

# ADOPTING A CLINICALLY INTEGRATED SUPPLY CHAIN

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## BACKGROUND

As health care organizations evolve, their strategies to include population health, the total cost, episode, and subsequently value of care provided will be determined by patient outcomes. And this means finding the right balance between Cost, Quality, and Outcomes is no longer a nice-to-have sentiment; it will be critical to sustaining one's viability across clinical, financial, and operational domains. Who better to help drive a deep understanding and collaboration across these domains than health care supply chain professionals as we live this balance every day by connecting those who purchase medical and non-medical goods and services with those who use these goods and services. Following a traditional sourcing process will not suffice. Value focused supply chain leaders are dynamically changing to a clinically integrated supply chain. This poster shows the difference and the steps necessary to pivot to clinical integration.

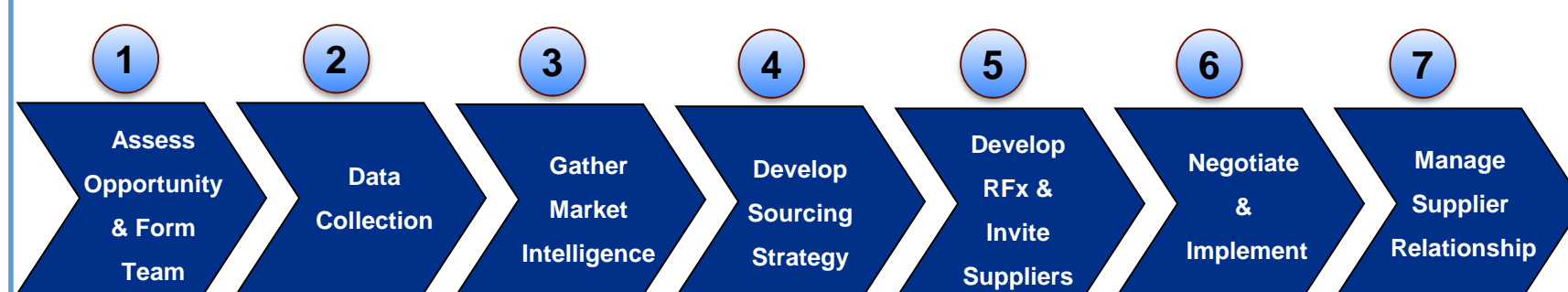
## TRADITIONAL SOURCING PROCESS

**What do you do if your contract for slipper socks is due to expire?**

Starting point under a traditional (non-clinically integrated) supply chain is viewed as traditional supply chain sourcing following a classic six or seven step process. An example of the process is shown below:

## GUIDELINES FOR USE OF SOURCING PROCESS

Many institutions only follow formal Strategic Sourcing process if the initiative is over a certain dollar amount (e.g. \$50,000, \$100,000 in annual value.)



- **Step 1** – Who are the key stakeholders and what is the goal?
- **Step 2** – What do we spend/buy and where do we buy it?
- **Step 3** – What is the current state of this supply market?
- **Step 4** – What are we bidding? How long of a contract, etc.?
- **Step 5** – Detailed Request for Information, bids, or proposals with strong service level expectations
- **Step 6** – Negotiation, contract, and implementation
- **Step 7** – Manage supplier relationship and performance

## CLINICAL INTEGRATION DEFINITION

**Clinical integration in health care supply chain is an interdisciplinary partnership to deliver patient care with the highest value (high quality, best outcomes, and minimal waste at the lowest cost of care) that is achieved through assimilation and coordination of clinical and supply chain knowledge, data, and leadership toward care across the continuum that is safe, timely, evidence-based, efficient, equitable, and patient-focused.**



**Cost** - all costs associated with caring for individuals and communities

**Quality** - care aimed at achieving the best possible health

**Outcomes** - financial results driven by exceptional patient outcomes

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## CLINICAL INTEGRATION COMPONENTS

*Shared Collaborative Approach*

<b>Executive Leadership</b>	<ul style="list-style-type: none"> <li>• Executive Sponsor</li> <li>• Culture of Shared Clinically Integrated Product Selection aligned with Quadruple Aim</li> </ul>
<b>Clinician Engagement and Education</b>	<ul style="list-style-type: none"> <li>• Strong Clinician champion (e.g. Physician, Nurse Executive)</li> <li>• Evidence-Based Decision Making (e.g. Physicians collaborate around benchmarking and practice variation)</li> </ul>
<b>Product Variation Reduction</b>	<ul style="list-style-type: none"> <li>• Outcome review</li> <li>• Cost optimization, standardization</li> </ul>
<b>Process and Practice Variation</b>	<ul style="list-style-type: none"> <li>• Review of process across every business unit</li> <li>• Change management to reduce variation</li> </ul>
<b>Supply Chain Leadership</b>	<ul style="list-style-type: none"> <li>• Clinically integrated sourcing process</li> <li>• Project management and change management</li> </ul>
<b>Data</b>	<ul style="list-style-type: none"> <li>• Regulatory or reimbursement change impact</li> <li>• Historical quality, outcome, and product usage data strive for true cost per case tied to quality measures</li> </ul>
<b>Clinical, Financial, Operational Alignment</b>	<ul style="list-style-type: none"> <li>• High quality + Outcome = Lowest Cost</li> <li>• Aligned incentives to maximize reimbursement, cost per procedure margin, and acquisition cost</li> </ul>

## QUESTIONS THE ORGANIZATION SHOULD ASK:

1. Who leads this group? Who gets the effort started?
  - ✓ Cultural alignment across the organization.
  - ✓ Get charge from the executive level or the initiative will not go anywhere. Who is in charge could vary across organizations?
2. What are the steps you should take to get key executives on board?
3. How is the opportunity started?
  - ✓ Starts with the data. What is the data showing: patients are falling on their own, falling in rehab, falling with family members.
4. Who sits around the table?
  - ✓ For patient falls: executives, physicians, nursing, finance, quality, PT, environmental services, pharmacy, supply chain, patient transport, volunteers, rehab., patient experience.
5. How to tackle the problem?
  - ✓ Identify root causes, alternatives, socialize issue of the problem, gain consensus around solution. Integrated systems have a project management component corporately.
6. What risk assessments and protocols need to be created (to reduce patient falls)?
  - ✓ Modify policies, procedures, and supply chain strategies to support risk models.
7. To solve clinical problem, how supply chain can improve problem?
  - ✓ Role of sourcing, value analysis, purchasing, logistics, distribution, and as part of a multidisciplinary team including risk management, environmental services, and clinical education.

## LEADERSHIP UNDER A CLINICALLY INTEGRATED SUPPLY CHAIN

Expand the premise that engagement is narrowed to physicians and clinicians. They are the biggest consumers but also think about how to impact other cost drivers like length of stay, readmissions, care coordination, risk management, and continuum of care.

• **Expanded Role** - What are the elements that supply chain can own outside of clinician involvement?

• **Product Optimization** - Clinical utilization and standardizing care. What is the role of supply chain?

• **Beyond Acute Care** - How can supply chain become more involved in the care continuum? Who are the other players in the continuum of care?

• **Home Health** - Are the same products being used across the continuum? Do we provide patient training in the hospital that would benefit from having the same products at home? Are we working to ensure that our distributors are helping our home care team?

• **Risk Prevention** - How is supply chain engaged in patient safety protocols that modify sourcing practices? (e.g. Risk program on falls.) How does Sourcing contract for socks?

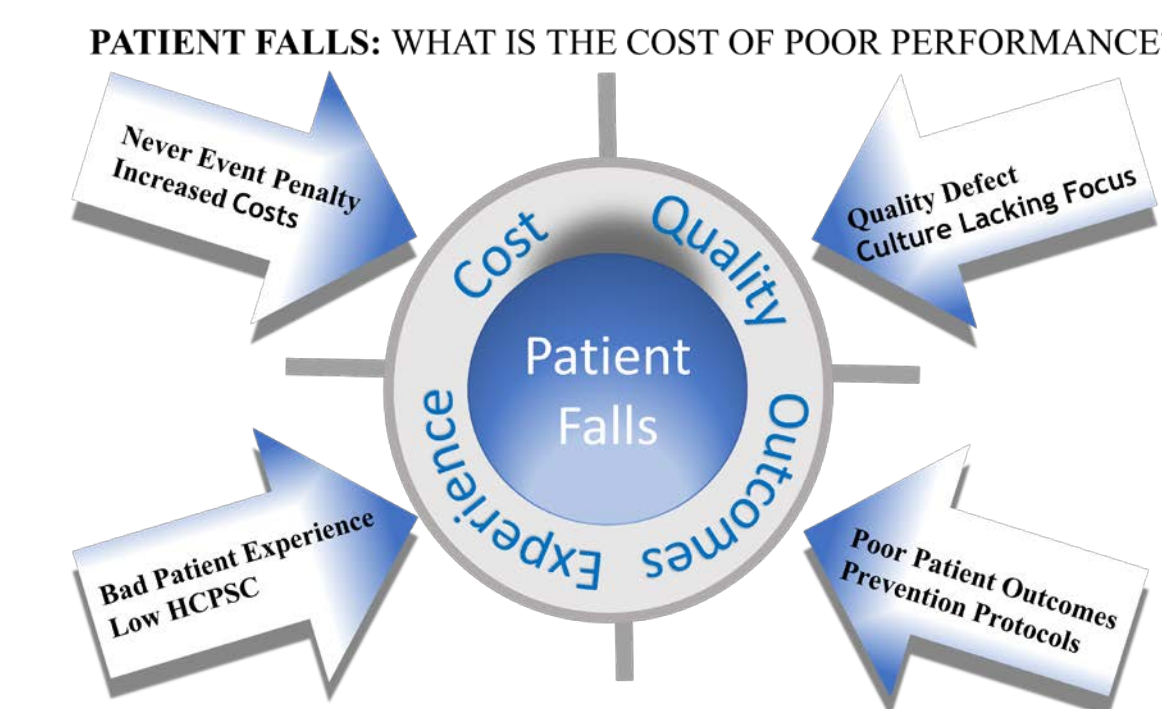
• **Care Coordination** - How do we work with the transition management teams to get patients out of the hospital or the home health teams to care for patients in the home?

• **Collaboration within the supply chain department**

• **Supply chain collaboration across the care continuum**

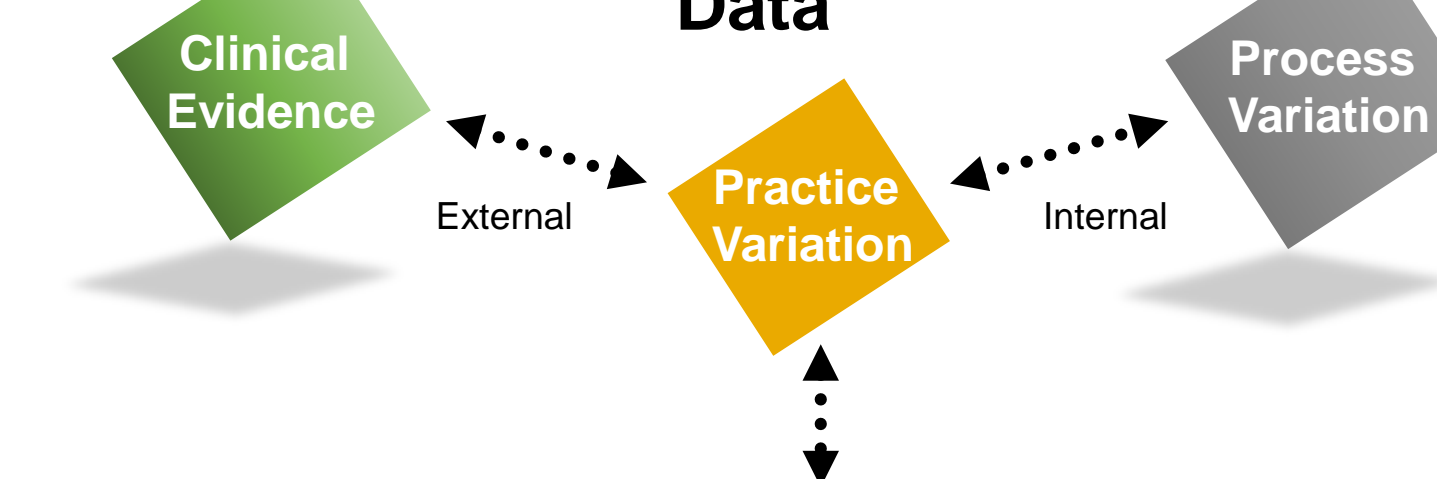
## CLINICALLY INTEGRATED EXAMPLE

Your CEO states that your organization needs to reduce patient falls.



## Addressing Patient Falls

Start by Reviewing the Data



## Patient Falls Data

- Historical fall and frequency data
- Cost of a fall to the patient and hospital
- Utilization of patient fall risk assessment and adherence to risk reduction protocols

## CLINICALLY INTEGRATED SOURCING PROCESS

Address each Clinical Integration component and encourage organizations to answer the seven key questions related to patient falls.

Demonstrate a clear understanding of the clinical needs and the fall prevention protocol.

- With a firm command of the data, follow the traditional seven-step sourcing process
- Create a comprehensive communication plan of the falls prevention with the group
- Create a training and implementation plan for the proper use of the slipper socks
- Establish a routine time for the falls prevention subgroup to review falls data
- Assess the role of the socks in reducing the number of falls

*Shared Collaborative Approach*