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Industry Prepared for COVID-19 Vaccine

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Building resiliency in the supply chain

AHRMM Director of Supply Chain: America's supply chain teams are working constantly to meet today's challenges



Heading into the upcoming respiratory season, there remain a number of challenges for hospital and health system supply chain teams, said Mike Schiller, AHRMM Director of Supply Chain. “First and foremost personal protective equipment (PPE) has been, and continues to be, strained since this pandemic began,” he said. “Worldwide demand for PPE, which is unlike anything we’ve ever experienced, and the recent increase in patient cases will put more stress on an already overtaxed and fragile health care supply chain.” To meet current demand, hospitals continue to turn to non-traditional or novel manufacturers and suppliers to bridge their current supply needs and to increase their emergency stockpiles.

Testing requirements and the supplies necessary to support testing is another area of focus and remains a challenge – inside and outside of the health care environment. Hospitals are building their safety stocks of critical

pharmaceutical products including sedatives, neuromuscular and vasopressors in preparation for an expected surge this fall in COVID cases.

Finally, with the pending availability of a vaccine, Schiller said supplies that

support vaccinations must be front of mind including alcohol wipes, syringes and basic PPE to health care workers administering the vaccine.

Key areas

While it’s early, there are a number of key areas supply chain professionals are focusing to build resiliency into their supply chains, Schiller said. Increasing on-hand inventory levels and relaxing Just-In-Time inventory principles. Contracting will change with some considering moving to multisource vs. sole source contracts, and opportunities to continue, or to strengthen sourcing relationships with local or regional companies that have been established over the past few months.

Longer-term objectives include the adoption and utilization of data standards, including the Unique Device Identifier (UDI); needed transparency, inventory availability and utilization data upstream and downstream within the health care supply chain; improved/robust analytics capabilities.

“Given all of these challenges, America’s hospitals and health systems are working constantly to meet the challenges of the COVID-19 pandemic, to protect our front line heroes, caregivers and patients,” Schiller said. ■



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Industry Prepared for COVID-19 Vaccine

Alarms were raised this spring and summer about potential shortages of vaccine-related products. Despite the uncertainty, industry experts expressed confidence the country would avoid situations such as the PPE shortages experienced earlier in the year.

The race to develop a COVID-19 vaccine has been in the public eye since

spring. The race to provide enough needles, syringes and glass vials to administer it has been somewhat lower key. Still, it hasn't been without nervous moments.

For example, in early May, Rick Bright, former deputy assistant secretary for preparedness and response and director of the Biomedical Advanced Research and Development Authority (BARDA), warned that the nation's stockpile of needles and syringes was only 2% of the required amount. (In addition to anticipating a two-shot vaccine, Bright's calculations included about 180 million more syringes for an increase in requests for flu shot, reported USA Today.)

Questions about the vaccine remain. For example, when will it be available? How quickly will it be rolled out? Will it be injected, or taken orally or nasally? Will it be delivered in pre-filled syringes? Will one injection be enough to achieve immunization, or will two injections be needed? How many Americans will actually get vaccinated?

Feds take action

The federal government has taken an active role, contracting for 820 million syringes, including 420 million by the end of 2020 and the rest in 2021, reported USA Today.

- › In May, BARDA – part of the Department of Health and Human Services' Office of the Assistant Secretary for Preparedness and Response – awarded contracts for needles and syringes for approximately \$110 million to Retractable Technologies (Little Elm, Texas) and Marathon Medical (Aurora, Colorado) for 320 million needles and syringes, and to Franklin Lakes, New Jersey-based Becton Dickinson for approximately \$11 million for 50 million units of needles and syringes.
- › Also in May, the Department of Defense and HHS announced a \$138 million contract with Apiject Systems America for U.S.-based manufacturing capacity that could produce approximately 100 million pre-filled syringes using the company's "blow-fill-seal" technology in 2020, and more than 500 million through 2021.
- › In mid-July, Smiths Medical announced a partnership with BARDA and the Department of Defense to expand capacity at its facility in Keene, New Hampshire, for production of integrated hypodermic needle and syringe products to support COVID-19 vaccination. The federal government will have priority access to this expanded capacity for vaccination efforts dedicated to COVID-19, flu vaccines, and future pandemics.
- › In July, BD announced a partnership with BARDA to develop new

manufacturing lines for injection devices that would provide priority access to the U.S. government for hundreds of millions of syringes and needles to support current and future pandemic vaccination efforts. BARDA agreed to invest an estimated \$42 million into a \$70 million capital project to further expand BD's operations and manufacturing capacity in Nebraska. The new capacity was expected to be online within 12 months. Later that month, BD signed an agreement with BARDA for 140 million injection devices for the U.S. market.

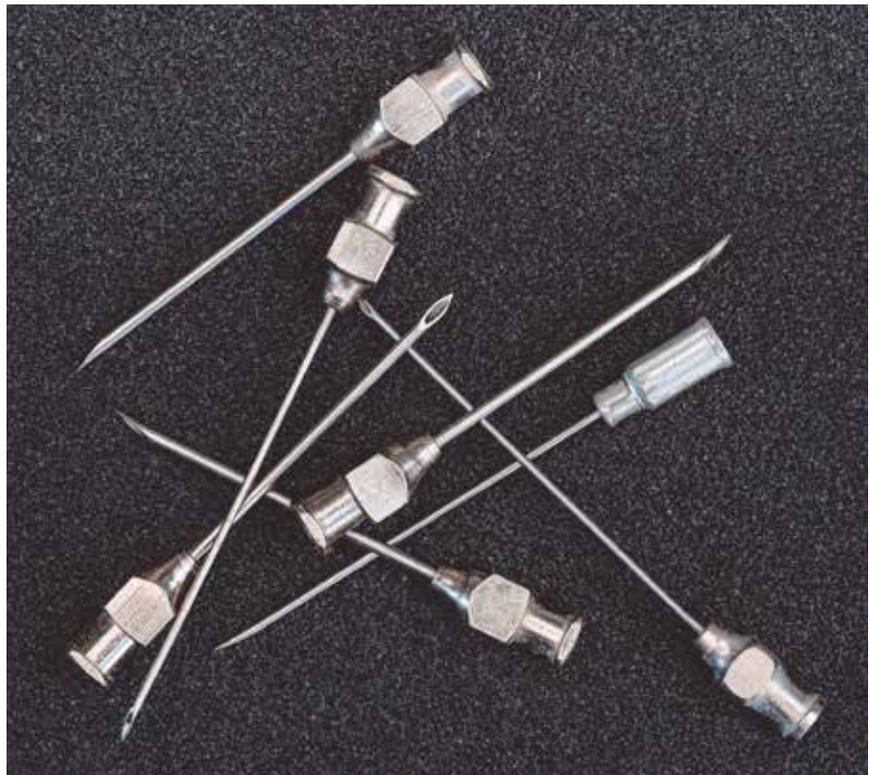
"We've been very clear that these large pandemic orders will not affect BD's ability to fulfill existing customer requirements for needles and syringes, including the annual flu vaccination and childhood immunization campaigns," BD spokesperson Troy Kirkpatrick said in mid-July. "We have capacity to manufacture hundreds of millions of syringes between now and January, but if governments wait too long, there will not be enough manufacturing capacity across the global industry to make billions of devices in a month or two.

"A vaccination campaign the size and scope of an entire country/world isn't something that happens in a month," he added. "It will be the better part of a year to get everyone inoculated, so even if the new lines don't come online for 12 months, there could still be a significant need for devices at that time."

Avoiding panic buying

Terry Altshuler, portfolio executive for Vizient Inc., said that needle-and-syringe

'Lead indicators show that providers and supply chain stakeholders are taking the right measures and steps to be prepared.'



suppliers indicate they have a surplus of product due to the decline of non-essential procedures that accompanied COVID-19. "In addition, suppliers are factoring in the possibility of a vaccine being available and making the necessary preparations," he said. "While they are allocating product to an extent, the intent is to avoid 'panic buying' and ensure that facilities throughout the country are able to obtain product."

Mittal Sutaria, Vizient's vice president, contracting and program services

for pharmacy, said that as of mid-July, Vizient was not aware of any members attempting to stockpile needles and syringes. "After the government began placing orders for needles and syringes in May in anticipation of a vaccine for COVID-19, most manufacturers and distributors put their products on protective allocation to prevent anticipatory purchasing by providers and to help ensure that available product is distributed as evenly as possible across all healthcare settings," he said.

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“From a vaccine perspective, there are still too many unknowns when it comes to considerations for creating a stockpile. The allocation of vaccine will involve many stakeholders, including manufacturers, distributors, hospitals, government and public health entities.”

‘From a vaccine perspective, there are still too many unknowns when it comes to considerations for creating a stockpile.’

Right measures and steps

Chau Powell, group vice president of strategic supplier engagement at Premier Inc., said that Premier members anticipate having enough needles and syringes to get through flu season and COVID-19 vaccines. “Lead indicators show that providers and supply chain stakeholders are taking the right measures and steps to be prepared,” he said.

“Over the next 18 months, we, as a nation, will have contracted to create more than 870 million syringes above normal production, which exceeds 5 billion syringes for the acute domestic healthcare industry alone. In addition, the private sector is also ramping up its production output. Assuming there are no

unforeseen external variables, we anticipate having enough syringes.”

The situation with needles and syringes differs from that faced with N95s earlier in the year, he added. “With N95s, we, as a country, went from a national consumption rate (specific to acute healthcare) of approximately 25 million masks annually to over 300 million. The twelve-fold increase was unsustainable. With syringes, our baseline is 5 billion consumed annually in the acute space. Adding another 800+ million syringes indicates an approximate 20% increase, but it is no comparison to the twelve-fold impact we saw with masks.” What’s more,

the U.S. healthcare supply chain has had the time and foresight to increase production and inventories of needles and syringes, he said.

Premier members express confidence that their physician practices will have enough needles and syringes to meet upcoming demand, added Powell. “In our June survey of acute care members, we asked our members how adequate they felt their inventory of vaccines was in physician offices. Eighty-three percent said they had an adequate supply, and in fact, a small number (2%) noted they were overstocked due to the decrease in other procedures.” ■

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A Continuation

AHA report: Financial Impact of COVID-19 Expected to Top \$323 Billion in 2020

The financial strain facing hospitals and health systems due to COVID-19 will continue through at least the end of 2020, with patient volume expected to remain well below baseline levels, according to an AHA report released this summer .

The report estimates an additional minimum of \$120.5 billion in financial losses, due in large part to lower patient volumes, from July 2020 through December 2020, or an average of \$20.1 billion per month. These estimates are in addition to the \$202.6 billion in losses the AHA estimated between March 2020 and June 2020 in a report released earlier in the year.

This brings total losses for the nation's hospitals and health systems to at least \$323.1 billion in 2020. "And while potentially catastrophic, these projected losses still may underrepresent the full financial losses hospitals will face in 2020, as the

analysis does not account for currently increasing case rates in certain states, or potential subsequent surges of the pandemic occurring later this year," AHA said in a release. If the current surge trends continue, the financial impact on hospitals and health systems could be even more significant.

"This pandemic has shown once again why America's hospitals and health systems are indispensable cornerstones of their communities. However, hospitals and health systems are in the midst of the greatest financial crisis in our history, as we continue to fight this pandemic at the same time that non-COVID patient visits

remain down," said Rick Pollack, AHA president and CEO. "While we appreciate the support to date from Congress and the Administration, this report clearly shows that we are not out of the woods. More action is needed urgently to support our nation's hospitals and health systems and front-line staff."

The report found that hospitals and health systems currently report average declines of 19.5% in inpatient volume and 34.5% in outpatient volume relative to baseline levels from 2019. In addition, most hospitals and health systems do not expect volume to return to baseline levels in 2020. The report's analysis does not account for currently increasing case rates in certain states, or potential subsequent surges of the pandemic occurring later this year.

While the financial impacts estimated in this report are comprehensive, and take into account the additional costs of acquiring personal protective equipment (PPE) as patient volumes return, they importantly do not include any direct COVID-19 treatment costs hospitals may incur over this time period, particularly if there are future surges of additional cases, AHA noted. Other expenses, such as increased acquisition costs for drugs and non-PPE supplies and equipment, are also not included in the estimates. "Thus, the estimated losses in [the] report do not reflect the full financial impact of the pandemic on America's hospitals and health systems in 2020," AHA said. "Nor do they include the long-term effects of the pandemic beyond 2020." ■





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

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Understanding the Differences

What are the differences between Influenza (Flu) and COVID-19? The CDC explains.



Influenza (Flu) and COVID-19 are both contagious respiratory illnesses, but they are caused by different viruses, according to the CDC.

“COVID-19 is caused by infection with a new coronavirus (called SARS-CoV-2) and flu is caused by infection with influenza viruses,” the CDC said on its website. “Because some of the symptoms of flu and COVID-19 are similar, it may be hard to tell the difference between them based on symptoms alone, and testing may be needed to help confirm a diagnosis. Flu and COVID-19 share many characteristics, but there are some key differences between the two.

While more is learned every day, there is still a lot that is unknown about COVID-19 and the virus that causes it. The following table compares COVID-19 and flu, given the best available information to date.

Signs and symptoms

Similarities

Both COVID-19 and flu can have varying degrees of signs and symptoms, ranging from no symptoms

(asymptomatic) to severe symptoms. Common symptoms of COVID-19 and flu include:

- › Fever or feeling feverish/chills
- › Cough
- › Shortness of breath or difficulty breathing
- › Fatigue (tiredness)
- › Sore throat
- › Runny or stuffy nose
- › Muscle pain or body aches
- › Headache
- › Some people may have vomiting and diarrhea, though this is more common in children than adults



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Differences

Other signs and symptoms of COVID-19 may include change in or loss of taste or smell. (More symptoms may be added following this issue.)

How long symptoms appear after exposure and infection

Similarities

For both COVID-19 and flu, 1 or more days can pass between a person becoming infected and when he or she starts to experience illness symptoms.

Differences

If a person has COVID-19, it could take them longer to develop symptoms than if they had flu.

COVID-19

- › Typically, a person develops symptoms 5 days after being infected, but symptoms can appear as early as 2 days after infection or as late as 14 days after infection, and the time range can vary.

Flu

- › Typically, a person develops symptoms anywhere from 1 to 4 days after infection.

How long someone can spread the virus

Similarities

For both COVID-19 and flu, it's possible to spread the virus for at least 1 day before experiencing any symptoms.

Differences

If a person has COVID-19, they may be contagious for a longer period of time than if they had flu.



COVID-19

- › How long someone can spread the virus is still under investigation. It's possible for people to spread the virus for about 2 days before experiencing signs or symptoms and remain contagious for at least 10 days after signs or symptoms first appeared.
- › If someone is asymptomatic or their symptoms go away, it's possible to remain contagious for at least 10 days after testing positive for COVID-19.

Flu

- › Most people are contagious for about 1 day before they show symptoms. Older children and adults with flu appear to be most contagious during the initial 3-4 days of their illness but many remain contagious for about 7 days. Infants and people with weakened immune systems can be contagious for even longer.

How it spreads

Similarities

- › Both COVID-19 and flu can spread from person-to-person, between people who are in close contact with one another (within about 6 feet).
- › Both are spread mainly by droplets made when people with the illness (COVID-19 or flu) cough, sneeze, or talk.
- › These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.
- › It may be possible that a person can get infected by physical human contact (e.g. shaking hands) or by touching a surface or object that has virus on it and then touching his or her own mouth, nose, or possibly their eyes.
- › Both flu virus and SARS-CoV-2 may be spread to others by people before they begin showing symptoms, with very mild symptoms or who never developed symptoms (asymptomatic).



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Differences

While COVID-19 and flu viruses are thought to spread in similar ways, COVID-19 is more contagious among certain populations and age groups than flu. Also, COVID-19 has been observed to have more superspreading events than flu. This means the virus that causes COVID-19 can quickly and easily spread to a lot of people and result in continuous spreading among people as time progresses.

People at high-risk for severe illness

Similarities

Both COVID-19 and flu illness can result in severe illness and complications. Those at highest risk include:

- › Older adults
- › People with certain underlying medical conditions
- › Pregnant people

Differences

COVID-19

- › School-aged children infected with COVID-19 are at higher risk of Multisystem Inflammatory Syndrome in Children (MIS-C), a rare but severe complication of COVID-19.

Flu

- › Young children*

*The risk of complications for healthy children is higher for flu compared to COVID-19. However, infants and children with underlying medical conditions are at increased risk for both flu and COVID-19.

Complications

Similarities

Both COVID-19 and flu can result in complications, including:

- › Pneumonia
- › Respiratory failure

- › Acute respiratory distress syndrome (i.e. fluid in lungs)
- › Sepsis
- › Cardiac injury (e.g. heart attacks and stroke)
- › Multiple-organ failure (respiratory failure, kidney failure, shock)
- › Worsening of chronic medical conditions (involving the lungs, heart, nervous system or diabetes)
- › Inflammation of the heart, brain or muscle tissues
- › Secondary bacterial infections (i.e. infections that occur in people who have already been infected with flu or COVID-19)

Differences

Additional complications associated with COVID-19 can include:

- › Blood clots in the veins and arteries of the lungs, heart, legs or brain
- › Multisystem Inflammatory Syndrome in Children (MIS-C)

Source: CDC website, www.cdc.gov/flu/symptoms/flu-vs-covid19.htm#table

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Combating COVID with Data

The Collective and Augmented Intelligence Against COVID-19 (CAIAC) alliance

An alliance of researchers across the country has formed to tackle complex data in an effort to better combat COVID-19.

The Future Society and Stanford Institute for Human-Centered Artificial Intelligence (HAI), with the support of UNESCO and the Patrick J. McGovern Foundation, announced the creation of the Collective and Augmented Intelligence Against COVID-19 (CAIAC) alliance. CAIAC will establish an advisory group which aims to welcome experts from international organizations, including UNESCO, UN Global Pulse and other UN entities.

CAIAC will structure the rapidly expanding collection of global health, social and economic data on the pandemic to enable the world's decision-makers to confidently take action. "By turning data into knowledge, CAIAC will help those at the forefront of the fight against COVID-19, including multilateral institutions, policymakers, healthcare leaders, and the scientific community," a release said.

Scarcity of data

Actionable COVID-19 data has been scarce because the virus is still novel, the CAIAC said. At the same time data is abundant, as it emerges quickly from many different sources with no trusted filter. Research institutions, think-tanks, and NGOs have hurried to add their analyses and models to the data being reported by countries. The result, however, is a mass of information and a shortage of insight.

"To respond to this pressing global challenge, CAIAC is bringing together multiple data sources and expertise from a diverse group of global initiatives and building a dynamic and state-of-the-art



decision-support tool that is comprehensive, authoritative, up-to-date, and ethical," the release said.

The initiative's founding members are partnering closely with private sector companies, including C3.ai, stability.ai, Element AI, Axis, GLG, and Planet on the technology that combines human and artificial intelligence to power this decision-making platform. Covington & Burling LLP is providing legal guidance for the

initiative. The platform will be available to multilateral organizations, governments and global entities. CAIAC will also collaborate with technical, scientific, and civil society partners around the world to collect data on COVID-19, identify critical domains where structured information on the pandemic is needed most.

CAIAC aims to create a Minimum Viable Product (MVP) focused on three initial use cases:

- › Tracking and tracing of contagion chains via mobility data and artificial intelligence
- › Identifying and addressing inaccurate information on COVID-19,
- › Finding marginalized areas most affected by second and third order pandemic impacts to deploy the appropriate interventions needed.

"CAIAC will enable the global community to better identify best practices and coordinate in the fight against COVID-19 by providing cross-country and cross-sector insights on all aspects of the pandemic," the release said. "The key to sustainable results is multi-stakeholder collaboration on a common, unified, transparent knowledge base that documents and disseminates best practices. CAIAC hopes to accelerate solutions that will help the world navigate the current pandemic, while also building a foundation of knowledge to address future global challenges."

For more information, visit www.caiac19.org. ■

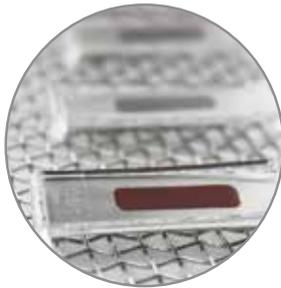
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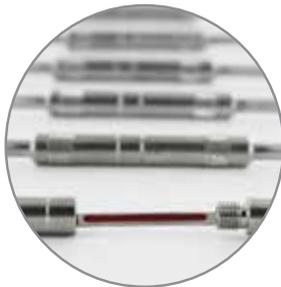
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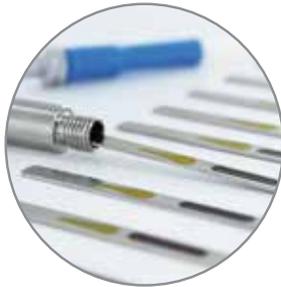
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Walgreens announces large-scale rollout of physician-led primary care clinics



Walgreens Boots Alliance, Inc. and VillageMD announced this summer that Walgreens will open 500 to 700 “Village Medical at Walgreens” physician-led primary care clinics in more than 30 U.S. markets in the next five years, with the intent to build hundreds more thereafter.

The clinics will integrate the pharmacist as a critical member of VillageMD’s multi-disciplinary team, and will be staffed by more than 3,600 primary care providers, who will be recruited by VillageMD, according to a release.

The clinics will accept a wide range of health insurance options, and offer comprehensive primary care across a broad range of physician services. Additionally, 24/7 care will be available via telehealth and at-home visits. More than 50% will be

located in Health Professional Shortage Areas and Medically Underserved Areas/Populations, as designated by the U.S. Department of Health and Human Services.

This rollout follows a trial with five in-store clinics in the Houston, Texas area, which produced very strong results after opening last November including high patient satisfaction, with Net Promoter Scores over 90, the release said.

Data from current Village Medical clinics shows that an integrated pharmacy

and primary care approach increases medication adherence and contributes to improved patient outcomes.

“This rollout is a major advancement of one of Walgreens Boots Alliance’s four key strategic priorities, Creating Neighborhood Health Destinations,” said Stefano Pessina, executive vice chairman and CEO, Walgreens Boots Alliance. “These clinics at our conveniently located stores are a significant step forward in creating the pharmacy of the future, meeting many essential health needs all under one roof as well as through other channels.”

“In the U.S., we spend \$4 trillion per year on healthcare, over 85% of that is tied to patients with chronic diseases. To improve our healthcare system and reverse the trajectory of health spending, we must meet the needs of all patients. This partnership allows us to unleash the power of primary care doctors and pharmacists, enabling them to work in a coordinated way to enhance the patient experience,” said Tim Barry, chairman and CEO, VillageMD. “The results of our initial pilot clinics highlight that these outcomes are infinitely achievable.”

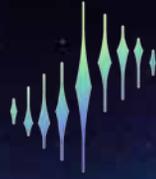
Most of the clinics will be approximately 3,300 square feet each, with some as large as 9,000 square feet. They will optimize existing space in the store, which will also still provide a vast range of retail products to customers. ■

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