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Food for Thought

How Cleveland Clinic is using supply chain knowhow in traditional med/surg purchasing to rethink its food services operations.

Over the last two decades, Cleveland Clinic has seen rapid growth. From 2020 to now, it's almost doubled in size through acquisitions, particularly in Florida, said Laura Johns, Senior Director – Enterprise Food & Retail.

A restructuring was in order. Cleveland Clinic's executive team went on a multi-year journey to restructure the organization into three main pillars: the institutes, which are clinical service lines; the markets, which operate each of the individual hospitals and are where the P&L sit; and the shared services, which are responsible for that standard of delivery across all the markets and institutes, whether that's IT, finance or something like food services.

"So often when we brought hospitals on, we didn't change a lot of what was there, so there were not clear owners of a shared service," Johns said. "Everyone was trying to make it work together, but we didn't have a decision-maker or know who the final decision-maker on certain points was. The restructuring was really around the ability to expedite decision-making, the ability to create accountability structures and continue to achieve our goals, with clarity of roles and responsibilities across the organization."

Since July 2023, Johns has led the food service arm of the supply chain and support services team. It is mostly an outsourced model. Cleveland Clinic has four vendor partners (three in the U.S. and one in Great Britain) who support the enterprise. "I'm responsible for partnering across the whole book of business," said Johns. This includes patient service operations, technology, and capital and asset acquisitions or maintenance across the enterprise (such as kitchen and retail services investments).

Before the restructuring, there was a mixed model where vendors might work directly with each local hospital or through the shared service when it came to food services contracts. Now, the process is much more standardized. "We don't let people add or subtract places," said Johns. "We all come together. We all agree on the financial targets, we all agree on the quality targets, the safety targets, and then my role is really to be able to hold both sides accountable."

Johns' team leverages the supply chain vendor management office for best practices and structure. The office also helps with some of the decentralized vendor partners. "They don't just service food, though food is a big portion of how we're working with those vendors," Johns said. "They're also involved in multiple other facets, whether that be on the clinical side or direct and other shared services. We utilize the supply chain vendor management office to have a full picture of what that vendor portfolio is so we can hold

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those vendors accountable and utilize that in strategic conversations."

Coming over from the operations side of the supply chain team, Johns did a lot rounding and lots of hands-on activities in her new role to better understand the nuances, motions, lingo and clinical side of food services. "I will say that while it is different, I was surprised at how much coming from supply chain helped me understand and pick up on certain aspects of food quickly or just seeing opportunities," she said. "At the end of the day, it really is a supply chain. There's a production piece in the middle of it, and that's really what we're doing. We're bringing products in, we're preparing them, and we're delivering them to the patient. So, it's all a very similar flow of product."

Johns and her team have examined ways to borrow from the traditional supply chain model in how they're handling food services inventory management, such as utilizing two bin technology. "We're asking, 'how can food services utilize some of those same principles to help manage stock or help manage vending that's congruent to our cafe spaces?'" she said. "We are re-evaluating those models to make them the most cost advantageous and structured."

Market forces

Although every sector of the U.S. healthcare system has felt the pain of staff shortages, the food services sector has been hit harder than most. "The workforce shortages are very real," she said. "Most hospitals struggle with attaining the right amount of staffing. And in the hospital environment, there are the regulatory requirements to work that are very different than going into a McDonald's down the road or some other entity."

Indeed, staffing is extremely competitive and difficult to come by. "In such a labor-intensive business, it is really making us think about how the patient side has to come first," Johns said. "When we put out huge operations on the patient and retail side, how do we optimize and utilize technology to help overcome staffing? Some options we're investigating are cashier-less checkout, order pay kiosks, and robotics."

The cost of food continues to increase and puts pressure on how providers manage food purchases with quality. "Going through our vendor partners, we do rely on them pretty heavily and their GPOs to create that appropriate formulary where we can get the best pricing. How do we make sure we're realizing that, because the cost has to be contained."

The future of food services

Looking ahead, Johns said she and her team are experimenting with how they could utilize supply chain principles in floor stock (i.e. nourishment rooms or food that's stocked in patient areas). "Today we do a lot of bento boxes or products that can expire quickly, so we're looking at whether we could service those types of products direct from the kitchen," she said. "Could we put food on a very similar system of control that we're already doing with supplies, and could materials management help us with that?"

Cleveland Clinic is looking to pilot this concept at a couple of outpatient locations that don't use food service management companies. "We're pretty excited about what the opportunity could be there, the efficiencies, and then the higher delivery of service that we would be able to provide."

"Today we do a lot of bento boxes or products that can expire quickly, so we're looking at whether we could service those types of products direct from the kitchen."

In November, Cleveland Clinic will roll out a patient ordering app. "It's a huge opportunity for patients to be able to see what they can have instantaneously on therapeutic diets," Johns said. "A lot of what's on our regular menu is potentially not available to patients on therapeutic diets. Especially when you're on multiple therapeutic diets, that restriction can substantially impact what you can order when you call to place your order or you're working with a menu specialist who comes to your bedside. It's a lot of trial and error. We will be able to give them direct access to the food choices they want and be able to have family members or care takers order on their behalf as well while they're in the hospital."

The supply chain team is also exploring AI innovations in how their data is analyzed, and robotics in several retail settings. "There are so many robotics in the food service space, so we are starting to play around with where that might fit and give us some advantage, whether it's in retail food delivery or the collection of dirty trays or even on the production side," Johns said. ■

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SHARING EXPERTISE

Building Goodwill Between Clinicians and Supply Chain

Clinical integration hinges on authentic partnerships with mutual respect and understanding.

BY R. DANA BARLOW

Editor's note: *The following is part two of a two-part series. Look for the first story in the September digital issue of* The Journal of Healthcare Contracting.

Physicians, surgeons and supply chain executives represent a different kind of circular economy that reinforces business, clinical and economic sustainability.

The round-robin process works something like this: Physicians and surgeons bring revenue into a healthcare organization – largely from payer reimbursement for procedures – but consume a tremendous number of resources in terms of costly devices, equipment and products. Supply chain executives, on the other hand, can rein in those costs through strategic sourcing, effective contracting, value analysis and facilitation and management consulting, but must equip and fortify physicians and surgeons to carry out their missions.

Without the proper, respectful and responsible balance between the two groups, everyone loses – particularly the patients.

The Journal of Healthcare Contracting reached out to three examples of these relatively new healthcare executives so they could shed some light on what they do and why they matter as well as share how their roles can be applied anywhere. They are:

Anand Joshi, M.D., MBA, senior vice president, Procurement and Strategic Sourcing, New York-Presbyterian Hospital

Jimmy Chung, M.D., MBA, FACS, FABQAURP, CMRP, Chief Medical Officer, Advantus Health Partners and Bon Secours Mercy Health;

Stacy Brethauer, M.D., MBA, Professor of Surgery, vice chair of Quality and Patient Safety, Department of Surgery, and medical director, Supply Chain Management, The Ohio State University Wexner Medical Center.

All three expressed optimism that more clinicians like them are emerging within forward-thinking hospitals and healthcare systems around the country, striving to achieve balance between physician influence and preference.

How much sense does it make to recruit and hire a doctor or surgeon on the supply chain staff to influence the business decisions of their colleagues and peers as well as promote relevant clinical intelligence to supply chain? Why?

BRETHAUER: It makes a lot of sense for a health system to invest in these positions. At OSUWMC, the medical director has 20% of their time paid for by the hospital, and I have two associate medical directors with 10% protected time. This investment by the hospital has a huge return on investment through the savings and variation reduction these leaders have achieved. Over the last five years, physician-led projects have saved more than $5 million annually for the system so supporting this effort makes great sense from a cultural and financial perspective. In addition to working on sourcing and new product decisions, we have redesigned our processes to make the value analysis and

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new product introduction more streamlined and easier for clinicians to navigate. This has built a lot of good will among the faculty toward these physician leaders and their roles in supply chain.

CHUNG: As long as there is a governance and executive structure in place to support the role, it makes complete sense to hire a physician leader for supply chain. The position can be supported by savings from appropriate utilization and contract compliance, as well as other sustainable resources such as rebates and admin fee sharebacks. It is critical that the right person is hired for this role; it would be more successful to recruit someone who has a strong commitment to improving the business of health care and is willing to be trained in supply chain. They should be considered an integral part of the supply chain management team, not just a 'doc' who is occasionally pulled in as needed.

JOSHI: I think it does make a lot of sense, and it likely wouldn't have to be a full-time team member. I think a model where you have segmented portions of people's time across a number of different subspecialties would work. For example, if there's a specific electrophysiology issue, you'll have office hours with an electrophysiologist once a week to talk through this. If there's an issue with trocars and mechanical staplers, then you have time with a general surgeon when you need it. I think that model could work very well, and it might make the most sense because it's not clear that surgeons or physicians are going to give up their entire livelihood to work in just supply chain. They still want to practice. The model of 10% engagement might work, but 20% may be too much, so 10% involvement may be enough for a number of subspecialists.

Why might appointing or employing a medical director of supply chain be appropriate or not appropriate for every facility? What are the characteristics of a facility that could use one vs. need one?

BRETHAUER: Most health systems across the country still do not have a physician leader in this role. In my opinion, every health system should have a physician leader in this role. Even in systems where physician preference dominates, there is a role for a medical director to start building a clinically integrated culture and to present data and opportunities to the faculty. In my experience, clinical groups respond well to data that shows they are outliers when it comes to utilization or pricing for specific procedures. Surgeons are competitive by nature and respond to data that shows they are underperforming their peers when it comes to bringing value to the system. For systems with a more mature culture of cost awareness, there will still be many opportunities for the medical director to lead sourcing projects to drive savings as pricing changes and new products enter the market.

CHUNG: If the goals of the role are clear, there is no reason that every facility shouldn't have a physician leader in supply chain. A medical director of supply chain may take on different forms in different hospitals; for example, a 0.1 FTE role for a practicing surgeon, added responsibility for a pre-existing medical director, combined responsibility for a larger leadership role, shared responsibility between two or more clinicians, a dyad relationship with an operational leader, or a full-time executive role. In any case, they should be empowered with influential leadership and formally accountable for reducing waste and improving quality.

JOSHI: I think any place that has significant spend in the ORs and in cardiac areas, such as catheterization and electrophysiology, those tend to be the most supply intensive areas where technical knowledge

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and engagement with physicians is most critical. If you're a community hospital generally doing basic surgical care with lots of emergency room visits and labor and delivery and caring for patients in a nursing unit, then you probably don't have as much of a need for a medical director of supply chain. Supply intensity in the OR, cardiology, neurosurgery and orthopedics spaces are the biggest drivers for a need for a medical director.

How does supply chain effectively state its case to the C-suite for the need to add a medical director of supply chain either on the payroll as a salaried employee or as a consultant via purchased services? Might anticipated smoother relations with clinicians, improved outcomes or cost savings be enough to establish a budget to support such an executive?

BRETHAUER: There is a clear return on investment for health systems to invest in physician leaders in supply chain. Through their influence, these physician leaders can drive millions of dollars of savings, cost avoidance and variation reduction every year, which is far more than the health system is spending for their time.

CHUNG: The medical director of supply chain is not a singular solution or a magic bullet. It is a key role in the overall supply chain strategy of clinical integration and value optimization. One would need to demonstrate the value of the clinically integrated supply chain and variability reduction to both patient outcomes and financial results, and then explain the value of a physician leader in this overall strategy. Patient safety and waste reduction are the primary goals of this strategy, and the medical director is accountable for reducing variability in product sourcing/utilization and clinically validated vendor/SKU reduction to reach the primary goals.

JOSHI: One relatively straightforward way would be to list out the various categories of spend – orthopedics, spine, interventional cardiology, electrophysiology, sutures, endomechanical staplers – just go through the categories and put the spend next to them and say, 'listen, we're probably going to get a 5% better outcome by having a clinician involved so here's how much it could be worth if we get a physician in each of these areas.' That would be my instinct. Would it be worth it if the money's there? If the spend is there then the value will be there, but you have to get the right mindset and person into those roles. There's dollars and cents to be saved, for sure, by having more truly engaged conversations with clinicians.

What are some of the biggest challenges that you face when trying to balance the needs vs. demands of clinicians vs. supply chain? How do you convince both groups that each is looking for the other to an extent in context of the organization being able to remain operational? How does the give-and-take work beyond "show me the data" and "gainsharing," among other well-worn options? Is it a price vs. quality issue on the surface alone?

BRETHAUER: One of the biggest challenges we hear, especially from the chairs, is that they can't recruit new faculty if they don't let them use what they want. We deal with this by educating new faculty about our process and inviting them to the table to help with decision-making. While they may not always get their preference items when they start working here, they can participate in ongoing decisions that will determine the products their group uses. When there is a lot of turnover in a department, for example, we sometimes have to re-issue an RFP to meet the clinical demands of the new faculty. The medical director and commodity manager can manage these discussions and set expectations so that new faculty feel like they are part of the process and have meaningful input as the product landscape changes over time.

"There has to be some give and take in these negotiations with the faculty. There are many cases where we 'give in' to a specific request to build good will with a physician or group and, in return, expect them to work with us when larger decisions need to be made."

Gainsharing is not something we have pursued here. Our executive leadership has made it clear that variation reduction and participation in cost savings is an expectation of the faculty and won't be directly rewarded. Having said that, we do make the argument to the faculty that cost savings from these projects do provide the system with more money for program development, recruitment and innovation, so there is still an incentive for them to participate.

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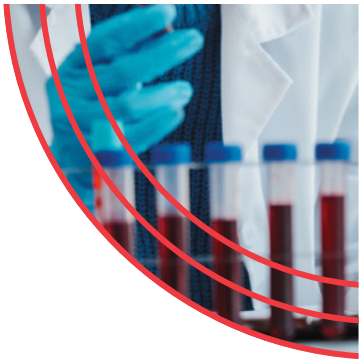

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When we hit barriers with specific physician or physician groups, we clearly state that the status quo is not sustainable and support this with data. It can take several meetings for them to come around to a reasonable decision, but in my experience, persistence and an engaged medical director make a big difference in getting these "hold outs" to change their behavior. Additionally, once a decision is made, we commit to providing these groups with utilization data to show them whether they are in compliance with a decision that was made. Setting expectations up front and providing utilization data updates can be powerful ways to drive adherence to changes.

CHUNG: In my opinion, the problem is mostly on the side of clinicians. We already know that unnecessary variations drive waste and harm patients. We have all the tools necessary to reduce variations to make health care safer and more affordable. Honestly, it is physician autonomy and the myth of the "art of medicine" that continue to drive the tolerance of variability in medicine. We assume that the "doctor knows best" and allow physicians to practice the way they want. The variability also originates way upstream, from residency and even medical school, where physicians are taught that medicine is a noble profession, and no one should violate the doctor-patient relationship.

Ironically, it is this tenet that can get in the way of efforts to standardize care to best practice toward optimizing the patient experience.

Despite the wealth of evidence-based clinical guidelines available, recent surveys showed that only a minority of physicians actually follow them, because they believe they get better outcomes doing things their way. From the patient perspective, this leads to uncertainty and variable risk that is dependent on whom they might choose as their doctor. Patients want reliability and consistency built into the system. This is why we don't have to choose a pilot when we fly on airlines.

That said, the needs and demands of clinicians are two different things that are managed very differently by supply chain. "Needs" can be determined with data and evidence. "Demands" are often based on preference and should be examined carefully to see what value they actually bring. Currently, the balance between clinicians and supply chain is heavily weighted on the clinician side. With a strong leadership commitment and physician leaders in supply chain, this imbalance could be better addressed, so that supply chain can actually recommend the appropriate product and evidence-based utilization to the clinicians. To "give" something to clinicians in exchange for "taking" something implies that we are misaligned on what each side thinks is the right thing to do. When we are aligned, there is no need for "give and take." For example, at ASCs where the physicians have a financial stake, there often doesn't seem to be any problem aligning and standardizing.

JOSHI: Maintaining that balance is the greatest challenge, weighing the needs and demands of the various constituents.

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We used to call some of our performance improvement teams that focused on non-labor spend the non-labor expense teams, but we've morphed them now into value-based management (VBM) teams. We take the classic value equation – outcomes over costs – and ask ourselves what are we doing to improve value? There are two ways to do it. You can reduce the denominator, or you increase or improve the numerator. In some instances, it's sort of easy math. If you know that you're going to keep the product the same, but you can lower the cost, then you're clearly proving value. Or, if you're going to keep the costs the same, and you know you're going to get a better outcome, then you're definitely increasing value, too.

It's when there's movement on both, cost is moving up and quality is going up, that it's harder to weigh. Is quality going up enough to warrant the incremental costs? That's where the math gets hard and where we have to have real transparent conversations with the physicians and surgeons. It can't be a transactional relationship with physicians. It has to be true engagement and long-term, trust-based relationships that will allow the trade-off between costs, outcomes and quality to come to fruition. For example, something may cost 10% more but patients get out the door two days faster. It takes time for those opportunities to come across people's radar. If you see this as a one-and-done interaction each time, then you won't get the value of the relationship that it ultimately yields.

How do you achieve some semblance of balance between preference and influence in terms of product and service evaluation, selection and acquisition?

BRETHAUER: There has to be some give and take in these negotiations with the faculty. There are many cases where we "give in" to a specific request to build good will with a physician or group and, in return, expect them to work with us when larger decisions need to be made. We are fortunate at OSUWMC in that all of our physicians are employed by the system, and we don't face the challenge of private physicians practicing in our hospitals.

At my previous institution though [Cleveland Clinic], we did have private surgeons working in our community hospitals and did face challenges in driving standardization. Ultimately, the medical director and supply chain relied on support from our executive team when difficult sourcing decisions needed to be made that upset the private surgeons. Having this "air cover" from the C-suite is critical to the success of the medical director as they try to reduce variation and drive savings, particularly in the high-cost, high preference areas of orthopedics, spine and electrophysiology and cardiology.

Ultimately, this is an iterative process. The medical directors and supply chain team have to decide which projects are achievable, how difficult they will be, and whether the potential savings is worth the effort required, so some projects are delayed until we feel the culture in those groups is ready for them. No matter what, the goal is to have the clinical groups feel that the decision is something being done by them and not to them. Empowering them with a robust process and reliable data goes a long way toward getting them to a reasonable decision in most cases.

CHUNG: Any balance between these two extremes has to be defined by organizational goals and data. That is, what is "balance?" Half and half? If the organization's goal is to provide affordable, evidence-based care to all people in a diverse population, while serving as good stewards of limited resources, then "balance" might be 90% standardization based on data and evidence and 10% based on individual preference.

We have to be blatantly honest that this is not about "fairness" or compromising. The balance described in this question is not a balance at all, but the extent to which hospitals are willing to concede to physicians to keep them happy. This concession leads to safety risks and waste, which then forces operational leaders to create innovative workarounds that create even more costs and waste (think preference cards and block times). While hospital administrators can't make overnight changes to address these challenges, supply chain can help drive the conversation and slowly make meaningful changes, such as developing the medical director role in supply chain.

JOSHI: As much as you can do things as transparently and consistently as possible – both on the price side but also on the quality and outcome side – and really press for that transparency, I think that helps. Ultimately, this would be an open book. That same methodology used this time will be expected next time. Transparency is really helpful to get folks to buy in that this is not a one-time thing but will continue. As much as we can get the parties to work together, the better off the entire organization is going to be, for sure.

Editor's note: *This story has been edited for clarity and length.* ■

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"Vendor credentialing also allows hospitals to know the duration of a vendor's visit, the key points associated with vendor compliance, vendor strength and values. This allows hospitals to triage why vendors are doing a good job, or why they are not," said Bradley.

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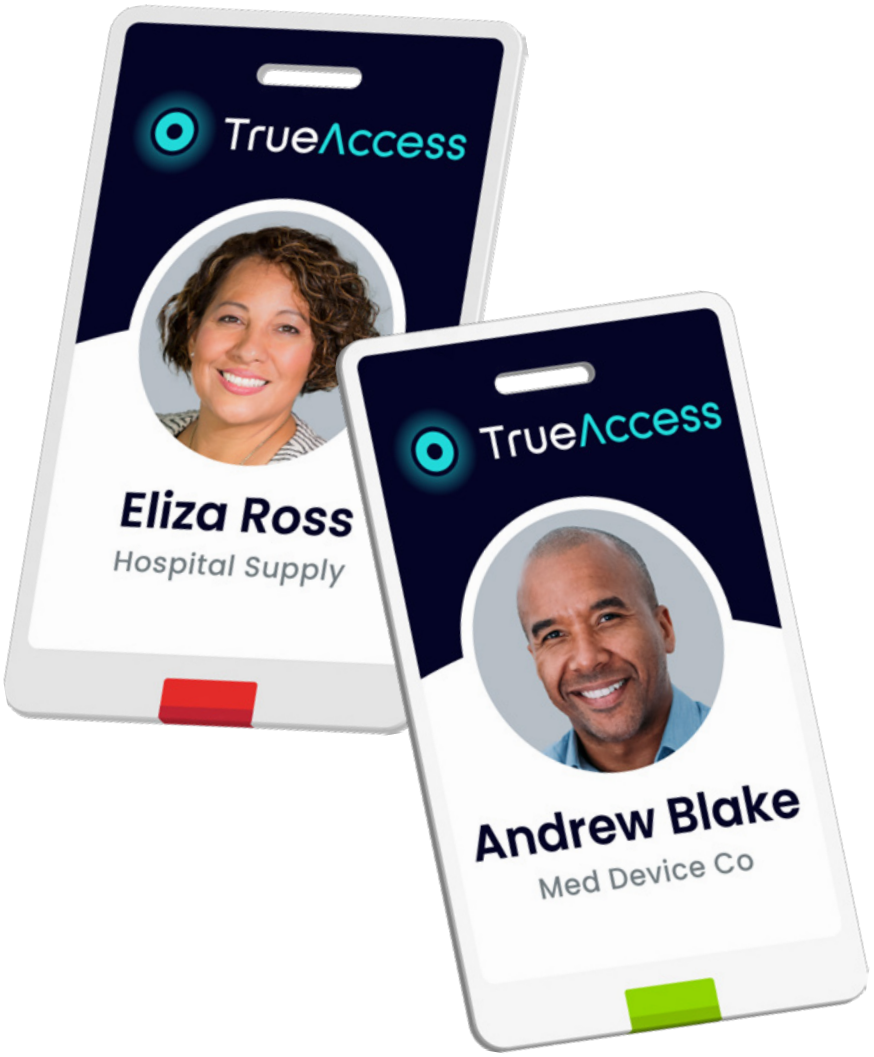

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Cultivating Supply Chain Talent

Investing in talent development, career laddering offers bedrock of success.

BY R. DANA BARLOW

Chinese philosopher Confucius once noted, "Choose a job you love, and you will never have to work a day in your life."

But if he worked in healthcare supply chain today, he might update that with, "Attract, mentor and retain the right people, and you will never have to worry about retirement."

Attracting, recruiting, educating, developing, training and retaining talent and skills remains among the essential aims of an elite, forward-thinking healthcare supply chain department. Investing in your staff and your workforce that can include third-party purchased services, through planning and implementation, fortifies and reinforces the lifecycle of talent that drives supply chain progress within healthcare organizations.

Talent development and career laddering among hospitals, healthcare systems and integrated delivery networks (IDNs) tend to concentrate on and emphasize three areas: Education, ideation and recognition, seasoned with scheduling privileges, swag and leadership face time and occasionally spiced with compensation boosts.

While each organization may provide these benefits in its own way, these organizations see similar outcomes of happier colleagues and employees who continue to perform and produce, leading to internal promotions and external opportunities.

Investing in humans

Provider organizations have myriad ways to fortify the human resources they have, starting with an innate appreciation of the human element.

"Attracting and retaining top talent is my No. 1 priority as a leader, regardless of the area," said Marisa Farabaugh, senior vice president and Chief Supply Chain Officer, AdventHealth, Altamonte Springs, Florida. "As we have all heard the saying, 'people are our greatest assets.' To me, this is the absolute truth.

"It is easy for leaders to turn away from focusing on hiring great talent – and it is easy to understand why with so many day-to-day fires are being fought," she continued. "The challenge I give to my leaders – and myself – is how do you lean into these moments and not out of them? At the end of the day, this is not the task I want outsourced to anyone. Whenever there is an opening on my team, it is my job to find the right talent for the team and where we want to take the business. I complete all initial phone call screenings. I place the calls into my network or to potential candidates. I do the research behind any possible candidates. This takes time, but it is time well-spent and focused on the most important decision around who will be on the team and lead others. I like to cast a deep and wide net, and you never know from where your next great candidate will emerge! I always try to hire the very best talent I can find and surround myself with many great leaders who are much smarter than I!


Marisa Farabaugh


Kate Polczynski

"Once talent is hired, the real work and time begins," Farabaugh added. "Spending time with the newly employed leadership is key to ensure assimilation into culture. This time and step are crucial for new leaders to launch into their role with the highest potential success rate possible. I am blessed to work with absolute top-level talent in the industry and learn so much from these leaders every day." She shared AdventHealth's "Talent Development and Growth Programs." [See chart, page 28.]

Kate Polczynski, MBA, CMRP, vice president, Enterprise Supply Chain, Supply Chain Services, Geisinger, Danville, Pennsylvania, embraces the philosophy of "supporting the human beyond the badge" within the organization.

"The traditional 9-5 does not often align with allowing employees to engage in professional development, family, faith, well-being or community priorities," Polczynski told *The Journal of Healthcare Contracting*. "Supporting volunteerism, providing opportunities for continued education and allowing flexibility in work schedules, where possible, is an investment that could foster further employee retention and engagement."

A sizable portion of that mix involves developing potential, skills and talent.

"As a life-long learner, one of the largest investments you can make in your workforce is the opportunity for professional development," she continued. "This can come through exposure to projects, facilitating their presence and participation at strategic forums, promoting formal learning opportunities, encouraging attendance at conferences as well as aiding in the expansion of networking across the industry. As I reflect on my own journey, the investment made by other leaders in my own development has been something I am most grateful for as it has helped me develop into the person I am today."

Polczynski acknowledges the capital expenditures necessary for technology investment to enhance productivity. "The financial commitments to support a technology install is investment No. 1, but the opportunity to conduct thorough

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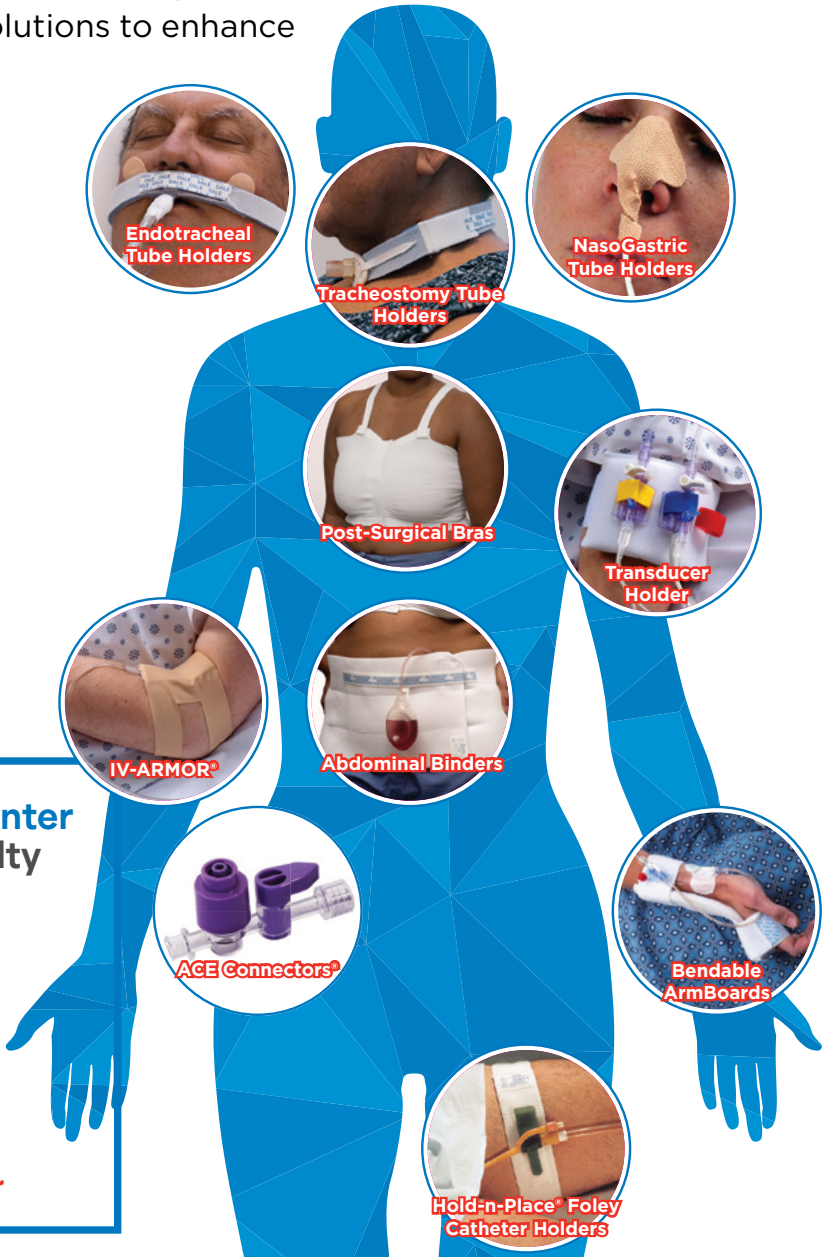

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pre-installation design to break the cycle of bad practice is an investment worth making as well," she noted. "With the potential efficiencies that can be gained through tech options such as robust ERP systems, logistics and inventory control solutions and utilization management tools, the future work of supply chain professionals will continue to evolve as it has over the past decade."

Clinical conditioning and integration represent another tangible but lesser-known benefit worth the investment, according to Polczynski.

"Within healthcare supply chain, one of the potential investments that is not always apparent is in clinical champions and team members who can aid in offering subject matter expertise to foster clinical integration across the healthcare continuum," she noted. "This can be through literal investment in positions and people, but it also can be in the investment of time and effort to establish robust networks and relationships. This investment helps a healthcare supply chain team navigate through rough waters with trusted partners, and also creates a roster of supply chain supporters who can ensure the team is represented and considered during discussions which they may not be a direct part of."

For Allison Corry, Chief Supply Chain Officer, Intermountain Health, Salt Lake City, her "secret sauce" emphasizes the "whole person" bringing his or her "best self" to the organization and the patients it serves. That philosophy not only calls for transparency and authenticity but also whimsy.


Mark Dozier


Allison Corry


Joe Colonna

"The No. 1 thing that I think I do is not only lead with transparency and authenticity, but with an expectation that we need to have fun, and we need to be able to laugh at ourselves," she said. "We need to be able to poke at each other a bit – and not just our ideas, but I want it to feel like a welcome space for everyone."

Corry stresses the value of supporting her team's family needs as a top investment she makes in them. "A lot of times we take for granted that the role our family plays in our ability to show up as we are," she added. To wit, Corry makes a practice of sending flowers or plants to her team members in lieu of Christmas gifts, something she tailors to each employee's preferences, based on an experience she had earlier in her career.

"The takeaway is to find a way to recognize the whole person, even if that means you need to make some personal investment," she indicated. "I can tell you that [this philosophy] offers well-paying dividends on my own personal investment in these gifts. A happy team is productive, so they may not need me as much. It's a back-to-basics approach in reiterating the whole investment in a person with fun and connectivity.

"If they choose to go somewhere else someday, I'll be the first one that has their back, if that's what they need," she assured. "I can think of no greater investment in oneself than to do that. And if I lead that way then my hope is that they'll lead that way and that slowly in time we create a culture that's the norm."

Intermountain takes pride in its flex-work and "telework" opportunities, which may be a huge recruiting and retention play, but also challenging to manage, according to Corry. Those who work on campus tend to be "outdoorsy"

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types who may "ski in the morning and rock climb in the afternoon and bike ride," but she also must work with team leaders in different places and time zones like St. Louis and Fargo, North Dakota. Intermountain operates 34 hospitals and 400 clinics in a six-state area comprising Utah, Idaho, Nevada, Colorado, Montana and Wyoming.

Corry feels that nurturing enjoyment, fun, participation and the spirit of consensus, regardless of location, helps to solidify team dedication and unity.

Like Corry, Mark Dozier, MPH, Associate Vice President, Supply Chain Services, Strategic Sourcing & Engagement, HonorHealth, Scottsdale, Arizona, considers flextime a legitimate part of staffers' mental and physical health.

"It's allowing my contracting team to work remote three days a week," he indicated. "I also strongly encourage all staff to schedule/take a 'renewal day' every quarter. This is voluntary and up to each staff member. Staff share renewal day highlights at our monthly department meetings."

Personal touches

Those who pursue a healthcare supply chain career must balance the interest in money vs. the interest in mission, according to Joe Colonna, Chief Supply Chain and Project Management Officer, Piedmont Healthcare, Atlanta.

"The nature of healthcare, at least in the provider world, is such that we will never be able to compete on pay alone," Colonna admitted. "We do tend to have better benefits, especially when it comes to healthcare. However, those items are unlikely to be the reason you can successfully recruit and retain employees.


Joe Loya


Ed Hisscock

The primary 'perk' is that you are working in a field that can literally be 'life or death.' This work can be at times both terrifying and incredibly meaningful. You can have a real and immediate impact on patient care and the people who provide care to patients. In healthcare you can work with people who deeply care about what they do.

"While we should strive for fair and equitable compensation, we should also reinforce the pride that supply chain professionals should have in a job well done," Colonna noted. "One example of how we do this is, we have a 90-day, new employee meet-and-greet. All new supply chain employees, regardless of their role, have a one-on-one meeting with me. During these one-on-ones I always thank the employees and remind them that every job in supply chain is a link, [and] if any one link fails [then] the chain fails. I thank them for their good work, tell them how proud they should be of their role and remind them that when it comes to the day-to-day of getting the shelves stocked, their role is much more important than my role."

When one staffer expressed interest in a promotion, Colonna remembers taking him aside.

"I had an Executive Director of Operations who told me he wanted to be a VP," he recalled. "I told him that there was only one of those jobs here and it was filled. However, if he gave me at least three solid years, I would help him to develop his skill set and even be a reference for him when it came time to seek his VP role. He is now a VP of his own shop. Based on what I have heard, he is doing quite well."

Colonna believes that team members should have a sense of pride in knowing how important their role is to the organization and the patient and that there are internal and external paths for growth.

"There will be a limited number of manager, director and VP roles in any organization," he said. "While we would love to see growth within our teams, we also recognize and support leadership growth outside of our organization. I never like to see good people leave, but I am also very proud when they leave for advancements in their careers. I want

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good people in our industry, whether that is here or in another organization."

Joe Loya, director, Purchasing & Distribution, St. Joseph's/Candler Health System, Savannah, Georgia, favors the one-on-one exposure as well. "During monthly meetings I make sure to address each team member and personally ask for any input to the meeting that they may have," he said.

can imagine, that necessitates a great deal of reflection and introspection in tough times, but it has yet to fail me. In my experience, people are rational and can deal with the toughest of topics if they are dealt with respectfully."

With Intermountain's generous flex-time opportunities, Corry tries to avoid micromanaging at all costs, allowing team members the time they need for errands,

In many of our corporate functions, we have deployed a remote working environment which has allowed us to complement our teams with bright minds from across the nation. This work style requires focused attention on team engagement, collaboration and communication to ensure all members feel a connection to the organization and the work they are performing.

But Loya recognizes that financials prove extremely valuable. "I successfully had the HR department review my staff's compensation," he noted. "By getting all my managers together, we rewrote job descriptions and key results that ended with significant hourly increases for all of my staff. They were extremely thankful of the effort and the result."

Invest in candor, transparency

To hear some supply chain leaders tell it, their colleagues and staff appreciate straight talk and prefer transparency.

"My leadership style is very open and transparent," assessed Ed Hisscock, senior vice president, Supply Chain, Trinity Health, Livonia, Michigan. "I lead with a philosophy that 'if I cannot justify openly and honestly an action that is being taken, I probably should not be taking it.' As you

family events and personal appointments. She only requires transparency through communication, highlighting timeframes and deadlines for desired outcomes and responses. "I try to be really flexible in that because I think it shows trust from me that I believe they're going to do what I need them to do," she said. Corry also heavily encourages team members to use their personal time off and truly disengage from the workplace if they can.

"I'm probably the worst example because I actually like to check my email on PTO so that I'm not the person that's the holdup," she admitted. "It's the way I feel less stressed about it. I think a lot of people say they're going to go somewhere but they're taking their computer to work two hours a day. I just tell them, please, you have PTO. Take the PTO. I also don't want you to sandbag it. If you're not working, then don't pretend that you're working. Use your judgment. I think it works out in the end."

Geisinger's Polczynski extols the flexible work model, too.

"Post pandemic, our organization embraced adopting a remote workforce in many areas," she said. "Within supply chain, our work includes that which must occur within the hospital, but also has several functions which can be successfully accomplished remotely. In many of our corporate functions, we have deployed a remote working environment which has allowed us to complement our teams with bright minds from across the nation. This work style requires focused attention on team engagement, collaboration and communication to ensure all members feel a connection to the organization and the work they are performing. This decision has also brought a level of lifestyle to those who are able to participate. Rather than investing time in a commute, this time is now able to be repurposed for the staff. What once was two-hour windshield time is now time for exercise, reading, or other personal priorities. This model certainly has its critics, but we have seen it be successful when deployed with effort and intention."

Invest in education

A considerable component of professional development involves education, which also contributes to career laddering and promotion. Even though traveling to conferences and trade shows can be costly, healthcare supply chain leaders do see and act on education as a worthwhile investment in their staff.

"I enroll new staff in the Capstone Learning Institute," St. Joseph's/Candler's Loya said. "If successfully completed,

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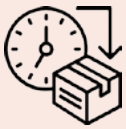

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References: 1. Data on file, Allergan Aesthetics, March 2024; Plastic Surgery Aesthetic Monthly Tracker. 2. Data on file, Allergan Aesthetics, July 2023; Surgical Scaffold AU Surgeon Perceptions 2023. 3. Data on file, Allergan Aesthetics, January 2022; Allergan Plastic Surgery Order Form. 4. Data on File, Allergan Aesthetics, January 2023; AlloDerm SELECT Ordering Information. 5. Data on file, Allergan Aesthetics, July 2023; Artia Ordering Sheet. 6. Data on file, Allergan Aesthetics, January 2023; STRATTICE Ordering Information.

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that team member is allowed to participate in the Capstone Annual Meeting."

Trinity's Hisscock sees education's value at the collegiate level prior to the start of a career.

"At Trinity Health, the supply chain team has developed relationships with 11 universities where we engage with faculty to deliver guest lectures, host students for job shadowing, fellowships and internships, judge case competitions and provide content for class projects," Hisscock said. "We have also served on an advisory board to help guide a university as it started a supply chain program. Engaging outside normal day-to-day activities as a resident 'expert' working with professors has proven to be a very rewarding experience for colleagues."

The educational aims move from generating benefits to spreading benefits.

"In addition to supporting colleagues' engagement with universities, Trinity Health offers several online courses that are available to all colleagues on-demand," Hisscock continued. "My leaders encourage participation in those, and there are bi-weekly 'Quick Coach' emails with three-to-four, 2-to-5-minute video sessions on everyday topics like 'Teambuilding without Time Wasting' and 'Leadership Characteristics from the Front Line.' These provide quick tips on important topics and, more importantly, serve as simple frequent reminders to invest in self."

Succession planning represents an essential, intentional aim, too, according to Hisscock. "In supply chain, we adapt HR tools and processes for leadership growth, development and readiness to all supply chain colleagues who manage people and those who aspire to manage people," he said. "However, these programs are guided by each leader's individual style and the needs of their team. We are in a people business – arguably, the most precious of people businesses, human health. Supply chain leaders in our organization lead with compassion, respect and dignity. Our values as a faith-based, nonprofit health system emanate from each leader and serve as inspiration for colleagues."

HonorHealth's Dozier refers to education as a "mental investment" to reinvigorate professional development.

"We are in a people business – arguably, the most precious of people businesses, human health. Supply chain leaders in our organization lead with compassion, respect and dignity. Our values as a faith-based, nonprofit health system emanate from each leader and serve as inspiration for colleagues."

"We send some staff to conferences each year," Dozier noted. "We bring in a guest speaker to each of my monthly 'live' department meetings. This allows my team to hear from service line leaders, outside of supply chain, and learn about other divisions' staffing structure, major projects, key processes, etc. We also end a guest speaker's presentation with a Q&A segment. This has been received very well by my team."

Intermountain has been moving to skills-based job descriptions with supply chain as another investment, according to Corry.

Previously, job descriptions concentrated on experience, degrees earned and years of experience in more of a content format, Corry says, but the new format emphasizes expectations per function, role and title and uses a five-point scale for employees and leaders to assess quantitative and qualitative measurements. She credits her predecessor and former boss for setting her on this path.

"I'll forever be grateful to John Wright who gave me the opportunity to lead procurement when I had no procurement experience," Corry recalled. "He said, 'I've seen you work. You know how to lead teams. You're really intelligent. You'll figure it out.' That's always stuck with me since I've moved here that I have to do the same thing for others."

Corry considers the migration to skill-set emphasis to be a long-term evolution that highlights change management and problem-solving that features exhibiting soft skills as well as hard skills.

"We're not there yet," she observed. "But the thinking of the leadership is different now than it was when we started and that challenges us to bring and have the right conversations, show the right transparency for the team and make better picks as it relates to new hires or new opportunities. We're not there yet but I like where we're going with the thinking, and it also changes the conversations when we talk openly with the team." ■

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AdventHealth shares blueprint for talent development, growth

AdventHealth strives to grow educationally and occupationally through internal and external resources that all follow a unified set of programs and standards for talent development and growth. They shared their blueprint with Gartner Group and with The Journal of Healthcare Contracting.

Talent Development – Growth Programs

Description: AdventHealth is committed to investing in talent development through a variety of programs, each designed to nurture skills and foster leadership both within the organization and within key aspects of our talent pipeline. While the structure(s) of specific programs within this project has been solidified, it is an iterative process that will be refined in years to come.

This strategy contains several key programs:

- **Associate Regional Director Program:** This program is designed to identify and develop future supply chain operations leaders within the organization. This program provides early- to mid-career high performers within AdventHealth with the opportunity to gain comprehensive knowledge and experience across different departments, preparing them for leadership roles within the organization.
- **Intern and Resident Program:** Aimed at increasing the quality and quantity of mission-oriented future leaders, this program offers rotations with various departments across supply chain and business services. These internships offer opportunities to complete real work related to data analytics, contract negotiation, value analysis, supply chain operations, distribution services, ancillary and support services, and environmental sustainability. Internships aim to generate interest in the AdventHealth Residency Program, and residents are strongly considered for future employment at the conclusion of their 2- to 3-year program. These programs have a strong focus on early identification and development of future talent.
- **University Partnerships:** AdventHealth has established partnerships with universities, including University of Florida, University of Central Florida, and Southern Adventist University, to engage students in healthcare-related projects and introduce them to employment opportunities within the organization. These partnerships also allow for the exchange of innovative ideas and the development of tools that benefit both the students and AdventHealth. AdventHealth's partnerships with universities are primarily formed with institutions near its facilities and corporate offices, fostering natural and sustainable relationships. The University of Florida is also exploring co-development of a healthcare track within the industrial and systems engineering department.
- **GE Biomedical Engineering Training Program:** This program, between AdventHealth University and GE, focuses on optimizing biomedical and imaging asset management. Ultimately it aims to graduate certified biomedical engineering techs from our AdventHealth University who can support our growing internal program across the organization. It includes comprehensive training for in-house teams, enabling them to manage and maintain medical equipment effectively. The program also provides ongoing education through a clinical engineering training allowance, ensuring that the in-house teams are up to date with the latest technologies and practices

Goals:

1. **Leadership Development:** Develop both strong graduates and experienced candidates for readiness in supply chain leadership by providing them with a broad range of experiences across various departments, preparing them for future leadership roles within AdventHealth.
2. **Collaborative Innovation:** By establishing partnerships with universities, AdventHealth seeks to involve students in healthcare projects, introduce them to employment opportunities, and foster the exchange of innovative ideas. This goal is to create tools that are mutually beneficial for students and the organization.
3. **Technical Expertise:** A key goal of the GE Biomedical Engineering Training Program is to provide comprehensive training to in-house teams, ensuring they are equipped to

manage and maintain medical equipment effectively, and to offer ongoing education to keep them abreast of the latest technologies and practices.

Scope: Current and future supply chain leaders, university students, biomedical engineers

Challenges: Recruitment challenges may be present with any aspect of this program, depending on the location of selected candidates, as participants may be required to relocate or consider alternative focus areas of employment. Team members' willingness to relocate upon the successful completion of any talent development program should be considered and addressed early in the process.

Additionally, a national decrease in college enrollment, the stigma of online education, changing demographics and brand distinction are included in the list of ever-growing recruitment challenges for AdventHealth university programs, including the GE Biomed program. However, additional pathways, i.e. apprenticeship, trade schools, certificate programs are becoming attractive alternatives, and these talent development programs offer an additional pathway to achieving education and obtaining experience by harnessing AdventHealth's existing tuition reimbursement program, ensuring little to no cost to the employee.

Expected Benefits:

1. **Enhanced Leadership Pipeline and Retention:** By identifying and developing future leaders, AdventHealth is ensuring a steady stream of qualified individuals ready to step into leadership roles and ample opportunity for developing talent through the organization's future growth.
2. **Increased Talent Quality and Cultural Enrichment:** The Intern and Resident Program is designed to attract and cultivate high-quality, mission-oriented future leaders, enhancing the overall talent pool within the organization.
3. **Innovation and Collaboration:** University partnerships provide a platform for the exchange of innovative ideas and the development of new tools, benefiting both students and AdventHealth.
4. **Create first-in-kind BMET Certificate and Degree Program:** The GE Biomedical Engineering Training Program combines the practical application and requirements of servicing medical equipment in a large, renowned HealthCare organization (AdventHealth) with the technical expertise of an Equipment Manufacturer (GEHC). In doing so, establish a pipeline for new BMETs to fill much needed positions both within AdventHealth and across the broader healthcare marketplace.

Source: AdventHealth

Supply chain invests in creativity, ideation

BY R. DANA BARLOW

Motivating healthcare supply chain leadership and staff to collaborate, ideate, operate, perform, produce and succeed extends well beyond cookies, donuts, lunches, pizza parties and branded swag, such as mugs and sweatshirts with organization logos to foster identity.

For many, these opportunities to show appreciation represent a good start, particularly during National Healthcare Supply Chain Management Week in early October. For some, they serve as a launch pad for their team members' capabilities.

Through these efforts, forward-thinking supply chain leaders can spot creativity within their team and see the inherent advantages of tapping into that creativity to improve, innovate, solve problems and succeed overall in the short- and long-run as well as bring everyone together.

Mark Dozier, MPH, Associate Vice President, Supply Chain Services, Strategic Sourcing & Engagement, HonorHealth, Scottsdale, Arizona, extols the emotional benefits that emerge.

"We have a 'Fun Squad' that plans fun events for our team throughout the year," Dozier noted. "Ice cream socials, luncheons, volunteering together at a local non-profit, sporting events. These festive activities help build camaraderie for our team."

Such camaraderie and unity can engender fiscal and operational benefits for the organization as it serves patients.

"We encourage our supply chain colleagues to experiment and ideate improvements to the work we do," said Ed Hisscock, Senior Vice President, Supply Chain, Trinity Health, Livonia. "It is important to engage those closest to the work in the process of problem solving and developing solutions. The collaboration and empowerment are key factors in team satisfaction."

Hisscock also recognizes that supply chain's program engagements with universities generate dual benefits.

"Originally designed as a recruitment strategy, the program quickly evolved into a significant retention strategy," he noted. "Colleagues really enjoy sharing their expertise and experiences with students and the benefits of keeping the technical expertise sharp fuels many of our improvement experiments."

Hisscock feels that his team has graduated from traditional recognition efforts.

"I've consistently found canned recognition programs to be ineffective," he admitted. "In my experience, simple, everyday interactions by management go a long way in making people feel valued. Again, we are in a people business and leading with intention, every day, generates real-time, in-contest recognition that goes further and runs deeper."

Kate Polczynski, MBA, CMRP, vice president, Enterprise Supply Chain, Supply Chain Services, Geisinger, Danville, Pennsylvania, confesses to moving beyond the "canned programs," too.

"What I have heard when listening to my teams is that the age-old 'pizza party' method of staff investment is not resonating for many," she indicated. "Finding other ways to appreciate and acknowledge the contributions of individuals amongst your team requires a deeper understanding of their unique personal motivators. As our workforce continues to evolve in response to industry dynamics and global influences, our thought processes will also need updating."

Just as Trinity shares experience with colleges and universities, Geisinger reaches back even earlier to high schools, according to Polczynski.

"The Volunteer Services team [here] coordinates an annual event named Aspirations in Medicine and Healthcare Initiatives (AiM HI) program with local high schools across the multiple regions to provide students exposure to all the many components of a hospital, including the services that are non-clinical, such as supply chain, but that are critical to a hospital's success," she said. "This program brings exposure to hundreds of students and provides another venue to share the amazing work our teams accomplish daily. This program also brings forward information related to Geisinger's high school co-op and summer programs to provide insights into other ways to get involved in the healthcare industry. These hands-on opportunities have been shown to inspire high schoolers to consider becoming future healthcare professionals, inclusive of those who venture into the supply chain pillar."

Intermountain's "Ask Me Anything" events

Salt Lake City-based Intermountain Health promotes creativity and fun to boost community, performance and productivity, particularly among a workforce spread out all across the nation, according to Allison Corry, Chief Supply Chain Officer.

Taking a cue from Reddit, Corry started scheduling "Ask Me Anything" events on at least a monthly basis where team members can pose questions to her in an online group setting via Microsoft Teams. She admits she always expects those "heat-seeking missile questions" but comes prepared to answer anything and everything – even with a simple "I don't know" when and where appropriate.

Aside from building authenticity and trust through transparency, "It really gives me a pulse for what's on their minds, what messaging didn't resonate so we need to reiterate, where they are concerned or scared or proud or they just want to know where my head's at," Corry said. "It's certainly made me more human to them."

The "AMA" grew so popular that her downline leaders adapted the model for their own teams. Because all her team leaders possess different backgrounds and skillsets, she knows that each "AMA" iteration may reflect those individualities and flavors, which she wholeheartedly supports. The concept ignited creativity across the board, she adds, starting with memes.

"During COVID I told everyone that whoever submits the best meme I'll take out to lunch," Correy recalled. "Of course, we had to go to lunch a year-and-a-half later. That was fun. But more often than not you have people sharing quips and GIFs."

HonorHealth's Dozier values the team luncheons as appreciation and recognition for completing major projects and key contract bid initiatives. "This is a great way to say thanks and to invest in relationships," he added.

Intermountain also spurs creativity and innovation through competition.

For the last 15 years, the organization has promoted the annual "Totally Awesome Innovation" or "TAI" awards that encourage employees to develop solutions to workplace challenges and processes that reduce waste and save time and money. The TAI competition includes internal operations as well as external relationships with suppliers and service companies. Participants describe their solution, document the savings and either submit photos or a short video about their work. Corry marvels at some of the visuals she's seen, chuckling at the "before and after" photo and video comparisons that may explore improvements in case-cart or crash-cart picking, for example.

The TAI awards also can encourage multi-departmental relationships. In fact, "one of supply chain's winning entries required the business analytics team to help support it so we celebrated [the TAI award] with them," Corry said.

During the early years the TAI awards involved a formal presentation where leaders would all wear red bow ties, according to Corry. "Now it's evolved into more of a digital event so it can reach everybody," she added.

To date, Intermountain has bestowed 119 total TAI awards across multiple categories that span multiple departments throughout the organization's three regions. Winners then share their award-earning ideas among internal departments and external audiences, according to Corry.

Last year Intermountain introduced the Pinnacle Award as the top prize to recognize those TAI ideas that extend beyond a single area and involve multiple areas, departments and functions.

Per Intermountain's internal newsletter, "this year's top prize was won by Business Applications Director Cynthia Shumway, Camille Gardner, Jeff Martin, and Jared Whipple and supported by Don Bradshaw, his Field Logistics teams, and many other departments. The team established a systematic process between Oracle Cloud, PeopleSoft and Tecsys to facilitate a smooth ordering, picking and delivery solution for St. Mary's Medical Center in Grand Junction, Colorado, from the Supply Chain Center in Midvale, Utah." The new process replaces services provided by a third-party distributor.

"The team also created bots (a software application that runs automated tasks) to handle the closing of POs and reduce workload," according to the newsletter. "This project has validated savings of $400,000 and created a baseline for duplicating this project with other facilities."

How might C-suite execs strengthen the supply chain workforce?

Leadership among healthcare provider supply chain operations certainly carries full responsibility and accountability for attracting and developing talent through skills training, but they also favor and appreciate reinforcement of their efforts by the C-suite.

What can C-suite do to bolster supply chain? Five supply chain leaders share their insights.

Joe Colonna, Chief Supply Chain and Project Management Officer, Piedmont Healthcare, Atlanta

"One of the reasons I have remained at Piedmont for 16 years is that our executives recognize that the supply chain team is vital to the success of the organization. Our team members and leaders are recognized and thanked by local hospital leadership and our system-level leadership. In addition, the organization has invested in the team by giving us the tools we need to do our jobs effectively and efficiently. We don't ask often, but when he do ask, we are rarely told no. However, the single most important thing our executive leaders do is treat supply chain as an equal member and of equal importance as any other, non-clinical department. Our profession still seems to be suffering from a sense of insecurity, so this kind of support goes a long way in dispelling the notion that supply chain is somehow less important.

"When I started here, part of the goal was to change the relationship with leadership from transaction-based to strategic partner. Having said that, it was probably 36 months before things began to really click, and leaders started pulling us into strategic discussions versus our team pushing our way in, proving that we could do more than just fill shelves and negotiate lower prices. I remember our CMO going from asking, 'why does supply chain care about this topic' to now inviting us into strategic discussions around quality of care."

Kate Polczynski, MBA, CMRP, Vice President, Enterprise Supply Chain, Supply Chain Services, Geisinger, Danville, Pennsylvania

"Consider strengthening learner programs to foster the next generation of healthcare supply chain. Providing exposure to the various components of healthcare supply chain can aid in exciting learners about the potential opportunities that could be available within this important work. During my undergraduate program, the content specific to supply chain was limited and did not spark excitement and curiosity. It was after I had the opportunity to enter the healthcare supply chain field that I was exposed to the many ways our industry has an impact on patient care and the communities we are so privileged to serve. There is a bright future in supply chain as C-suites bolster the importance of these teams and the impact they can have in an organization. This recognition has carried over, with many higher education settings now offering dedicated supply chain tracks and degrees!

"Healthcare supply chain is often viewed as a silo within the broader industry, but the talent and expertise needed in this space is similar to those working in non-healthcare. To attract and retain talent to support this important work, an organization should explore trends of the supply chain workforce, outside of healthcare.

"Leadership should also support existing supply chain organizations in establishing career ladders but also career pathways. The traditional ladder often provides an image of a ceiling in an employee's journey, but I have seen many instances where individuals thrive as they traverse the many career pathways within the broader supply chain organization or healthcare industry. The experience that is learned in pillar one carries over to form a strong foundation for success within pillar two. This approach also helps to limit the "we've always done it this way" mentality as the teams are infused with thinking from other areas of the business to improve process and outcomes."

Ed Hisscock, Senior Vice President, Supply Chain, Trinity Health, Livonia, Michigan

"It's important for healthcare supply chain workforce to receive support for travel and engagements outside the organization. The benefits of the knowledge and skills gained through external engagements and networking with peers far outweigh any productivity loss from being away from the office.

"Likewise, participation in fellowship and internship programs, job shadowing and improvement experimentation are valuable for healthcare supply chain colleagues. Oftentimes, experiments require pilots with suppliers, other departments and capital investment, all of which require support from an executive leadership team."

Allison Corry, Chief Supply Chain Officer, Intermountain Health, Salt Lake City

"I'd like to give a big shout-out to Nannette Berensen, Chief Operating Officer for the system, because she recognizes the intricacies of the supply chain, and she understands risk mitigation, operational sustainability, recovery and resiliency. She does a tremendous job in our business reviews and our staff reviews with the team by reiterating she sees them. There is no way this organization would survive for a week or even a day or even an hour without the supply chain team. She says, 'you guys make it happen.' That's a level of support that I'm still learning to work with because it also requires a level of understanding of the business that I don't think she actually has to understand. I'm used to trying to convince people to understand the why, and I think she just intuitively gets the why. The shout-out to her is that her presence in front of the team, her advocating for resources when we ask for them, despite the position of the organization financially – everyone's in this quandary – she shows up for us. My leadership team would say they feel tremendously supported by her, so I would encourage anyone else from a C-suite to [follow her example]."

Mark Dozier, MPH, Associate Vice President, Supply Chain Services, Strategic Sourcing & Engagement, HonorHealth, Scottsdale, Arizona

"Seek to listen, understand and support supply chain in delicate matters, [such as] disenchanted, unprofessional physician encounters. Give shout outs to supply chain a few times a year in organizational newsletters, leadership meetings and leadership videos to company personnel. Be intentional in visiting/touring supply chain departments to greet staff, learn about their roles and thank them for their services."

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A United Front

Debugging supply chain-clinician partnerships requires transparency, tact and some finesse.

BY R. DANA BARLOW

If you believe the stereotypes whispered throughout the underground crosspatch, you likely buy into the perceived love-hate relationship between physicians, surgeons and supply chain.

Physicians and surgeons love to hate supply chain because they argue that supply chain's focus on cost savings can impede the level of patient care they seek to deliver.

Supply chain hates to love physicians and surgeons when clinicians collaborate and cooperate because it happens so infrequently as they try to balance financial operations with high-quality patient care.

The reality resides somewhere in the gray gulf in the middle where the needle vacillates between the black and red fringes of the balance sheet.

Some observations to bank on:

1. There are plenty of collaborative and cooperative physicians and surgeons who partner with supply chain.
2. There are plenty of supply chain professionals who have cultivated successful relationships with these physicians

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and surgeons who understand how to deliver business and clinical excellence.

3. If only there were a validated list of these professionals to poach and recruit for your organization.

How can you arrive at that point of clinical business nirvana (short of having access to "the list," of course)?

Some supply chain leaders point to the well-worn mantra of "show them the data," as others stress involving physicians and surgeons – where appropriate – in the decision-making process without entangling them in the weeds. In short, the successful strive for facilitation over "fascism," so to speak, on either side even as many know that the mystery surrounding the balance between clinical and business decisions remains less a democracy, monarchy or republic and more a strategic alliance of "frenemies" to operate within a "payorocracy."

"Medical students and residents get little – if any – education about supplies, cost or value as part of their traditional training," indicated Stacy Brethauer, MD, MBA, Professor of Surgery, Vice Chair of Quality and Patient Safety, Department of Surgery, Medical Director, Supply Chain Management, The Ohio State University Wexner Medical Center. "Graduate medical education, medical schools and health systems can do a much better job preparing their faculty for this kind of work, so they are prepared to participate in the business of medicine. Offering courses, seminars or lectures to those audiences is a start but ultimately, it should become a core part of these curricula."

Anand Joshi, MD, MBA, Senior Vice President, Procurement and Strategic Sourcing, New York-Presbyterian Hospital, acknowledges a larger void.

"Overall, there is a general gap or deficit in what I would describe as systems and operations training in medical school for what happens after medical school," he noted. "Supply chain would just be the tip of the iceberg in terms of the things that medical students are not educated on during the course of their medical school career that are critically important for actually being a practicing physician in a hospital setting. I think there actually is a gap.

"We can't hold the surgeon personally responsible for adding cost to the system. In private practice, that may be different, but it's not possible in a large academic medical center with salaried or contracted surgeons. We do work with surgeon groups to capitate prices if we can't agree on a single or dual vendor contract."

Yet, these recommendations serve more as workplace meds applied to symptoms. In fact, inoculation to prevent these attitudes from developing may be necessary.

What if training could start in medical school to prepare physicians and surgeons for the business and market dynamics of practicing medicine, which includes supply chain?

"In some ways it's unclear that that gap necessarily needs to be filled in medical school," Joshi continued. "It could certainly be filled increasingly in residency programs. I believe in the curriculum of the ACGME, the certification and accreditation council for residency and fellowship programs, is placing a greater emphasis on systems learning – not necessarily specific to supply chain, but more broadly. What does quality look like within a large healthcare organization? What do supply chain and finance look like? This type of training is probably better suited in the residency years than in medical school. In medical school, you're still many years from being your own independent physician who's asking for new stuff."

Maybe it's time to update medical school curricula, according to Jimmy Chung, MD, MBA, FACS, FABQAURP, CMRP, Chief Medical Officer, Advantus Health Partners and Bon Secours Mercy Health.

"Ideally, we would begin by redefining what medical practice is all about," he said. "We need to teach that healthcare is a team sport and that we have to be mindful of resources and affordability. Maybe things are different now, but when I was in medical school, talking about finance was frowned upon because that was for the administrators to worry about, and our job was to deliver the best care possible. Medicine is not an art; we can't leave care delivery to be creatively determined by the individual physician. It has always been a paradox to me that doctors are scientists by (self-selected) nature, but then we allow them to practice according to individual desires instead of scientific methods."

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Capitulation or some type of coerced collaboration might be options. Yet, how much sense does it make to give the physician or surgeon what he or she wants because they've trained on a particular product and are comfortable with that product, which likely translates into patient safety because the surgeon doesn't have to learn about a new product?

Ohio State Wexner Medical Center's Brethauer urges caution and careful consideration.

"That is always a consideration, particularly in specialties like orthopedics and spine surgery," he noted. "Our contracts never require 100% compliance with the vendors that are chosen, so if we are 80% committed to specific vendors, we sometimes allow a new physician to use what they were trained on as part of the remaining 20% spend. If their spend starts to impact our current commitments, though, we work with them to start using on-contract devices as much as possible for certain cases.

"If adding a device for a new physician isn't an option, we leverage our current faculty and vendors to get them trained and comfortable with the devices on contract and invite them to participate in our sourcing process when that contract is over," Brethauer continued. "All of the devices are FDA-approved, used by thousands of surgeons, are safe and provide good outcomes. It's usually just some nuance in using the products that requires a short learning curve, and we support them through that transition if needed."

If selected products are deemed to have clinical equivalency in terms of basic operation, then how much sense does it make to tell the surgeon that the organization is only willing to pay a certain amount for the "non-contract" product (based on the "contract" price negotiated) so if the surgeon wants that product the surgeon will have to pay the difference personally?

"We can't hold the surgeon personally responsible for adding cost to the system," Brethauer countered. "In private practice, that may be different, but it's not possible in a large academic medical center with salaried or contracted surgeons. We do work with surgeon groups to capitate prices if we can't agree on a single or dual vendor contract. If the group feels we need to have four vendors for a specific service line, we set prices that the vendors must meet in order to get their product on the shelf, and this strategy has been effective, particularly when the surgeon gets involved in the negotiations and is willing to stop using their product if they don't come in at our price point."

Ultimately, this shouldn't be about nursing frenemies but articulating teamwork united by a common cause. ■

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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