcing clinicians and managers to think differently and aggressively incorporate CI principles into practice.

To evaluate the roles of physician leaders in supply chain management and personal protective equipment use, in May

2020, Vizient, along with its Large IDN Supply Network (LISN) and its subgroup the Supply Chain Physician Collaboration (SCPC) reviewed daily pre/post COVID-19 PPE usage as well as conservation strategies, policies and protocols employed by 24 of the nation's largest health systems represented in LISN. The 24 IDNs in the Vizient LISN represent more than 500 acute care facilities across the country.

Noting variation in quantitative survey results detailing policies, conservation strategies and daily PPE usage per COVID-19 patient, in June of 2020, a COVID-19 Workgroup of LISN SCPC designed and administered a qualitative survey of senior, system-level supply chain leaders across LISN on "COVID-19: Supply Chain Physician Collaboration." Completed survey responses were compiled and analyzed regarding the culture and perceived importance of CI and physician leadership in supply chain.

## The average daily use for critical PPE items surged dramatically with the greatest increases in use of N95 masks (870%), face shields (1,055%) and goggles (1,168%) at these organizations.

The LISN SCPC methodology involved evaluating supply chain physician leaders' roles, PPE use and related policies from March 28, 2020 to May 11, 2020, when COVID-19 cases began surging in the U.S.

### Critical PPE use surges dramatically during crisis

Results from LISN's first survey provide a perspective on the PPE resources that needed to be managed and leveraged

during COVID-19's first surge. The inquiry about PPE-related policies drew responses from 63% of the IDNs in LISN.

As expected, responses indicated a crisis was at hand. The average daily use for critical PPE items surged dramatically with the greatest increases in use of N95 masks (870%), face shields (1,055%) and goggles (1,168%) at these organizations. Among the health systems, the average number of COVID-19 positive patients who were inpatients at the time of our survey ranged from 55 to 1,700 with a median of 114 patients. A smaller number of COVID-19 persons under investigation (PUI) were admitted to these health systems with a median number of 34, a range of 2 to 100. The percentage of COVID-19 positive inpatients who were admitted to the intensive care unit ranged from 15% to 35% with an average of 28%.

At the time of LISN's initial survey, the system with the largest number of

applied, while other policies were put in place only at some of the health systems, factors likely dependent on PPE inventory, the availability of re-sterilization systems for N95 masks, and the degree to which COVID-19 had affected health systems at the time of the survey.

Positives were gleaned from the survey results. We found that the pandemic has strengthened the CI culture in hospital systems and established a precedent for multidisciplinary teams working together for delivering high-value health care. Leveraging the experience of physician leadership will be crucial to CI's success at these provider organizations as they continue to manage COVID-19 surges in their region.

### Executive leadership: supply chain physicians very or extremely valuable during COVID

Results from the second survey focused on site culture of CI and physician leadership in the supply chain. Feedback from the survey, which drew responses from 71% of the IDNs, was also intended to understand roles. Sites were asked to describe the scope of the role as well as the title, tenure and background of the physician leader in the health system's supply chain.

The responses indicate that these leaders' activities were primarily focused on communication with supply chain, health system faculty, and executive leadership. As supplies of PPE and the nature of the crisis were changing daily, supply chain involvement was critical to ensure alignment of PPE inventory and rapidly changing policies. Supply chain physician leaders were expected to address policy development, COVID-19 projections, average daily PPE use, current PPE inventory, changes in practice, extended

use or reuse of PPE (contingency or crisis standards), and applicability and safety of using substitutes. These responsibilities placed supply chain physician leaders in a unique position to add value and contribute by communicating critical information to key health system stakeholders.

During the pandemic, physician supply chain leaders were mostly seen as a valuable resource for clinical issues related to COVID-19 (77%) and for disseminating supply chain information to the faculty and clinical leadership (59%).

LISN member organizations highly valued the role of their supply chain physicians. Eighty-eight percent of the supply chain leaders reported that physician leadership was a very valuable or extremely valuable resource during COVID-19. Among the health system executive leadership, 82% saw the supply chain physician leader as a very valuable or extremely valuable asset during COVID-19.

The survey also asked about the role of the supply chain physician leader during the health system's eventual emergence from the pandemic. Again, the roles of communication and clinical decision-making were felt to be most relevant.

Roughly a third of survey respondents had assigned a role of Medical Director of Supply Chain and 52.9% of the respondents have a physician with another administrative title who is responsible for supply chain activities. Physicians in these roles have a wide variety of medical and surgical specialties and clinical backgrounds and 64.7% have held their supply chain role for over three years while 65% have received salary support for their work in the supply chain.

Physician supply chain leaders were also perceived to be accessible: 71% of facilities utilized the physician leader 12 or more times per month.

The survey's conclusion was that hospital support for a physician leader in the supply chain is "critical to developing a culture of clinical integration and resource stewardship in times of crisis." The COVID-19 crisis has strengthened the clinical integration culture in these hospital systems and established a precedent for multidisciplinary teams working together to deliver high-value health care.

## **In normal times, supply chain physician leaders focus on pricing, sourcing, utilization and variation at both the physical and enterprise level. But the pandemic rapidly altered the role of the supply chain physician leader, gaining in importance in the health systems.**

### **How the role of supply chain physicians shifted during the crisis**

In normal times, supply chain physician leaders focus on pricing, sourcing, utilization and variation at both the physical and enterprise level. But the pandemic rapidly altered the role of the supply chain physician leader, gaining in importance in the health systems.

In times of crisis such as COVID-19, the role of supply chain physician leaders shifted from leading culture change to communicating the urgent needs and limitations of supply chain resources to the faculty and health system leadership, and helping to solve related problems. LISN SCPC findings demonstrate that health systems can benefit from having a clinical leader in supply chain. To facilitate and manage changes in costs, utilization, sourcing, and variation, strong clinical leadership is required. An effective leader in this

role can drive value in the system by balancing costs with outcomes, innovation, and the clinical mission.

### **Supply chain physicians poised to lead through post-pandemic recovery**

As health systems emerge from the acute phase of COVID-19, the financial impact

will continue well into 2021. The supply chain physician leader will take on an important role in these financial recovery efforts and their prominence during the crisis will have positioned them well to lead the process.

This initial study into the role of physician leaders in clinical supply integration revealed broad variations in title, specific responsibilities, and impact on organizations during a pandemic. As such, the optimal description of the supply chain physician leadership role, including whether ad hoc or permanent, advisory or executive, and operational or strategic, has not been well-established, unlike other traditional physician leadership positions.

In terms of studying the long-term value of standardizing physician leadership roles in supply chain, the skillsets and training required for these positions, and where they would fit in the organization's leadership structure, further research is warranted. ■

# Healthcare GPOs: Critical Partners to America's Providers and the Patients They Serve



BY KHATEREH  
CALLEJA, J.D.

**The COVID-19 pandemic has impacted every aspect of the American healthcare** system, placing unprecedented pressure on hospitals, nursing homes, physicians, and the healthcare supply chain. Throughout this tumultuous time in healthcare, one thing remained constant: the critical role that healthcare group purchasing organizations (GPOs) play in supporting hospitals, other healthcare providers, and the patients they serve.

HSCA, which represents the nation's leading healthcare GPOs, recently released its 2020 Annual Report detailing the impact of GPOs and it confirms what hospitals, healthcare providers, suppliers, and policymakers see every day: GPOs improve healthcare quality; reduce costs; increase competition; drive transparency, visibility, and predictability; and add value to all supply chain stakeholders.

For example, GPOs have taken a number of innovative steps to support COVID-19 response efforts, including supply coordination efforts to help medical teams obtain much-needed supplies and support surge capacity, adding new manufacturers to contracts to rapidly increase supplies, and working with non-traditional and adjacent industries to fill supply gaps for essential products such as hand sanitizer, isolation gowns, and surgical caps. Multiple GPOs launched programs to strengthen the resiliency of the supply chain of essential drugs and shore up domestic manufacturing, helping enhance competition, mitigate shortages and increase supplies of critical drugs for patients.

GPOs are supply chain leaders in quality assurance and take a comprehensive approach to purchasing that considers not only the competitive pricing offered, but also the quality of the manufacturer and the reliability and stability of supply as well as key FDA inspections as part of the contracting process. GPOs' fierce commitment to quality helped to protect member hospitals from purchasing counterfeit or inferior goods during the COVID-19 pandemic, working around the clock to field thousands of inquiries and vet new manufacturers for compliance with standards set by the FDA and National Institute for Occupational Safety and Health (NIOSH) and ensure safeguards for product quality.

As organizations moved to virtual operations, GPOs played a key role in helping member providers swiftly transition to telehealth. According to a GPO's data, provider use of telehealth skyrocketed from fewer than two percent of providers prior to March 2020 to more than seventy percent by the end of April. GPOs took several steps to support

acute and non-acute healthcare providers' rapid transition to virtual visits, including weekly education and training sessions, providing timely updates on policy developments supporting telehealth adoption, and helping members apply for telemedicine funding from The Coronavirus Aid, Relief, and Economic Security Act (CARES).

GPOs are actively involved in policy efforts to strengthen supply chain resiliency, enhance upstream visibility, and drive quality throughout the healthcare system. HSCA supports measures like those included in the CARES Act, which strengthened reporting requirements for manufacturers, including certain information about active pharmaceutical ingredients and other raw materials, to better prevent, assess, and address shortages of medical products. HSCA also issued a series of principles and recommendations to further strengthen supply chain resiliency and enable an effective response to public health crises.

GPOs' unique line of sight across the entire healthcare system enables them to help providers anticipate and respond to rapid changes and unprecedented situations like the COVID-19 pandemic. As we look ahead to 2021 and beyond, HSCA and its members remain committed to helping hospitals and healthcare providers deliver the most effective and affordable care possible to the patients they serve. ■

Khaterah Calleja, J.D., is the president and CEO of Healthcare Supply Chain Association (HSCA).



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