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ART DIRECTOR

5 Things with Bruce Radcliff

A Supply Chain Hub Executive Interview

Bruce Radcliff, Systems VP, Supply Chain with Advocate Aurora Health (AAH), recently discussed many topics surrounding the Midwestern healthcare system's supply chain operations and the pandemic with Maria Hames, a partner with HealthCare Links, for the Learning from Leaders Webinar Series with ANAE, the Association of National Account Executives. AAH is based in Illinois and Wisconsin.

The conversation's highlights included:

1 Value analysis is a taboo phrase at AAH

Value analysis programs of the past have been focused on cutting costs and using subpar products if you ask clinicians, according to Radcliff. AAH has moved to a service line integration model, incorporating clinicians and all on the service lines, asking questions surrounding optimization and value creation for the patient.

Bruce Radcliff

"It's a more collaborative environment than before," said Radcliff. "We're relying on the service lines to guide us through." Radcliff added that AAH's structure is still traditional as a site-based operations and logistics and sourcing supply chain but is unique in how it interacts. "We're traditional but different," he emphasized.

2 The Midwestern health system utilizes immense data sets

Midwestern people don't migrate much, according to Radcliff, and therefore AAH utilizes large cradle-to-grave data sets. "That's where analytics starts becoming a differentiator within the supply chain," said Radcliff. "We have immense data sets and a singular EHR between

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the two states [Illinois and Wisconsin]. Our data mining is rich and robust. Analytics in our supply chain allows us to look at things differently but to look at it in scale.

"For example, if I'm looking at total joint, I'm not pulling hips, knees and shoulders from two or three sites. I'm pulling them from 30. I have over 100 physicians practicing the same standard procedure in different venues of care. I have an ecosystem of data and the analytics team is poised to help us understand what is actually driving value."

Radcliff described AAH as a large system in a small space, taking up as much capacity in Illinois and Wisconsin as possible with 27 hospitals, over 500 points of care and over 50 surgery centers all within four-and-a-half hours of each other.

3 Improving supply chain resiliency post-pandemic

The lack of resiliency in the healthcare supply chain was an eye opener for Radcliff, but he's proud of AAH.

"All things considered, AAH did a great job," Radcliff said. "We never had to go without, adhered to FDA and CDC guidelines around usage and protocols, and our supply chain never broke. It bent but we learned where the stress points were and how to get better. Our organization has invested in building capabilities where we saw weakness.

"For example, domestically produced PPE was a unicorn before the pandemic. But we've made investments to bring some PPE back to the U.S., including through our GPO, Premier, and along with other health systems, purchasing an equity position with Prestige Ameritech, a domestic N95 and PPE provider in Texas."

4 Suppliers must add short-term and mid-term value when building back to normalcy

"Supplier engagement is critically important," Radcliff explained. "Suppliers must be ready to have conversations with procurement teams or C-suite executives about adding value. Explain your successes or what you learned through failure. Help build diversification and resiliency. Help plan the return to normalcy."

> **"Everyone is at a different level on the return to normalcy," he said. "And a return to normalcy is a short-term process that must be met by organizations and suppliers. Also, suppliers must bring a six- to 12-month plan that adds mid-term value to the organization."**
>
> – Bruce Radcliff

Radcliff expanded by saying suppliers must meet organizations where they're at in the process. "Everyone is at a different level on the return to normalcy," he said. "And a return to normalcy is a short-term process that must be met by organizations and suppliers. Also, suppliers must bring a six- to 12-month plan that adds mid-term value to the organization.

"How can suppliers help an organization's optimization opportunities and economic efficiency opportunities? Those questions must be asked.

5 The digital transformation and rise of telehealth

Telehealth has had exponential growth during the pandemic. "It's always been on our radar," Radcliff said. "But significant shifts in business during the pandemic has forced its growth. At-home businesses are growing, and we must meet patients where their needs are." He explained that AAH had seen over 500,000 telehealth visits in seven months of the pandemic in 2020.

"Supply chain is trying to get ahead of it," he said, "and learning how to provide services at different venues of care. That's where a lot of the transformation will happen. Supply chain has been thought of as a hospital type of shared service, but clinics were introduced five to seven years ago and we're expanding capabilities in non-traditional venues."

AAH is currently using Workday to standardize their technology footprint. "We need harmonization in tech as venues grow," said Radcliff. "It's a major investment in the next 12 to 18 months for us. It's a massive digital transformation to build a more scalable and robust platform. We've made the investment in Workday to get it right the first time," Radcliff said. ■

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1 B. Braun Data on File, 2020

BY JESSICA DALEY AND WAYNE RUSSELL

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

Consolidated Service Centers and COVID-19

The advantages and challenges to self-distribution during the pandemic

BY DANIEL BEAIRD

Many hospitals and IDNs have implemented a self-distribution strategy taking on the costs and responsibilities that used to fall to a distributor. What were some of the advantages and challenges during the height of the pandemic for Consolidated Service Centers (CSCs) and self-distribution?

Panelists from three IDNs joined Moderator Brent Petty, a leading healthcare consultant, and Jaime Kowalski of Jamie C. Kowalski Consulting for *The Journal of Healthcare Contracting's Self-Distribution Webinar sponsored by Health Products Xchange*. They discussed Kowalski's latest survey findings on CSCs operating through the pandemic and shared examples from the three IDNs self-distribution operations.

The panelists included:

- **Mike Martin** – VP, Supply Chain Operations, Trinity Health
- **Tim Nedley** – VP, Materials Management, UPMC
- **Paul Oppat** – Executive Director, Supply Chain Service, Banner Health

Kowalski's survey on CSC performance during the COVID-19 crisis showed favorability toward the model as the pandemic shed light on all supply chain resiliency. CSC operators agreed that having a self-distribution operation put them in a better position to handle the pandemic as they quickly qualified and vetted new suppliers and had access to manage additional volume and SKUs through in-house sourcing capabilities. Access to inventory and additional supplies in their own warehouses added to increased volume and dollar value to the CSCs.

"We had enough safety stock and pandemic stock on hand and an aggressive sourcing team to qualify one-off vendors and non-traditional vendors to purchase PPE," said Nedley about UPMC's self-distribution operations.

"Having an existing warehouse system and an inbound ordering process helped us respond quickly to a more national footprint," added Martin about Trinity Health's CSC operations. "Routine business had to carry on, but we also had a large amount of space to accept container loads and quickly say yes to new products. Orders were processed within days and out the door within days at the pandemic's start."

As third-party partners struggled to meet needs on PPE during the worldwide shortage, CSCs saw their efficiency helped through warehouse management systems and pick-and-pack systems.

"We had multiple means of distribution to acute care facilities all managed through our CSC in Pennsylvania," said Nedley about Pittsburgh-based UPMC. "We pushed product across the state into doctors' offices and into facilities in New York and Maryland. We had systems that helped efficiency."

Collaborations have included GPOs and distributors tackling creative solutions through alternative manufacturing and alternative sources, as well as shipping product to non-acute sites.

According to Nedley, UPMC had 90 to 120 days of inventory at its highest consumption. It tripled on-hand inventory dollars, rented supplemental space to house inventory, and containers partnered with its GPO and distributor to keep product moving. It had plenty of product during the peak of the pandemic and now is determining how to maintain that product as states like New York require 90 days worth of onsite supply at hospitals.

"Once we get word to reduce our on-hand supply, we'll push it through the supply chain and into the hospitals and doctors' offices," added Nedley. "We're collaborating with other healthcare organizations, both locally and nationally, and sending truckloads of isolation gowns elsewhere as we swap and share to make sure everyone is provided for. But we'll keep pandemic stock on hand should it happen again."

Joining forces

UPMC partnered with its largest competitor in Pittsburgh through its distribution centers to make sure senior living centers were taken care of and fulfilled unmet needs.

"If we're sitting on millions of dollars' worth of PPE, it makes sense to join forces and connect the dots," said Nedley. "As an operations guy, it was stressful but good seeing everyone cooperating with each other."

Collaborations have included GPOs and distributors tackling creative solutions through alternative manufacturing and alternative sources, as well as shipping product to non-acute sites. With more and more self-distributing IDNs, creating a network of supplies through excess product is very welcomed in non-traditional sources, according to Martin, especially those that don't have a defined path to find an exchange for masks and gowns.

"Small facilities get pushed to the back of the line," said Martin. "But it's powerful for nothing to go to waste – for

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example, having too many gowns and being willing to swap out. It's about working with those who are buying something similar and working with non-acute sites to move product."

Martin added that Trinity Health's CSC allowed it to have a centralized supply based on usage and not emotion, while controlling the allocation.

"Our CSC created a level of visibility of what was on the shelf," said Martin. "It allowed us to tie it to demand with an idea of when the big wave was coming. Staff understood when product was going to arrive, what was in transit and how fast it was moving off the shelf."

Oppat cautioned that as valuable as CSCs are, they can also be a single point of failure. As the pandemic raged in 2020, warehouse volume increased dramatically, more than doubling inventory value overall in many warehouses – some by necessity and some through reserve inventory. Hospitals leveraged CSCs to manage new service lines. All respiratory supplies became a concern. Potential virus breakouts amongst warehouse crews were constantly worrisome.

So, a pandemic of this magnitude caused a complete reevaluation of the healthcare supply chain.

While CSC operators felt like having access to a self-distribution operation put them in a better position during the height of the pandemic, they also touched on many ways to improve their processes for the future in Kowalski's survey, including:

- Reevaluating inventory position and sourcing strategy for critical supplies
- Less reliance on single distributors for sourcing with more reliance on multiple sources
- Investing in systems and resources to make internal processes more functional and more robust – particularly forecasting and product allocation
- Reconsidering capacity and scale required for CSCs in the immediate future and
- Considering opportunities to collaborate with other CSCs.

Oppat added that IDNs and suppliers must have good relationships so that a supplier is willing to notify an IDN when a problem arises and IDNs have enough time to react.

"It's far too late to find out on a back order," said Oppat. "Relationships are key. Disruption may not be avoidable, and failure can be a topic of discussion. The process hasn't worked as we imagined but 2020 was whack-a-mole from product disruption to service disruption to something new every day."

"There were new shortages every day," added Nedley. "Knowing as early as possible is helpful. Staff will conserve when asked. We're all in this together." ■

"Relationships are key. Disruption may not be avoidable, and failure can be a topic of discussion. The process hasn't worked as we imagined but 2020 was whack-a-mole from product disruption to service disruption to something new every day."

– Paul Oppat

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Telehealth Expansion is Part of 2021 Fee Schedule

What COVID-19 kick-started, the Centers for Medicare & Medicaid Services endorsed in the 2021 Medicare Physician Fee Schedule, adding a list of reimbursable telehealth services.

"The American College of Physicians is pleased that CMS has made the expansion of telehealth a priority in the physician fee schedule," says Brian Outland, the College's director of regulatory affairs. "The flexibilities that were put in place earlier in the COVID-19 pandemic have been important for patients to access care, and important for physicians to keep their practices open and operating. Many physician practices have faced dire financial situations while we have been dealing with the COVID-19 pandemic. While telehealth visits won't make up for that entirely, they do help to keep practices open and help patients who would avoid in-person visits to access care."

Before the COVID-19 public health emergency (PHE), only 15,000 fee-for-service beneficiaries each week received a Medicare telemedicine service, according to CMS. Under a special waiver for the PHE in March 2020, Medicare was authorized to pay for office, hospital, and other visits furnished via telehealth, including those originating in patients' places of residence. Preliminary data shows that between mid-March and mid-October 2020, over 24.5 million out of 63 million beneficiaries and enrollees received a Medicare telemedicine service.

Services added to the Medicare telehealth list in the 2021 Physician Fee Schedule include "domiciliary, rest home or custodial care services," home visits with established patients, "cognitive assessment and care planning services," and "visit complexity inherent to certain office/outpatient evaluation and management (E/M)." Additionally, CMS created a temporary category of criteria – called Category 3 – for services added to the Medicare telehealth list during the public health emergency that will remain on the list through the calendar year in which the PHE ends.

Despite some disappointment around CMS' decisions regarding remote patient monitoring, the American Telemedicine Association believes that overall, the final rule is a positive step, says Kyle Zebley, director of public policy. "CMS has gone out of its way to think creatively." Still, some roadblocks to fuller implementation of telehealth exist, he says.

For example, CMS lacks the authority to permanently permit reimbursement for home-based telehealth. "As it stands, you have to be at a provider's location in order to have reimbursable telehealth," says Zebley. "That is an outdated law written decades ago, and it needs to be changed." But only Congress, through legislation, can make that happen. Likewise, only Congress can change existing law that (but for the public health emergency) restricts reimbursable telehealth services to patients in defined rural geographic locations, he says. "Of course, we believe telehealth should be available to those in rural areas, but we also think the law should cover telehealth services for Medicare recipients no matter where they live." ■

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Primary Care Doctors Fare OK Under New Fee Schedule

Evaluation-and-management services will be rewarded

Primary care physicians generally are pleased with the 2021 Medicare Physi-cian Fee Schedule, as reimbursement for office-based evaluation and management (E/M) services will increase this year. So will the value of many bundled services, such as maternity services and transitional care management. What's more, the new fee schedule means primary care doctors should experience less red tape and "note bloat" when seeking reimbursement.

"What will this mean for physicians who see patients in the office?" asked Kathy Blake, M.D., MPH, vice president, Health Care Quality, for the American Medical Association, at a virtual panel in mid-December. "We're expecting you'll be able to spend more time with patients and less time on documentation and coding. And really, the hope is that we can correct the current imbalance, which is that for every hour physicians spend with a patient, they spend two hours behind a computer screen."

Two choices

The final rule simplifies coding for E/M services, so that physician practices can code based either on medical decision-making or total time.

Prior to this, E/M codes were dependent on the physician evaluating the chief complaint, history of present illness, review of physiological systems, and past, family and social history, says Lisa Satterfield, senior director, health economics and practice management, for the American College of Obstetricians and Gynecologists. "These requirements were not clinically applicable to all patients and required significant documentation. Now physicians can choose between the total time caring for the patient on the date of service, which includes the review of records and documentation from other providers, or the complexity of the patient. The changes allow the physician to focus on the patient and their clinical needs, and removes the check-box-like system."

AMA President Susan R. Bailey, M.D., told *Repertoire*, "The process for coding and documenting E/M office visit services is now simpler and more flexible. It has been estimated that the new E/M coding and documentation guidelines for office visits will save clinicians 2.3 million hours per year."

Family physicians

Kent Moore, senior strategist for physician payment, American Academy of Family Physicians, calls the changes to the office/outpatient visit E/M codes "the most significant since the codes were implemented in 1992.

"Prior to the new rule, physicians could only code based on time if counseling and/or coordination of care dominated the encounter, that is, consumed more than half of the physician's face-to-face time with the patient," says Moore. Now,

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References: 1. Nelson R, Samore M, Smith K, et al. Cost-effectiveness of adding decolonization to a surveillance strategy of screening and isolation for methicillin-resistant *Staphylococcus aureus* carriers. *Clin Microbiol Infect.* 2010;16(12):1740–1746. **2.** PDI *in vivo* Study 0113-CTEVO.

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physicians can code based on total time spent on the date of service, including time spent before and after the visit, he says. "The significance of coding office visits based either on medical decision-making [MDM] or total time is that physicians have only one element – MDM or total time – to consider when selecting a level service, [instead of] three elements (history, exam, and MDM). How all of this will influence physicians' behavior remains to be seen."

CMS had initially proposed implementing a primary care add-on code (G2211) for complexity. But in December, Congress put off implementing the code for three years, in order to make an adjustment to the overall Medicare conversion factor.

Patient-focused

"We anticipate that many obstetrician-gynecologists will appreciate the change of the codes being patient-focused, and will likely use the medical decision-making algorithm when seeing their patients," says Satterfield. That algorithm takes into account three things: patient complexity, the amount and complexity of the data the physician must review in order to determine a proper course of treatment, and the risk of treatment or lack thereof.

Prior to the new rule, decision-making was based in part on how many physiological systems – e.g., neurological, circulatory, etc. – the physician reviewed, in addition to a history and physical. "It was based on what the physician did and not how the patient presented," says Satterfield. "Now payment is aligning with how physicians are practicing."

'Now payment is aligning with how physicians are practicing.'

The decision disappointed AAFP, says Moore. "CMS estimated that physicians who rely on office visit E/M codes, such as family physicians, would have used G2211 with 90% of visits. The payment associated with G2211 would have helped support family physicians and other primary care physicians in their efforts to meet the needs of their patient populations. For the patients of AAFP members, the delay in implementation of G2211 is neither good nor bad news in most cases, because AAFP members will continue to provide the same high standard of care to those patients, regardless. It will just be harder to do so without the support that G2211 would have otherwise provided."

ACOG takes exception to a few provisions of the 2021 fee schedule. "Because of some technicalities in statute, CMS determined they could not update the post-surgical visits bundled into the surgical codes. That decision, along with the overestimation of G2211, results in a significant decrease for all physicians, and especially surgical services. Gynecologic surgeries are necessary and important to women's healthcare.

"While Congress temporarily mitigated some of the significant cuts in payment through the recent COVID relief bill, most physicians are going to see approximately 5% decrease in overall payment for Medicare patients in 2021," Satterfield says. "The effects are even more detrimental to those who provide services for beneficiaries of the Medicaid program, where the average payment is about 68% of Medicare rates. These cuts are occurring when obstetrician-gynecologists are providing care to women across the lifespan and making accommodations in their practices to minimize their patients' exposure to COVID."

Like ACOG, the American Medical Association takes exception to a few E/M provisions of the 2021 final rule. Last fall, the AMA had recommended that CMS incorporate increases of reimbursement for office visits into surgical global payments. The final rule does not include that provision.

"Medicare and many other payors do not allow physicians to report hospital and office visits that occur in the post-operative payment," says Bailey. "For a major surgical procedure, all visits performed for 90 days following the surgery are considered bundled into the payment for the surgery. Historically, when hospitals or office visits have increased, the payment for these visits within the bundle has also increased. The AMA, the RUC [RVS Update Committee], and numerous national medical specialty societies continue to call on CMS to fairly increase the payment for these visits incorporated into the surgical global payments." ■

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BY DEANNA LEONARD

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Supply Chain leaders have never played a more pivotal and meaningful role than they do today. Covid-19 put them at the forefront. Even if they were not the ones getting public applause, those who work in healthcare know what a difference was made by the supply chain leaders in their facilities. While the traditional healthcare supply chain model often failed, cracked and sometimes cratered during 2020, the supply chain leaders where the ones to step up ensure the 'essential stuff' was on the shelf and ready to use. They got creative – and quickly!

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From offshore, to nearshore, to reshore – strategies changed and are continuing to change. In 2020 it was less about stepping back and looking at the supply chain strategy and more about immediate needs. And those immediate needs became the full focus of supply chain leaders around the world. As we enter Q2 of 2021, we are exhaling a bit, although just a little bit. Most supply chain leaders I have had the pleasure of speaking with are looking for continuity, consistency, reliability, and stability – and a most importantly, a back-up plan. Some are finally able to come up for air – and focusing on how to figure out the right equation and balance of offshore, nearshore and reshore. Some have shared with me that key to this is the flexibility component and how quickly supply chains can flex up and flex down. Their goals to ensure facilities have the right amount of 'stuff' on the shelf so the facility runs safely, without having so much stuff, there is no place to store it.

Running congruently to ensuring the right 'stuff' is in the right place – articles, podcasts, and interviews are shifting focus to the 'staff.' The healthcare staff, the front line workers are burning out, and have been pushed to the brink. A nurse hero I interviewed a few months ago told me one of the bigger challenges she was facing was "the random feeling of guilt – guilty for time spent at work when I'm not spending more time with my family, and guilty for time at home when I'm not spending time caring for my patients. It's an unending cycle." Often she felt powerless, even though she knew that she and her team were providing the best possible care. The entire conversation got me thinking about how we need to look at putting healthcare 'staff' in first place. How do we help them and all they have endured during the last year?

For this year's Nurses Week celebration (5/6-5/12/21), Encompass Group and Jockey are focused on providing comfort for those healthcare heroes who need it most! We are giving away Jockey Scrubs, Spa Gift Cards, and Head-to-Toe Comfort Baskets. It's a small and humble gesture, but very needed – to say thank you and that we appreciate everything you have been through. From a supply chain perspective, we can help there too. As a nearshore provider of professional healthcare apparel with short lead times and ample inventory on great brands like Jockey Scrubs, let us help you make a difference for your staff.

As I stated last in last month's article, it probably goes without saying, but all of those involved with ensuring our healthcare systems kept moving forward in 2020, and 2021, have earned our sincerest gratitude at Encompass Group. We would like to say thank you by sending you the most comfortable scrubs you'll ever wear. You helped everyone stay safe and comfortable – now it's our turn. We appreciate all you do and know what a difference you and your teams make. If you would like to try Jockey Scrubs, as seen in our ad, scan the QR code or visit our site.

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2021 Physician Fee Schedule Raises Smiles, Frowns, Among Doctors

Primary care physicians are pleased they will be rewarded for the time and energy spent on evaluating and managing their patients, especially those with chronic conditions, per the 2021 Medicare Physician Fee Schedule (PFS), which became effective Jan. 1. But doctors who bill more surgical and procedural services and fewer E/M services have less to smile about.

The Centers for Medicare & Medicaid Services says the new fee schedule reflects the agency's investment in primary care and chronic disease management and will cut some of the red tape

Proposed payment cuts would harm patients by forcing doctors to make extremely difficult decisions.

traditionally associated with reimbursement. The rule also addresses telehealth and remote patient monitoring, and nails down new responsibilities for non-physician practitioners.

Under the schedule, some physician specialties will likely see a rise in Medicare reimbursement, including endocrinology, rheumatology, family practice and hematology/oncology. Other specialties, including anesthesia, emergency and surgery, won't.

"The payment improvements will go a long way to helping physician practices over the next year as we continue to deal with COVID-19, and in the future," said Jacqueline W. Fincher, M.D., MACP, president of the American College of Physicians, in a statement issued on Dec. 2, one day after CMS released the final schedule. "We need to ensure that practices across the country are able to continue to operate and provide front-line care in their communities."

On the other hand, the American College of Surgeons said the new fee schedule "will harm patients and further destabilize a healthcare system already under severe strain from the COVID-19 pandemic." The organization said that a survey it conducted in September showed that proposed payment cuts would harm patients by forcing doctors to make extremely difficult decisions, such as reducing Medicare patient intake, laying off nurses and administrative staff, and delaying investment in technology.

Since 1992, Medicare has paid for the services of physicians and other billing professionals under the Physician Fee Schedule. Payments are based on the relative resources typically used to furnish the service. Relative value units (RVUs) are applied to each service for physician work, practice expense, and malpractice. These RVUs become payment rates through the application of a conversion factor. Payment rates are calculated to include an overall payment update specified by statute.

To account for the increase in RVUs for E/M services and still maintain compliance with a budget neutrality adjustment, CMS decreased the 2021 conversion factor to $34.89, down $1.20 from the previous year's conversion factor of $36.09. ■

Projected winners, losers from 2021 Medicare Physician Fee Schedule

SPECIALTY	IMPACT
Winners	
Endocrinology	14%
Rheumatology	13%
Hematology/oncology	12%
Family medicine	12%
Nephrology	11%
Clinical social worker	9%
Physician assistant	9%
Nurse practitioner	9%
General practice	8%
Psychiatry	8%
Interventional pain mgmt.	8%
Clinical psychologist	8%
Allergy/immunology	8%
Urology	8%
Losers	
Anesthesiology	-1%
Vascular surgery	-1%
Cardiac surgery	-2%
Chiropractor	-2%
Interventional radiology	-2%
Physical/occupational therapy	-2%
Pathology	-2%
Radiology	-3%
Nurse anesthetist/assistant	-3%
Somewhere in between	
Obstetrics/gynecology	7%
Pediatrics	7%
Internal medicine	6%
Geriatrics	6%
Otolaryngology	6%
Podiatry	6%
Dermatology	5%
Cardiology	4%
Pulmonary disease	4%
Gastroenterology	2%
General surgery	0%

Source: American Medical Association. (For a complete list of specialties, see: American Medical Association)

Preventive Care Guidelines

Researchers suggest it might be time for some 'de-intensification'

Does anybody actually oppose the concept of preventive medicine for kids and adults? Ask yourself: How many people do you know who believe that regular blood pressure checks at the pediatrician's office or annual well-woman visits are bad?

Yet in a research report and accompanying editorial in *JAMA Internal Medicine* this fall, clinicians from the University of Michigan and elsewhere raised a red flag: They ask, Have we reached a point where providers have too many guidelines to keep track of, including those pertaining to preventive care? When professional societies or governmental agencies add recommendations to their guidelines, do they remove others of lesser value? Is it time to "de-intensify" preventive care guidelines?

"Much of health care involves established, routine, or continuing use of medical services for chronic conditions or prevention," write the authors of "Identifying Recommendations for Stopping or Scaling Back Unnecessary Routine Services in Primary Care." "Stopping some of these services when the benefits no longer outweigh the risks (e.g., owing to older age or worsening health) or when there is a change in the evidence that had previously supported ongoing treatment and monitoring, presents a challenge for both clinicians and patients and is rarely done successfully even when evidence favors cessation."

Personalize preventive care

"If we don't work to get healthier as a nation, we will not be able to afford our healthcare," says Eva Chalas, M.D., FACOG, FACS, president of the American College of Obstetricians and Gynecologists. "The steady and rather dramatic rise in healthcare cost is unsustainable.

"Prevention is truly worth a pound of cure," she says. "Unfortunately, most Americans take better care of their cars and pets than their health. The obesity epidemic – which is responsible for the development of many other conditions, including hypertension, heart disease, type 2 diabetes, cancer and musculoskeletal diseases, amongst others – continues to be on the rise. We must convince our populations to engage in healthier lifestyles, and that medications are not a substitute for lifestyle changes."

Preventive care guidelines can help, but "we should not practice 'one size fits all' medicine," says Chalas. "I believe that preventive care should be personalized and as such, based on each patient's risk factors to develop a particular condition." In this, she agrees with the JAMA researchers, who advise against performing annual cardiac testing in individuals at low risk for cardiovascular disease.

"Gaps in health care of our patients continue to exist, and we need to find ways to engage them in their healthcare to minimize risk of development of chronic diseases, such as obesity, type 2 diabetes, hypertension, heart disease and cancers related to inherited deleterious mutations. Because obstetricians and gynecologists care for their patients across their lifespan, we are uniquely positioned to predict the risk of development of these conditions, since many initially occur in pregnancy, and help patients mitigate these risks.

"I believe that in the future, we will be using genetic information to identify risk factors for chronic diseases at birth, and working with parents and pediatricians on mitigation strategies," she says.

'Clear and unambiguous'

Suzanne Berman, M.D., a pediatrician in Crossville, Tennessee, and chair of the American Academy of Pediatrics' Section on Administration and Practice Management,

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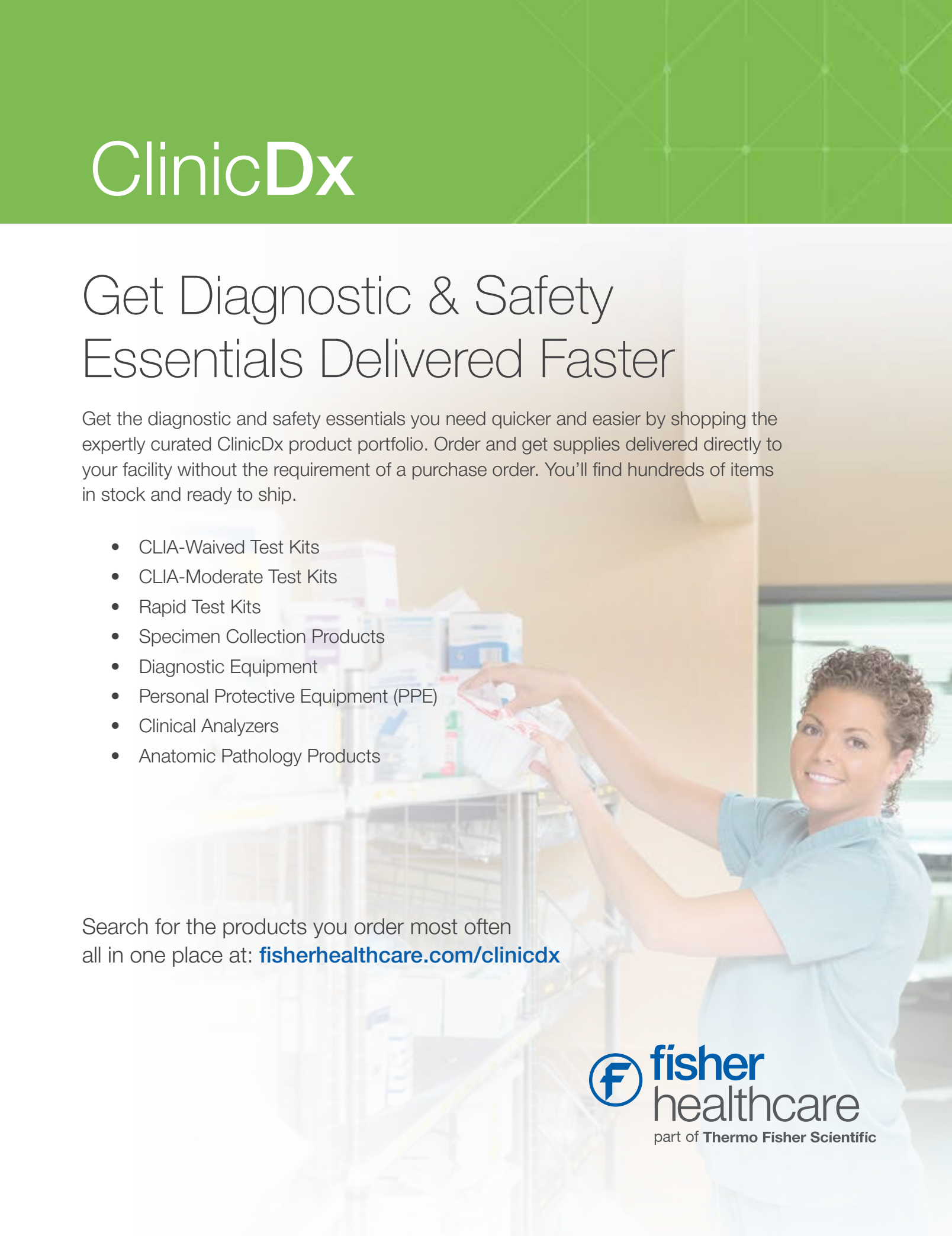

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agrees with the JAMA authors that subtracting one preventive care guideline for every new one that's added isn't a bad idea. But it's not always possible, particularly with pediatrics. It's difficult to characterize any pediatric preventive-care guidelines as non-essential, as they may add decades – not merely months or years – of healthy living to kids' lives, she says.

But like the JAMA authors, Berman believes that guidelines – whether for prevention or therapy – must be clear and unambiguous. "A guideline that says 'Avoid use of drug X for condition Y' is too vague," she says. "What does 'avoid use' mean?" Does it mean never use the drug for that condition, or does it mean only use it under certain circumstances? And are those circumstances clearly defined?

AAP policy-writers of the organization's Bright Futures preventive care guidelines strive for precision, she points out. First launched in 1994 and updated regularly, Bright Futures offers a schedule of recommended preventive services for children, and it forms the basis for Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.

Berman points out one more difficulty associated with guidelines: It can take a long time – years, in fact – for new ones to become standard practice. For example, a study may show incontrovertibly that early supplementation of iron for babies with anemia improves outcomes, yet years may pass before the majority of pediatricians are onboard. Perhaps it's force of habit on the part of physicians or even insurers, or simply the fact that it takes time for the majority of clinicians to become aware of new guidelines, let alone integrate them into their practices.

At the same time, years may pass before the majority of doctors finally abandon practices that have been discredited. "We sometimes shake our heads and ask, 'How can people still be doing that?'" she says. "After all, we are supposed to learn how to continually evaluate medical evidence." But doctors are busy, they have their families and friends, or they may simply fail to stay current with certain protocols if they rarely see patients to which they apply.

Evidence-based medicine

"Preventative care is an integral and important part of family medicine," says Amy Mullins, M.D., medical director for quality and science, American Academy of Family Physicians. "Screening for disease, then altering the course of that disease if needed, is life-changing for patients and ultimately saves the health care system dollars.

AAFP supports the use of evidence-based medicine, she adds. "This involves all aspects of medicine and is necessarily complex, complicated, and requires the use of many different guidelines."

The AAFP reviews recommendations put forth by the United States Preventive Services Task Force (USPSTF) and the CDC's Advisory Committee on Immunization Practices (ACIP), and either chooses to agree or disagree with their recommendations, says Mullins. "We also review guidelines from other medical organizations and either endorse, provide an affirmation of value, or do not endorse.

"Guidelines are routinely updated, and some are retired, as are the quality measures that are typically developed using the guidelines. The USPSTF and ACIP recommendations are also routinely updated. The AAFP utilizes a specific methodology for developing clinical practice guidelines based on available evidence and patient preferences." ■

Preventive care guidelines: Resources

- Advisory Committee on Immunization Practices (ACIP), Centers for Disease Control and Prevention, www.cdc.gov/vaccines/acip/index.html
- Bright Futures, American Academy of Pediatrics, https://brightfutures.aap.org/Pages/default.aspx
- Clinical Preventive Services Recommendations, American Academy of Family Physicians, www.aafp.org/family-physician/patient-care/clinical-recommendations/clinical-practice-guidelines/clinical-preventive-services-recommendations.html
- Comparative Guideline Tables, American College of Physicians, www.acponline.org/clinical-information/guidelines/comparative-guideline-tables. (Summaries of recommendations from a variety of U.S. and international organizations regarding controversial topics in screening, prevention and management. Available to ACP members.)
- Women's Preventive Services Initiative (WPSI), American College of Obstetricians and Gynecologists, www.womenspreventivehealth.org/about
- U.S. Preventive Services Task Force, www.uspreventiveservicestaskforce.org/uspstf


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[1] https://www.ncbi.nlm.nih.gov/pubmed/10450120
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