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The Journal of Healthcare CONTRACTING

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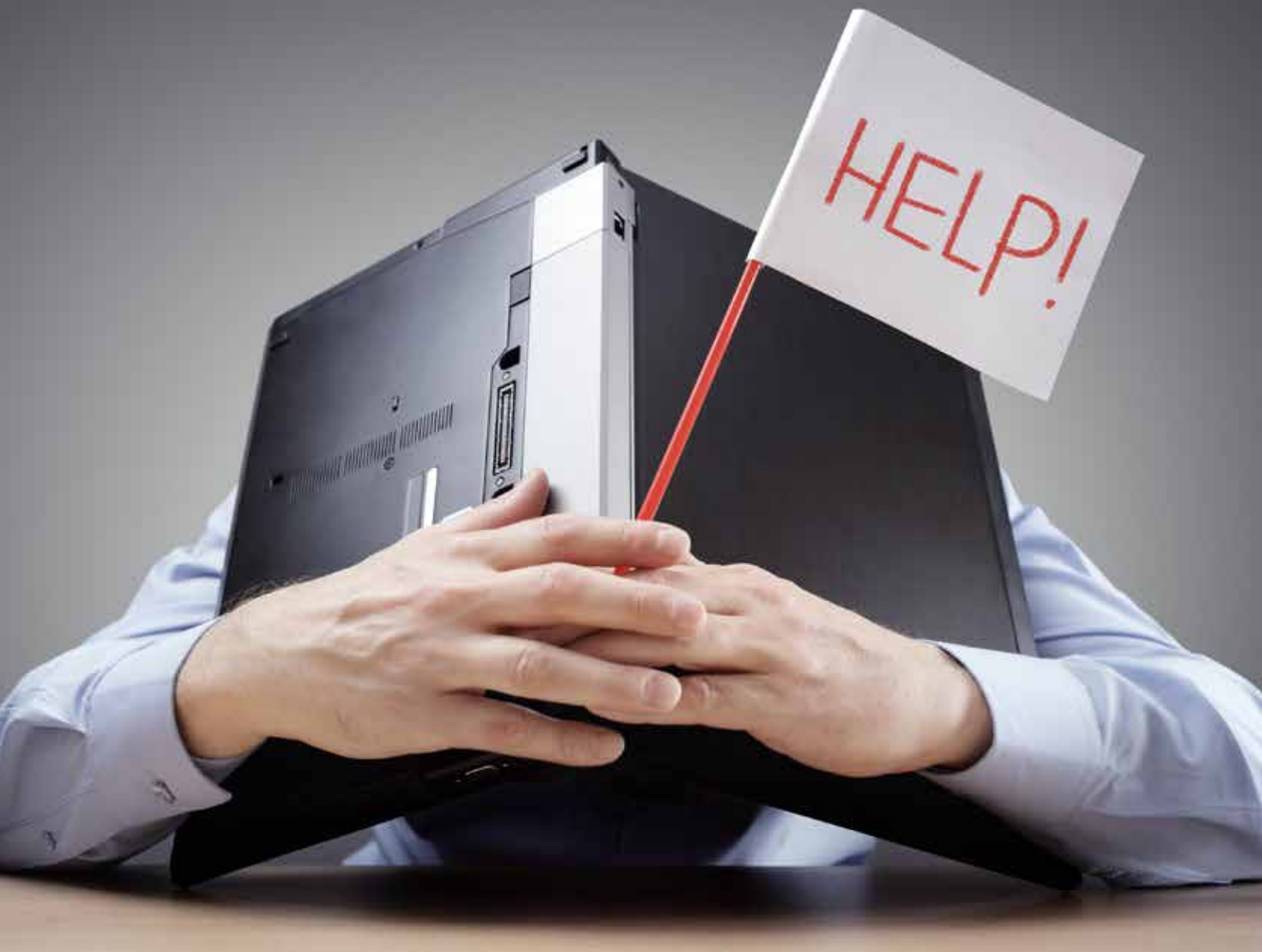
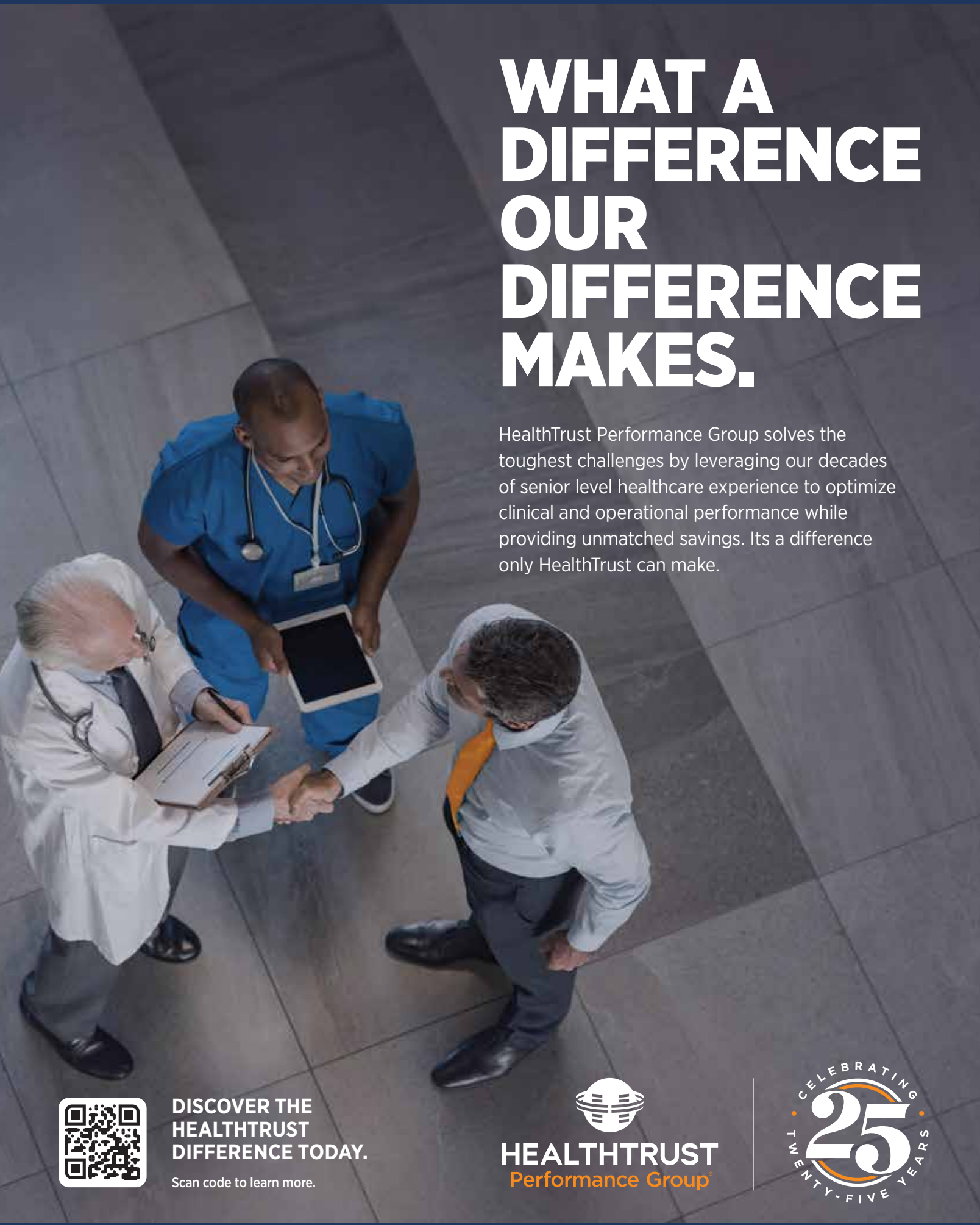
Cybersecurity efforts rattle sacred cows of technological belief

Wait ... it's not just the bad guys and hackers we have to worry about anymore?

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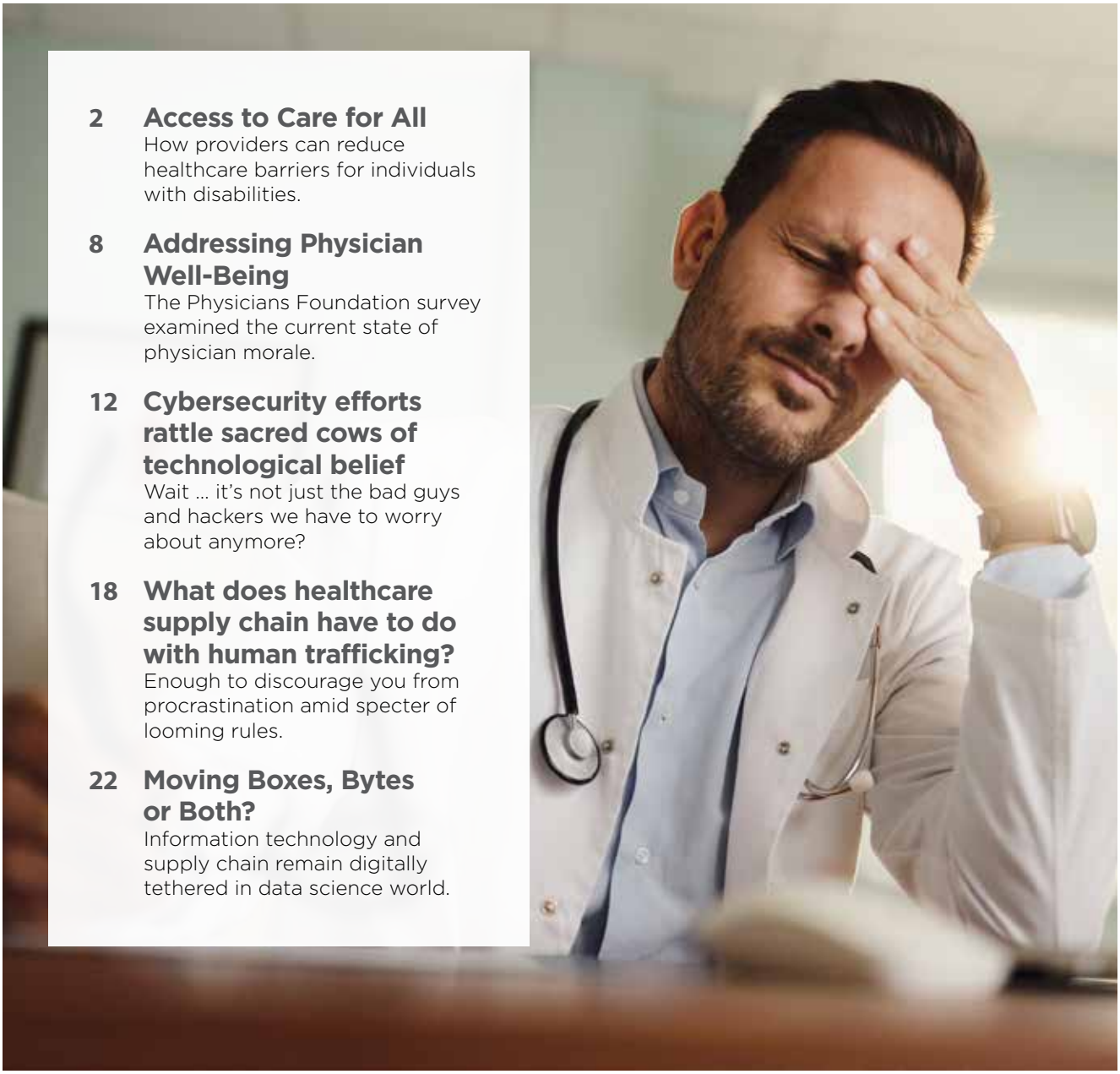

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Access to Care for All

How providers can reduce healthcare barriers for individuals with disabilities.

BY JENNA HUGHES

Health equity refers to all individuals having the access to care needed to be as healthy as possible. The healthcare industry plays an important role in ensuring the equitable care of people of all ages with disabilities. As of 2016, an estimated one in four (61 million) adults in the U.S. reported a disability, according to the Centers for Disease Control and Prevention's Division of Human Development and Disability (DHDD).

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There are numerous definitions of a disability; the Americans with Disabilities Act (ADA) defines a person with a disability as someone who "has a physical or mental impairment that substantially limits one or more major life activities, such as walking, hearing, seeing, has a record (or past history) of having such an impairment, or is regarded as having such an impairment."

People with disabilities often face increased barriers to healthcare access. According to the CDC, studies show that individuals with disabilities are more likely than people without disabilities to report having poorer overall health. CDC data from 2019 also shows that compared to those without disabilities, people with disabilities have less access to health care, increased rates of depression and anxiety, and are more likely to engage in risky health behaviors more often such as smoking, or engaging in less physical activity.

Research further reveals that within healthcare, people with disabilities are less likely to receive comprehensive preventive healthcare, diagnostic imaging, and cancer screenings, according to the Centers for Medicare & Medicaid Services (CMS).

Additionally, secondary conditions such as pain, fatigue, obesity, and depression can occur because of having a disabling condition, according to the CDC, overall decreasing an individual's overall health and quality of life and making them more susceptible to preventable health problems.

Physicians play a significant role in addressing these barriers to care by creating more accessible hospital and in-office environments.

Physical accessibility barriers

Accessibility within healthcare encompasses both doctor and patient communication and physical ability to access care. Specific patient needs should be addressed by healthcare professionals before a patient visits the doctor's office or has a telehealth appointment.

Adults with disabilities are almost twice as likely as other adults to report unmet healthcare needs related to the physical accessibility of a doctor's office or clinic, according to CMS. A survey from CMS of U.S. physicians found that among those seeing patients with significant mobility limitations, only 40% always or usually used accessible exam tables or chairs.

Inaccessible exam tables, weight scales, infusion chairs, mammography machines, and radiology equipment can impact a patient's treatment outcomes and care quality, according to CMS. Even when an office has accessible medical equipment, patients with disabilities may still experience disparities due to lack of physician awareness about individually required accommodations, varying office rules and procedures, and physician bias.

To ensure physicians' offices are accessible, according to CMS, considerations for facility modifications include evaluating the entire in-office experience for patients, such as updating public transportation, parking, universally recognized symbols on signage, addressing any specific patient needs at check-in, and installing any needed safety features or office modifications in advance.

Assessing and addressing common barriers to healthcare for patients with disabilities, according to CMS, also requires eliminating any potential physical barriers within the office, discussing a patient's in-office needs at check-in, and addressing the accessibility of exam rooms with exam tables that can be adjusted to different heights with transfer supports, lift equipment, and clear floor space next to the exam table for ease of access.

The states serve as communities of practice and play a much-needed role in identifying effective practices, policies, and services for people with disabilities.

Simplifying communication

Proper communication is a key component of accessibility. Reasonable accommodations refer to any changes that a healthcare organization can provide to better serve patients with different communication needs, according to CMS.

Healthcare organizations should conduct a needs assessment to understand the needs specific to their patient population, engage in active planning to more effectively meet patient communication needs, and periodically update these plans. This process helps ensure that organizations have auxiliary aids and services necessary to serve all patient populations.

Healthcare providers themselves play a significant role in the equitable care

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of all people with disabilities through patient communication. According to the Surgeon General's report titled, "Call to Action to Improve the Health and Wellness of Persons with Disabilities," healthcare staff should support the equitable treatment of all patients by giving each individual, including those with disabilities, all of the information needed to live a long and healthy life, listen and respond to each patient's health concerns, give prevention and treatment advice, communicate clearly and directly to all patients, and take the time needed to meet a patient's healthcare needs.

Taking action

There are numerous programs currently in place in support of health equity for all patients. Both the CDC and CMS have implemented a variety of programs aimed at making healthcare more accessible for patients with disabilities.

The CDC's Division of Human Development and Disability (DHDD) monitors recent public health data to reduce the nation's health disparities. DHDD also promotes healthy living through inclusive programs for those with disabilities and provides information to the public and healthcare providers through the collection of data through the Disability and Health Data System (DHDS), which contains the latest data on U.S. adults with cognitive, mobility, vision, self-care, independent living, and deafness or difficulty hearing, and more. The DHDD additionally provides state-level disability data on 30 health indicators such as smoking, heart disease, receiving the flu vaccine, and more.

Another way the CDC supports individuals with disabilities is by providing funding to the National Centers on Health Promotion for People with Disabilities, also known as the National Centers on Disability, to prevent disease and promote health and wellness for people with disabilities. Through this initiative, the CDC works with state-based disability public health programs to improve the health of populations as a whole and develop and implement public health programs for people with specific conditions. This public health strategy employs prevention efforts to help make the broadest health impact possible on the health of populations, in this case, people with disabilities.

Nineteen of the state-based programs that the CDC assists promote equity in health, prevent chronic disease (such as diabetes, asthma, and high blood pressure), and ultimately strive to increase the quality of life for people with disabilities. Each program customizes its activities to meet its state's needs. These state programs represent a network of standardized programs committed to helping people with disabilities benefit from public health services. The states serve as communities of practice and play a much-needed role in identifying effective practices, policies, and services for people with disabilities.

The CMS Office of Minority Health (OMH) also offers technical assistance for health care organizations working to advance health equity, and serves as the principal advisor and coordinator to the Agency for the needs of minority and disadvantaged populations. The CMS OMH consults with Human Health and Services (HHS) Federal agencies and other organizations to collaborate on addressing health equity.

CMS additionally offers a resource inventory which provides compiled accessibility topics for physicians such as "Opening Doors to Everyone" , "Accessible Medical Examination Tables and Chairs", "Access to Medical Care for Individuals with Mobility Disabilities," and more from the ADA for healthcare professionals to access to better serve all patient populations.

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Addressing Physician Well-Being

The Physicians Foundation survey examined the current state of physician morale.

BY JENNA HUGHES

Many physicians in the healthcare industry have long attested to well-being as a significant workplace challenge.

A recent survey by the Physicians Foundation all but confirms it. According to the data, well-being has remained critically low post-pandemic among physicians across the nation. The report, titled "2024 Survey of America's Current and Future Physicians," unveils an urgent need to improve physician mental health and integrate physician perspectives in healthcare decision-making.

Physicians keep the healthcare industry afloat, providing positive patient health outcomes and saving lives, and it is increasingly important for health systems to look out for their staff's well-being to retain a strong workforce among rising industry challenges.

Facing burnout

Six in 10 physicians and residents and seven in 10 medical students reported experiencing burnout "often." Additionally, more than half of physicians know of another physician who has considered, attempted, or died by suicide.

"While physicians' emotional outlook shows some signs of potential improvement, the overall state of well-being for current and future physicians remains low," said Dr. Gary Price, president of The Physicians Foundation. "We consistently hear that the top factors negatively impacting physician well-being and driving burnout are administrative burdens and loss of physician autonomy."

Physician well-being has been trending downward since the beginning of the pandemic. Physician-related well-being needs have become an urgent focus across the industry, requiring healthcare leaders to bear in mind physician perspectives when making workplace decisions.

Burnout is a leading cause of workplace challenges in healthcare, and the tragic outcomes affecting the mental health of physicians. Many physicians are still afraid of speaking up to seek mental health help. According to the Physicians Foundation report, more than four in 10 (44%) residents and half of medical students were either afraid or knew another colleague who was fearful of seeking mental health care, based on questions asked in

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medical licensure/credentialling/insurance applications. Additionally, medical students (49%) are more likely than residents (33%) and physicians (18%) to seek medical attention for mental health issues.

"While we are seeing a shift with medical students being more likely to discuss mental health with peers and classmates and go on to seek care, there are still stigma and structural barriers that prevent current and future physicians from seeking mental health care, and this must change across the industry," said Dr. Price.

A number of residents (18%), students (22%), and (12%) physicians revealed they know of a colleague or peer who has considered suicide in the past 12 months. Generational shifts, however, have resulted in these groups to be much more likely than before to have had a conversation about seeking mental health support. According to the report, 60% of students agree that well-being is an important topic of conversation in their classes.

In recognition of National Physician Suicide Awareness Day (NPSA Day), the Physicians Foundation and The Dr. Lorna Breen Heroes' Foundation have started to call for systemic change through *Vital Signs: The Campaign to Prevent Physician Suicide*, according to the Physicians Foundation, aimed at improving the wellbeing of current and future physicians.

Impact of healthcare consolidation

Healthcare consolidation, or the process of merging or acquiring hospitals and physician practices into large conglomerates, is a significant contributing factor to the current rates of high physician burnout. At least three in 10 physicians who have experienced a merger or acquisition have reported negative affects in job satisfaction (50%), quality of patient care (36%), independent medical judgement by physicians (35%), and healthcare costs for patients (30%).

"Consolidation is dramatically changing the healthcare landscape and practice environment," said Dr. Price. "Current and future physicians agree that these changes are not good for physicians, patients, and the future of healthcare. Even before the pandemic, physician well-being was in jeopardy; now, the rapid pace of healthcare consolidation is further deteriorating the practice environment."

Healthcare consolidation inevitably impacts the patient as well as physicians, and according to the report, seven in 10 physicians and medical students believe that consolidation is negatively impacting patient access to affordable and quality care.

"A first step should be for physicians to be part of the decision-making process when it comes to healthcare consolidation," said Dr. Price. "Furthermore, we need to increase education and awareness for physicians who are considering a healthcare consolidation scenario to ensure policies are included that preserve physician autonomy and keep patient care as a central focus for the practice."

Safeguards for consolidation identified by physicians, residents and medical students include high rates of agreement with 90% in favor of preserving physician autonomy, 87% in favor of maintaining patient standards, 86% in favor of increasing transparency and disclosure, and 84% in favor of assessing the long-term impact of healthcare consolidation.

Prioritizing well-being

Current and future physicians undoubtedly need well-being solutions that are prioritized by healthcare leaders. These solutions should consider the actual needs of physicians and aim to improve physician well-being while simultaneously retaining more physicians in the industry now and into the future.

In the Physicians Foundation report, 79% of physicians and 87% of residents indicating that the reduction of administrative burdens would prove helpful.

According to the report, 60% of students agree that well-being is an important topic of conversation in their classes.

Furthermore, 71% of residents and 59% of students found that the change or removal of medical licensure questions that stigmatize accessing behavioral healthcare to be helpful.

"Physician's viewpoints on workplace issues will be critically important to ensure that our healthcare system works as it should for everyone, especially those who work within it," said Dr. Price.

There have been signs of positive improvement for physician mental health, which offers hope for future healthcare industry initiatives that prioritize well-being. Significantly fewer physicians, nearly four in ten, or 38%, have reported withdrawing from family, friends, or co-workers, compared to 42% in 2023 and 46% in 2022.

"Physicians are the cornerstone of healthcare, and they must be able to prioritize their own health to provide the quality of care that people deserve," said Dr. Price. "We need our country's physicians to be able to care for themselves so that they can continue to care for the rest of us."

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Cybersecurity efforts rattle sacred cows of technological belief

Wait ... it's not just the bad guys and hackers we have to worry about anymore?

BY R. DANA BARLOW

What transpired this past summer on July 19 clearly was unexpected and unfathomable.

Perhaps the Associated Press categorized this aptly with the keen weekend headline, "Technology's grip on modern life is pushing us down a dimly lit path of digital land mines."

Many acknowledge that traditional cybersecurity measures are designed to help you defend and prevent illegal and unauthorized hacking and intrusions from bad guys. In short, they are designed to prevent – not cause – computers to crash.

Unfortunately, when a "trusted business partner" in the cybersecurity arena (like, for example, CrowdStrike) suffers a problem that negatively impacts programming from one of the world's largest companies (Microsoft), seriously impeding all sorts of communication, commerce and care on a global scale, you might wonder whether you now must worry about and protect yourselves against authorized vendors, too.


HELP!

In his story that was updated on July 27, AP Technology Writer Michael Liedtke called this incident, which reportedly affected an estimated 8.5 million Windows devices around the world that slowed or stopped operations among airlines and airports, businesses, hospitals and others, a "telltale moment – one that illustrates the digital pitfalls looming in a culture that takes the magic of technology for granted until it implodes into a horror show that exposes our ignorance and vulnerability." (SOURCE: "Technology's grip on modern life is pushing us down a dimly lit path of digital land mines," AP News, July 27, 2024.)

The Journal of Healthcare Contracting reached out to a variety of supply chain executives to learn how their organization dealt with the digital dilemma and established defensive as well as offensive strategies and tactics to combat future occurrences. Unfortunately, few were willing to share their observations on the record due to the sensitive nature of the event, its impact on their organization and the publicity safeguards their respective media communications teams erected.

However, supply chain executives at two prominent integrated delivery networks (IDNs) were willing to provide a glimpse into what happened at their organizations, how they handled it and how they are working to avert future incidents, if JHC granted them anonymity. Here's what they shared.

Digital systems are complex, vulnerable and have some level of inherent risk. We need to continue to improve the quality and assurance of digital products, isolate and protect our most critical assets (including the ability to rapidly roll-back of any changes) and continue to improve our risk identification and mitigation

Liedtke quoted Paul Saffo, identified as a Silicon Valley forecaster and historian: "We are utterly dependent on systems that we don't even know exist until they break. We have become a little bit like Blanche DuBois in that scene from 'A Streetcar Named Desire,' where she says, 'I have always depended on the kindness of strangers.'" Liedtke included a YouTube video link to the scene.

One southeastern healthcare supply chain executive attempted to squeeze lemonade out of lemons with a cheerily optimistic observation of a key benefit from facing the electronic abyss.

"We got to see all of our IT folks show up here at work at the same time!" the executive chimed.

***JHC:* What hardware and software products/systems specifically at your organization were affected by CrowdStrike's action(s) and how did that affect your operations and services?**

PROVIDER 1: Generally, a significant portion of workstations and servers were impacted. Each has to have a hand on them to apply a fix, so this took significant time and resources. Most systems were back up in 48 hours. All were up in five days. In supply chain, our ERP and handhelds worked, but the middleware between them was impacted so orders to distribution did not go out in the first 24 hours. But this was quickly resolved.

PROVIDER 2: Like most, travel. We worked with our travel partners to prioritize workload, diverted work to other tools, such as phone and email and limited access to the digital platform. There were also indirect impacts in the supply chain as a whole and some disruption. Unfortunately, we have gotten quite good at dealing with various supply-related disruptions post-COVID.

***JHC:* How did you (try to) maintain operations and services – either through alternative technologies or reversion to manual processes?**

PROVIDER 1: We had existing plans to cut over to down-time procedures that supported a continuation of operations. It was painful, nonetheless. Examples include clinical documentation, how to place and prioritize lab orders, etc. For supply chain, we replicated a prior day order to get products from the distributor. This has its own challenges as you are not necessarily getting the supplies you need or too many of others.

PROVIDER 2: We have a long tradition of having downtime procedures for all critical functions of our supply chain. Digital risk is not necessarily new, albeit with cloud/multi-tenant/multi-enterprise solutions and consolidations, the risk is far greater as an industry.

***JHC:* What did you learn from this incident in how to respond to future challenges like this? What did this crisis teach you about trusting your business partners?**

Navigate Labor Shortages and Improve Supply Chain Operations With Strategic Support

Saint Francis Health System recently utilized Nexera workforce support to advance their supply chain maturity while facing staffing challenges. Saint Francis was in need of skilled resources to execute on transformation efforts in the midst of labor shortages, so the organization tapped into Nexera for interim support in three main areas:

- Sourcing/Contracting
- Inventory and Logistics
- Value Analysis

As a result, Saint Francis gained invaluable support operating their supply chain in each area mentioned above while also seeing more than $5.6 million in implemented savings.

Listen firsthand to how Saint Francis and Nexera partnered together to enhance their supply chain operations while navigating labor shortages.

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PROVIDER 1: The biggest learning was the need for a more detailed plan on what system needed to be brought up first in the restoration plan. This would be agreed upon by service. With limited resources and capacity, a plan to return the most critical systems first allows the best use of resources. We have Level 1 systems but not prioritized more granular than that. We also learned a lot on how to mobilize additional resources to put hands on keyboards to apply any fix.

Organizations need to know their risk tolerance and own their quality control. This is key to the ability to trust partners. The way CrowdStrike-type software works, this event could easily happen with any software that does this type of service. The security software is in the guts of operating systems and software. It monitors and is constantly learning what is happening in the environment and making decisions on what looks suspicious and proactively turns parts of applications off.

PROVIDER 2: It is easy to get into a pattern of deprioritizing risk detection and preventive controls. The most recent issues were a good reminder that technology is far from bulletproof, and interruptions from time to time (while not welcome) are expected. We all need to make sure we are prepared with effective DR plans that are regularly reviewed and tested.

JHC: **Why do (or don't) you believe CrowdStrike's solution to the problem and prevention from happening again is enough?**

PROVIDER 1: They have increased transparency on how quality control/assurance works, how it failed and what the go-forward correction is. They also have provided organizations more flexibility and options on rollout of the service to allow early/mid/late adopter status and additional capability to run in part of system as a test prior to launching across entire network.

Along with TPRM you need a very strong supply chain risk function that is continuously monitoring risks and mitigation.

PROVIDER 2: Digital systems are complex, vulnerable and have some level of inherent risk. We need to continue to improve the quality and assurance of digital products, isolate and protect our most critical assets (including the ability to rapidly roll-back of any changes) and continue to improve our risk identification and mitigation. Risk as well as outages are not going to go away, and we should be aware, make best efforts to prevent as well as prepare in the event we are impaired.

JHC: **Irony aside, how much – if at all – should healthcare supply chain pros be concerned about companies that create cybersecurity products designed to prevent disruption/interruption of operations and services, but then actually "cause" the problem(s) themselves and why? What should organizations – suppliers and providers, vendors and customers – take away from this?**

PROVIDER 1: In overall context, CrowdStrike-type services have saved our organization from bad actors and downtime far more than the impact of this one instance. The benefit/risk is without a doubt worth it. That being said, organizations need to know how these systems work and understand third-party risk. Only with a solid understanding can we assess the true risk and level of protection, etc. needed. We are further consolidating our third-party risk management into a streamlined Vendor Credentialling process that centralizes workflow, risk assessment and risk management.

PROVIDER 2: As a consumer in the healthcare space – where we have a high degree of technology – we should be aware of these types of risks or have partnerships with those that specialize in this area. Having a strong third-party risk management (TPRM) program is a must in today's environment. TPRM processes should be continuous, particularly when change is introduced, and not for just new suppliers/partners. In other words, "trust" but "verify."

Along with TPRM you need a very strong supply chain risk function that is continuously monitoring risks and mitigation. Also, while not new to anyone, supplier relations should be built on transparency, frequent communication and discussion as to not just what has been accomplished and needs to be done but also any risks that either party sees and how to best mitigate them. ■

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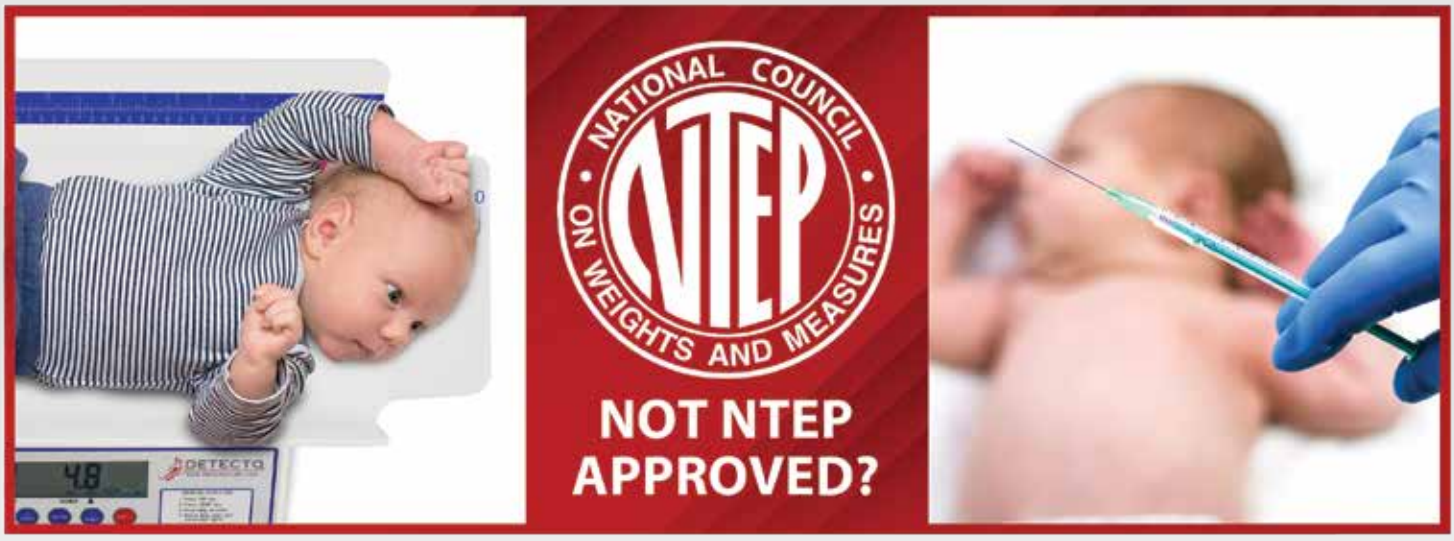

We've all used scales that are NTEP certified when buying bananas at the store, since it's critical for the weight to be accurate between the buyer and seller of the bananas. And yet a pediatric scale weighing our baby or a physician scale weighing us before surgery for assigning dosages isn't held to the same criteria as a bunch of fruit or vegetables.

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What does healthcare supply chain have to do with human trafficking?

Enough to discourage you from procrastination amid specter of looming rules.

BY R. DANA BARLOW

COLUMBUS, OH – Imagine if government agents showed up in your office one morning accusing you and your organization of participating in human trafficking for labor purposes. All before you took a sip of your first cuppa joe.

"Wait, whaaaaa? Really? How?"

"Yes, you buy a significant number of selected products from a company that profits from 'cheap' labor sourced by human traffickers."

"Wait! I didn't know! How are you supposed to know that?"

Their reply: "You should have known."

Chilling.

Now rub the nape of your neck to smooth down those little hairs.

This scenario isn't real … at least not yet. But the potential, the possibility, lingers and should resonate in the back of your mind.

First, let's dispense with the obvious. Human trafficking – whether for labor, sex or anything else – is evil and illegal. Deep down, most of us agree and acknowledge both. Further, something must be done to slow these transactions to a trickle, to strangle the pipeline to an emphatic stop and then to prevent it from ever happening again – an extinction-level event. Quickly.

Alas, it may be an ideal that likely won't materialize. Even one victim of human trafficking now on the public speaking circuit sharing her harrowing tale of abuse here at the annual conference of the Association of Health Care Resource & Materials Management (AHRMM) acknowledges that, "I know we can't abolish it, but we need to become more aware of it." Still, that doesn't dilute her point of view nor negate the emphasis and essential nature of the words in the prior paragraph.

Beyond any initial virtue signaling the questions then arise on how to determine the most effective, efficient and expedient (triple E) way(s) to accomplish this, who should do it and what happens when it doesn't happen fast enough as determined by … someone else?

Think of it as a kerfuffle morphing into a gurgling miasma at loggerheads with reality.

You surely don't want this to fester into an "O-Ring Committee" situation, a reference to a scathingly satirical political cartoon about the decision-making

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process during the ill-fated Space Shuttle Challenger mission in 1986. The cartoonist used the design of the shuttle's O-Ring failure as the position of the decision makers – all standing in a circle, each one pointing to the person next to him or her.

During the AHRMM show in late September, the educational session/learning lab title, "Mitigating Human Trafficking in Healthcare Supply Chain" likely raised attendee eyebrows out of sheer initial curiosity, but unfortunately not enough to pack the room full of people.

AHRMM Executive Director Mike Schiller, who spearheaded the topic and session for the parent American Hospital Association (AHA) represented the small crowd in the room showing support for this simmering under the shelves issue. Schiller referred attendees to the association's official policy on human trafficking in the healthcare supply chain, which can be found online here. The link provides samples and templates for management systems, risk assessment tools, due diligence explanations and worker engagement and training exercises. Be sure to check it out.

Amid all the increasing supply chain pressures in a post-pandemic marketplace that really involved many of the same pre-pandemic pressures not yet solved but infused with nitrous oxide, three major issues need to be addressed – specifically and realistically (maybe not in that order) – to connect the dots.

1. How to expand due diligence policies and procedures with all existing and prospective vendors to identify issues.
2. How to incorporate legal declarations and severe penalties for non-compliance in binding contractual language. Anyone remember when Walmart required suppliers and vendors to adopt and implement bar coding or they would not be allowed to back their semi-trailers to warehouse docking stations?
3. How to convince and persuade the C-suite to take this issue seriously enough to warrant it as a high priority among competing priorities.

At first glance, human trafficking doesn't sound like an individual or local healthcare organization supply chain issue to address. Instead, it resonates more like a federal issue to be mitigated through the Commerce, Justice and State Departments – particularly if the human trafficking victims enter the U.S. illegally at coastal shipyards or even airports. But even actual U.S. citizens can be victimized.

Still, fundamental questions linger that can and should be resolved so that no one can or should dismiss this issue as someone else's problem.

One recommendation is for supply chain to require of its contracted suppliers, vendors and service companies some type of proof that they have not used or are aware of their downlines using trafficked humans. Yet this raises even more questions. What constitutes and qualifies as proof? Which agency is qualified to certify this process? Who generates revenue and profits from this investigative and certification process? Should they? Might this be incorporated into the vendor credentialling process? Should suspected flagrant abusers be targeted first while the rest leak and slip through the cracks? Who should be doing this? You? Your GPO? Your distributor? Your manufacturer? Then think about all the administrative and operational costs that will be incurred to carry this out and likely buried in the prices or total delivered costs of all products.

Here's the fundamental kicker, however: How do you either discourage, if not prevent, people from lying, and short of that, how do you catch people in their prevarication?

But let's be clear and resolute: None of these questions should nullify a response and justify looking the other way. That would be a reckless disregard of reality and the truth.

To perform due diligence and make hard decisions during any contracting efforts, you will see costs rise and therefore, prices. When you poke a balloon at one end, you'll notice that either a bubble will protrude in the opposite hemisphere, or the balloon will pop. It's not unlike the privacy vs. security debate. If you want more security, you may have to sacrifice some privacy and vice versa.

Yet it's important for the healthcare provider industry to get ahead of this issue and implement diligent and legitimate safeguards proactively before the federal government is properly motivated to force a corrective solution that might be more costly than indifference and lethargy. True healthcare extends way beyond selfcare as a shared service with sacrifice, and on this wise we should be thankful. ■

R. Dana Barlow serves as a senior writer and columnist for *The Journal of Healthcare Contracting*. Barlow has nearly four decades of journalistic experience and has covered healthcare supply chain issues for more than 30 years. He can be reached at rickdanabarlow@wingfootmedia.biz.

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Moving Boxes, Bytes or Both?

Information technology and supply chain remain digitally tethered in data science world.

BY R. DANA BARLOW

In this accelerated Information Age, you'd be hard-pressed to hire someone without any information technology experience or expertise.

You likely also would expose yourself and your organization to a grave disservice.

Should a candidate applying for a supply chain position within healthcare organizations need IT experience of any kind? Many would respond that this candidate would be remiss not to be familiar with basic databases and relevant software applications. And you as the hiring body would invite some degree of risk to your organization by adding this person to your team based on unnecessary delays to accommodate a learning curve.

But what if you flipped the hypothetical and welcomed a candidate applying for a supply chain position that specialized in IT without having any supply chain experience whatsoever?

Which might you consider more reliable and valuable to your team – a supply chain person with no IT experience or an IT person with no supply chain experience? What's the value in supply chain hiring someone with an IT background, experience or skills going forward knowing that data and information remain lucrative commodities in transacting business versus hiring someone grounded in supply chain?

As healthcare supply chain operations adopts and implements more automation, business intelligence and "control tower management" strategies and tactics among others, slicing and dicing minimum requirements for employment can be akin to chess moves.

One supply chain executive quipped, "It helps to hire people with an IT background because you can teach them supply chain, which may be easier than teaching IT to supply chain people."

Not everyone agreed, however.

Matthew Palcich, system director, Resource Analytics, MultiCare Health System, Tacoma, Washington, pondered the question a bit before straddling "both" as a balanced response.

"Hiring individuals who possess the right kind of curiosity, a working knowledge of problem-solving and tools like Excel/SQL, strong people skills and a desire to improve healthcare is crucial in this space," he said. "Supply chain expertise can be taught, and with advancements in low-code, easy-to-create application development, these skills can also be acquired. These 'hybrid' supply chain and analytics

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professionals, who remain laser-focused on the needs of their customers, tend to generate the best concepts to market."

MultiCare supply chain leaders, as well as others with whom *The Journal of Healthcare Contracting* spoke, maintain extensive IT capabilities to manage and streamline their respective consolidated service center, warehouse or multifacility contracting, distribution and logistics operations.

Supply chain executives and leaders must be vigilant about the opportunities and candidates that cross their paths, according to Doug Bowen, senior vice president, Supply Chain Services, Banner Health, Phoenix.

"There is an opportunity for healthcare supply chain teams to better recognize the market value of seasoned IT professionals who bring skills related to system development and analytics," Bowen told *JHC*. "In many cases, healthcare supply chain IT teams are supply chain professionals who have good analytical skills and some technical capability, but they often are not individuals who have dedicated their career to this space through education, certification and experience. Investing in the right talent is a key critical success factor."

Bowen promptly extoled one of his own mores, "Great strategies and great products do not make a great supply chain. Great people make a great supply chain!"

Still, supply chain professionals need to embrace data science to some degree in the contemporary marketplace, Bowen continued.

"To meet today's supply chain challenges, all supply chain team members need to be citizen data scientists to some degree, capable of generating and analyzing data to make timely and sound business decisions," he said. "With the introduction of modern ERP systems and self-service analytics, we can put decision-making information in front of the end users to enable personal empowerment allowing for decision-making to move at the speed of business. Banner Health continues to invest in data management solutions that make this possible."

Steve Downey, Chief Supply Chain and Patient Support Services Officer, Cleveland Clinic, acknowledged that IT has become something of a job requirement in supply chain.

"Many components of today's supply chain are technical, so I believe technical competence is becoming more and more required in the daily job," Downey noted. "I do believe you need caregivers that are passionate about service to patients, that can learn supply chain and are interested in the work. I wouldn't hire an IT professional to just develop commercial supply chain IT solutions unless we had a very targeted business model towards that. Our primary job is ensuring we take care of patients and doing that may require the system to have IT-skilled caregivers."

Dan Hurry, CSCO, Cincinnati-based Bon Secours Mercy Health, and president, Advantus Health Partners, remained non-plussed.

"I think it could go either way," he indicated. "I don't know if I fully agree with that. I think the biggest challenge is having somebody that can be dangerous enough in both aspects of what we do, and which is why in some of our heavier tech solutions we actually outsource [other companies]. We'd rather have people that understand the why and the how we do things and apply technology rather than the other way around. Whether you like him or not, think about how Steve Jobs always looked at his software applications or hardware or anything he looked at from a tech solution. He looked at end-user applicability first and then moved up to the tech, which is why I lean into that sort of model to make sure we understand what we're doing. I've seen models where if you try to just conform to what technology will do, then that doesn't always lend itself well to application." ■

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