ROUNDTABLE: INTEGRATED SUPPLY CHAIN

OPTIMIZING CLINICALLY INTEGRATED SUPPLY CHAIN

Purchasing accounts for about 25% of operating expenditures at healthcare organizations. With a large portion of the bottom line as well as clinical outcomes at stake, finance leaders, physicians, and supply chain managers need to work together when making purchasing decisions. A clinically integrated supply chain that balances cost, quality, and outcomes can achieve efficiency and value objectives.

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HIGHLIGHTS

HealthLeaders: *What are the essential elements of a clinically integrated supply chain?*

Frank Eischens: A supply chain needs to be built on a foundation of data analytics, point-of-use management, and strategic contracting, but those three things do not do anything by themselves. You need relationships with clinicians in a way that allows them to see the outcome of their choices, including technical data and the financial data associated with the supply decisions that they are making. Providing that data in a neutral and consistent fashion helps clinicians be more engaged in the business aspect of medicine as well as the clinical side.

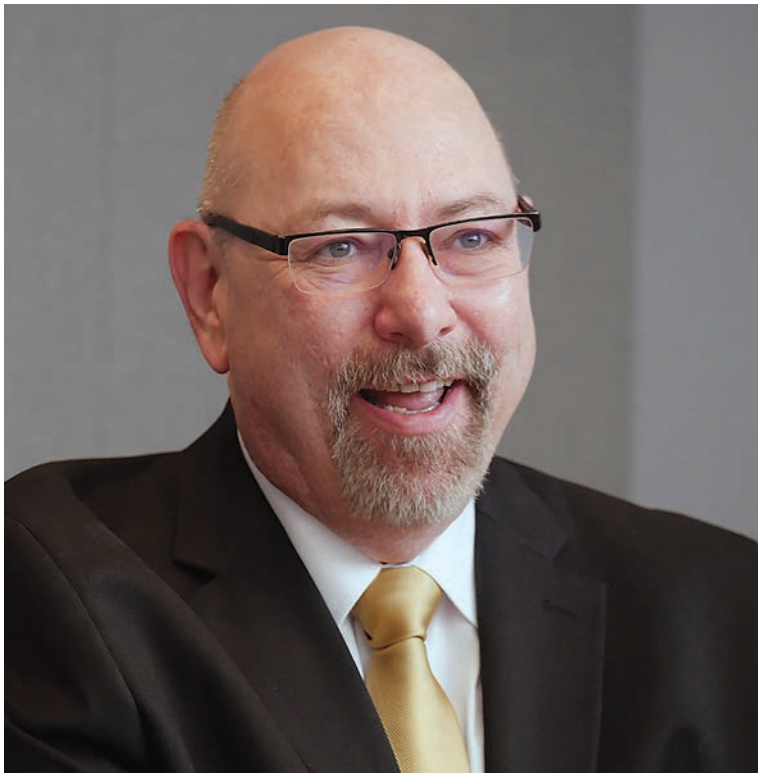
Allen Passerallo: One of the key elements is to have a culture within the organization that is supportive of value-based care and is communicating properly through those channels. You are buying an acceptance from a clinical aspect. Whether it is an employed model or private practice model, you have to be transparent with your clinical objectives, then utilize a collaborative relationship with supply chain to help facilitate and bring strategy to the table to see how we can achieve quality and cost savings.

Martin Lucenti: I want to take one step back and just start with the basic premise: Why is clinical supply chain integration so important now? It really comes down to the context and the change of reimbursement in healthcare. Twenty years ago, doctors were the hospitals' customer, and reimbursement was pretty much cost plus. A hospital having an opinion on how I practiced was somewhat ludicrous. Basically, medicine was an individually practiced endeavor. Then, on the facility side, reimbursement started to be tied to outcome. All of a sudden, the health system got very vested in how I was practicing medicine, and there was the assumption of risk. So, 20 years ago, if I had a complication, what did that mean to the hospital?

HLM: *More money.*

Lucenti: More money. So, the reimbursement dynamic has changed. Second, any complications or deviations from the way I practiced that led to problems became the hospital's financial problem, not the payer's financial problem. There is now an incentive that the health system is vested in creating influence to make sure we are practicing to great outcomes, and that we are conscious of some of the costs. If you are going to embark on taking out the non-value-added cost in the provision of healthcare, the endeavor is a multidisciplinary action led by your practicing clinicians.

Trisha Gillum: I'd take it one step further because we saw the reimbursement change with DRGs, but we did not have a clinically integrated supply chain at that point. We did not have the physician engagement. Value-based purchasing and pay-for-performance has definitely driven hospitals to partner more with physicians, but physician reimbursement has engaged physicians with the hospitals as well. The business model is pulling us closer together to allow us to have conversations.



Frank Eischens, RN
director, supply chain, University of Iowa Hospitals & Clinics, Iowa City, Iowa

HLM: *How do you engage clinicians to become more active participants in supply chain?*

Passerallo: We have medical directors that are part of our supply chain department. So, we align with our medical operations division, and they help fund the medical directors to be a part of our department. That gives us credibility with the physicians throughout the enterprise. We have four medical directors inside of our supply chain. We utilize them in every aspect of supply chain, whether it's clinical or nonclinical. Regarding participation from a champion level, we are not going to go into a strategic sourcing opportunity without a physician who is going to be part of the process and by our side communicating the initiative and collecting clinical data. We preach that it's always about quality first; cost is second.

HLM: *How do you deploy those four medical directors?*

Passerallo: They are divided by service lines. We have two orthopedists, a general surgeon, and an anesthesiologist. So, the anesthesiologist will have areas like heart and vascular, imaging, and anesthesia.

Gillum: We do not have medical directors in supply chain, but we

take a very similar approach. Working with our service line leaders and executives at each of our facilities, we identify physician champions. We usually spend time sitting down with them reviewing data, reviewing the value proposition both from a research basis as well as the financial contract offering. Then we look to those physician champions to help with the communication as we reach out across the various facilities and physician meetings.

HLM: *How do you identify physician champions?*

Gillum: It could be someone who has a personal interest in a particular topic. It could be a physician who is an industry leader in a particular area. It could just simply be the volume. Sometimes, it is the power position of a service line director.

Eischens: We've taken more of an organic approach—taking a page from industry. We have hired more people with clinical backgrounds into supply chain. They are comfortable going to the ORs, going to the cath labs. We train them on communication, professionalism, and all of the things that they need to do in order to build meaningful professional relationships with physicians. Based on those personal relationships, we are trying to have physicians trust and be engaged with supply chain at least as much as any company that they might be working with.

Lucenti: The best way to engage the clinicians is to put them in charge—make it their responsibility. It is always incredibly painful for the supply chain to try to take out $20 million in costs while coercing a group of doctors. Give the doctors $20 million of cost reductions, and they will figure out a way to take that out without consequence to their patients. The second part of it is preparing practicing clinicians to lead this process. At Cleveland Clinic, there is a lot of clinician mentoring.

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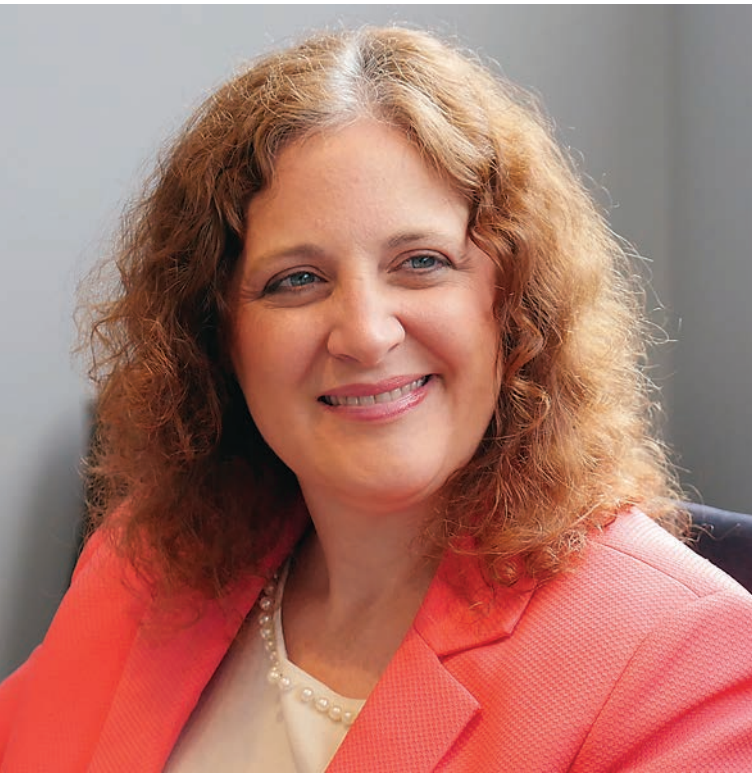


Gillum: We can't underestimate the trust factor. Physicians need to have a full seat at the table, you have to earn their trust, and they have to trust the data you are using.

Passerallo: Another form of engagement is acknowledgment and credit. One of our supply chain medical directors just became vice chair of surgical operations. Another one just became chairman of vascular surgery. Being a medical director in supply chain is a stepping stone for them to get to those positions.

Lucenti: In the military, as you try to move toward a command position, you try to be the ops person and the personnel person. You try to have the multidimensional aspects as you move into a leadership role.

Eischens: To champion means, in a lot of ways, to engage in conflict. So, with your medical directors or with the people that you get to be champions, how do you assist them when conflict might threaten progress?

Passerallo: If there is a conflict, we go to the champion of the project first, educate him or her on what the issues are, bring them to the table, and try to help find a resolution. The next escalation path is through the medical director and supply chain, and then we have an ability to go to the CMO for guidance and assistance.

Lucenti: There doesn't necessarily need to be that much conflict. The nursing side is so much better in this. If the nurses change a product, what happens right afterwards? Massive, hospitalwide in-service. Right?

They understand that the second there is change, there is training that is required.

Passerallo: You try to put change in physicians' words so they understand it more. If you put a business side to it, they immediately push back.

Gillum: Some of the trust you can gain is by leading with the quality, the outcomes, the elimination of variability, and creating standardization. Other industries have shown that if you can eliminate variation, you can improve quality. As opposed to leading with a financial case, you can show that you are considering other interests as well. Your end goal may be reduction of costs, but that can't be what you are leading with.

Eischens: You have to build the relationship. If you lead with the ask vs. a relationship, chances of failure are much higher. One of the things that we have done is try to figure out what the pain points are for physicians beyond supply chain. Sometimes it could be training of fellows and residents; sometimes it is getting education materials. These things fall outside of what would normally happen in supply chain, but if we can solve some of those pain points for physicians, they are more likely to partner with change.

Gillum: One of the best things is, physicians are a competitive group. If you can leverage that, if you can present your data and your reports in a nonthreatening environment, natural competition will take off on its own—and it is amazing what physicians can do when they want to change.

HLM: *What are the best focal points of educational efforts with clinicians when you are trying to*

get sustained participation in a clinically integrated supply chain?

Lucenti: I have seen a few places where they rotate people into project leadership, maybe even medical directorship roles. I have also seen a couple health systems put together a one- or two-day course of everything you need to know to enter into a leadership role in the supply chain space. We run a one-day course about what you need to know to play a leadership role in supply chain. We talk about clinical governance structures; we talk about alignment and compensation models. We talk about data, and we show the clinicians what a chargemaster is. What you are starting to see is, people are building Supply Chain 101 into a precondition to come into some of these roles.

Passerallo: Depending on the level of your physician champion, you have to understand the objectives of the organization. They need to understand the organizational objectives, both from a quality as well as a growth and financial strategy perspective, because that can help them in their communication with their peers. It makes them more part of the team.

Gillum: A lot of these physicians have not been trained to be leaders. So, we are sending them to an advisory board retreat and education so that they can develop leadership skills and be able to step in and have crucial conversations or do strategic planning.

Passerallo: We are fortunate: We have a department called the Cleveland Clinic Learning Center. So, when you are on a path to be a leader within the organization, you go through a core curriculum of classes, and one of those is conflict management.

Gillum: We talked earlier about reaching out and finding physician champions. At times, the physician champion may come from the group that has gone through our leadership education. They are engaged and have chosen to get involved with leadership.

Passerallo: We have a very intensive program. It's a Harvard Business School–type program where we go for nine months of training, one Friday a month for all day long. You have a capstone project.

HLM: *How do you achieve standardization through a clinically integrated supply chain?*

Gillum: Lean heavily on your data. You have to start with data to understand where your opportunities are and where you even want to spend. It may be that there is a standardization that we don't want to do because there is no value in the change, or the time and the energy that goes into it. Also lean on your relationships. We spend a lot of time talking to our physician champions, saying, "What do you think? Is this something we want to take on?" Using information from the data, the vendors, and the physicians, we are working to target what we want to standardize.

Lucenti: If you are doing all your homework and you are giving a clear picture to the clinicians, they can make decisions. In good standardization, it's about the staff work. Value analysis and other core staff capabilities underpin good clinical decision-making.

Eischens: We take advantage of the contracting opportunities. We always determine what a standardized value would be as part of the contracting/bid process. So, when done, we can say, "Here's the pricing for six vendors. By the way, if we can get down to two, there's another $500,000 savings that can be achieved." It always helps to present to physicians the cost aspect of supply purchasing practices.

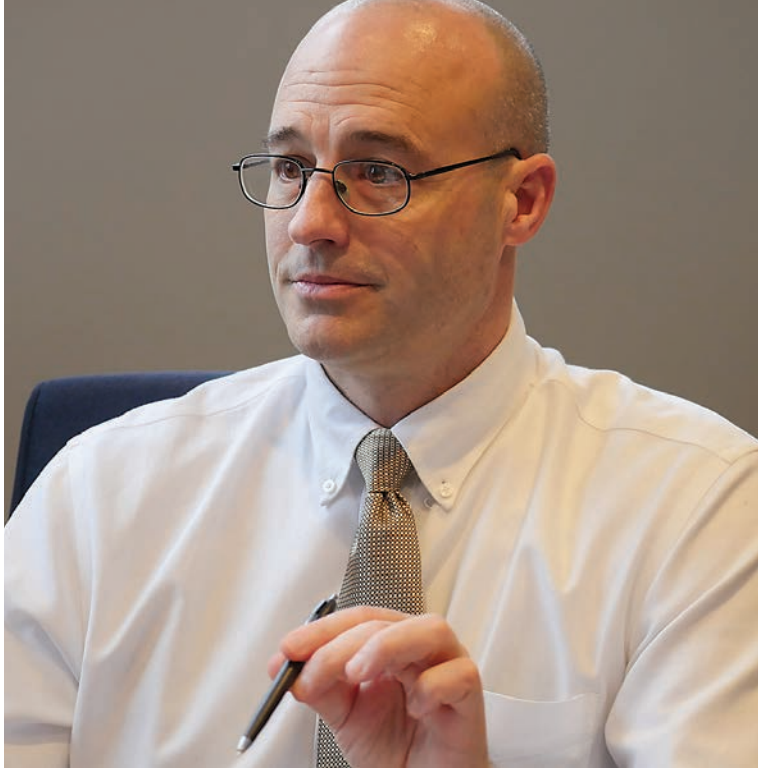
HLM: *What are the biggest challenges in achieving standardization?*

Lucenti: It comes back to apprenticeship learning. They have locked in a practice through their training, so there's always a little bit of hesitance to change.

HLM: *How do you cut through that?*

Lucenti: You have to have a mechanism to get them across that discomfort. If I am going to change something that I think is fundamental in my practice, I want to be reapprenticed. Let's do a cadaver lab and have somebody that uses this product walk me through two cases, so that I feel comfortable again.

Gillum: You also have to make sure that there's a nonthreatening environment. … We have to acknowledge that what we're asking the physicians to do is uncomfortable. At times, it comes back to that recognition, and acknowledging that they are making a change and the sacrifice of expending energy on behalf of a cause.



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"THE BEST WAY TO ENGAGE THE CLINICIANS IS TO PUT THEM IN CHARGE—MAKE IT THEIR RESPONSIBILITY."

Eischens: The influence of industry on physicians is dramatic. What influences physicians? That could be everything from education, to revenue, to professional growth/acknowledgment, to case support, to any one of many pain points or desires. Industry plays that game well. They are investing in physicians, and not just in money, but in lots of different ways in order to build relationships that influence preference.

Lucenti: It is important to understand the value proposition of a vendor rep for a practicing surgeon. There's an alliance between the two. If I have a complicated case, it is not the hospital administrator who is in that case with me when my patient is hemorrhaging, or standing right next to me. I have what I need: It is the vendor rep.

Gillum: Unless you are using teams in the OR, that sales rep may be the only consistency that you have from case to case.

Passerallo: The supply chain department can help manage that issue. I believe that there should be a relationship between physicians and vendors because we can't advance healthcare without physician input. Should they do it for free? No, they are intellectual property; they should be paid appropriately. The supply chain department can help generate a process—and transparency—to take relationships with vendors into consideration when you are sourcing and with regards to standardization. We also have a robust conflict-of-interest policy.

HLM: *How do you address the influence of industry? How do you manage that?*

Eischens: It is a full-time job trying to manage. There are a lot more company employees calling on the hospital than there are supply chain people to manage. We have a standardized approach: No rep can come to the hospital without checking in. We make sure we know where the reps are going and who they are talking to. If there is an ongoing competitive process, we watch that very closely because we are a state institution. It's all about building relationships with physicians and helping them understand the larger game that we are all playing.

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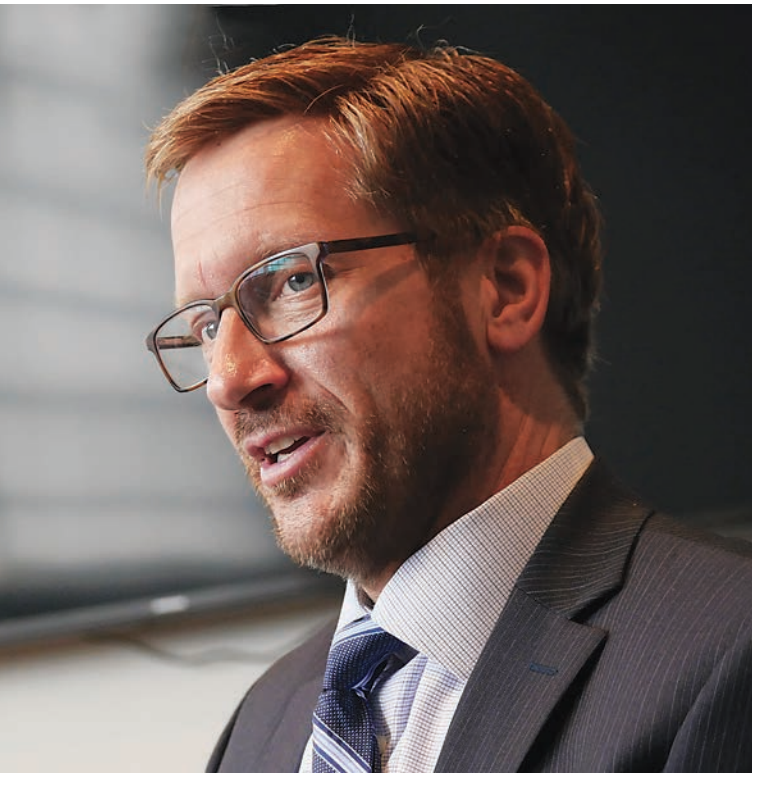

Passerallo: We use similar processes, but we also set the tone. We have a vendor policy handbook that goes out to all vendors. It's on our website. When you log in to it, vendors can check in and out of the hospital. We also speak to our physicians about supply chain being the gatekeeper to opportunities in contracting. Vendors know that they can talk to a surgeon about clinical aspects of a product, but when it comes time to enter discussions about trials or purchasing or a contract, they have to come through supply chain. That is just a culture that we have been able to build.

Eischens: If a vendor does bring something in that has not gone through the appropriate process, the vendor donated it. The hospital does not pay for it.

Gillum: We have taken it one step further into a "three strikes and you're out" approach. First strike, we treat it like our employee reprimands and talk directly with the sales rep. Second strike, we start involving their leadership. Third strike, that individual is banned from our facilities. If that sales rep picks up and moves to another company, the ban follows them to that new company.

Passerallo: For us, when reps walk down the hallway or into the OR, you know exactly who a rep is because they have to wear their badge on top of their orange scrubs.

HLM: *What impact does a clinically integrated supply chain have on sourcing decisions?*

Lucenti: The sourcing strategy has to be led in a multidisciplinary endeavor with practicing clinicians at the table leading some of the discussions. You also have got to teach your clinicians strategy in some of these spaces. Strategic sourcing requires sophisticated interaction with clinicians and administration. It requires a different set of skills.

Passerallo: The key thing: practicing physicians.

Lucenti: It's beyond even that. I am an ER doc, but I do not want to tell an orthopedic doc what to do. I want a group of orthopedic docs who do the procedure doing the talking.

Gillum: Having a clinically integrated supply chain causes a lot more variability on the timing of our sourcing. Sometimes, the process can jump ahead because the clinicians are excited about something and ready to go, moving quicker than you can imagine. Other times, you are waiting for the structured meetings, waiting for the data, pulling it together, and having conversations, which can take a lot longer than you anticipated.

Lucenti: What's often challenging when you get into this collegial and collaborative sort of endeavor is determining timing, tempo, and pace. I can warn you: Clinicians are very used to it being their timing, their tempo, their pace. Most clinicians live in a world where they have lots of people around them doing everything imaginable to get the most bang out of their very expensive hour. So, they are used to being the center of the timing. H