AHRMM
Advancing Health Care through
Supply Chain Excellence

CQO:
The Health Care
Supply Chain

Cost, Quality and Outcomes (CQO) Summit

CQO AND THE CLINICALLY INTEGRATED SUPPLY CHAIN

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The Association for Health Care Resource & Materials Management (AHRMM), a professional membership group of the American Hospital Association (AHA), is the leading professional organization for the health care supply chain field. AHRMM advocates on behalf of the health care supply chain profession and supports its membership through the development of relevant educational content. It is committed to preparing supply chain profession to adapt, and strategically guide their organizations as they navigate today's rapidly changing health care environment.

AHRMM

Mission

AHRMM strives to advance health care through supply chain excellence by providing education, leadership, and advocacy to professionals in hospitals, health systems, and related organizations that are accountable to the community and committed to health improvement.

Vision

Advancing health care through supply chain excellence.

Values

Vision • Integrity • Excellence • Risk Taking • Strategic Partnering

CQO: The Definitions

The Cost, Quality, and Outcomes (CQO) Movement focuses on the inter-relationships between:

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

The CQO Movement

AHRMM launched the CQO Movement to advance the role of the health care supply chain in delivering higher quality care at a more affordable cost and in a manner that delivers the highest value to patients. The CQO Movement explores the inter-relationships between cost, quality, and outcomes as opposed to the more traditional view in which these factors were considered separately, often by different functions within the hospital environment, e.g., clinical, financial, etc. The CQO Movement encompasses all activities designed to support both better health and patient care across the entire care continuum.

More information about CQO and a wide array of tools, leading practices, and educational resources are available at:

› ahrmm.org/CQO

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Executive Summary

Each year at the annual AHRMM CQO Summit, participants throughout the health care field come together to share their knowledge, leading practices, and ideas on supply chain's role in delivering higher quality care at a more affordable cost. The Summit discussions, in turn, inform the next year's CQO report, which guides the development of the agenda for that year's Summit.

Since the launch of the CQO Movement, this iterative process has inspired supply chain leaders to expand their thinking, collaborate cross-functionally throughout their organizations and with clinical and business partners, and push the boundaries of their work to support both better health and patient care across the entire patient journey.

> *"The new CQO world that we are living in requires a new way to bring together teams. Those teams will need to exercise great change leadership to redefine the culture that has existed in many organizations."*
>
> Mike Schweitzer, MD, MBA
> Chief Population Health, Verity Health

The clinically integrated supply chain was the focus of this year's CQO Summit, which was held on August 13, 2018, during the AHRMM18 Conference in Chicago. The AHRMM Clinical Integration Task Force has defined clinical integration in terms of the health care supply chain as follows:

"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."

The 2018 CQO Summit featured the introduction of the 2018 AHRMM CQO Report on the Clinically Integrated Supply Chain, presentations, a roundtable, and panel discussions. The central focus was on clinician engagement in CQO initiatives, including the challenges that health system and supply chain leaders must overcome in order to gain the trust and support of the clinical community. This report summarizes the Summit presentations, panels, and roundtable discussions that took place.

Clinician Engagement: Key Recommendations

Everyone in the room had the opportunity to share their insights and experiences on the clinically integrated supply chain, including challenges and opportunities in this area. Below are some of the key recommendations on securing clinician engagement that were put forth by the presenters, panel participants, and Summit attendees:

> *"As a physician, I saw a huge opportunity to learn more about leadership development and finance in order to understand cost structures and how decisions focused on quality might also impact cost of care."*
>
> George Cheely, MD, MBA
> Medical Director for Care Redesign, Duke Health

Clinician champions must learn to lead: A survey of hospital CEOs found nearly 70 percent of the concerns keeping them up at night were related to physician leadership. Clinicians typically do not receive any leadership training in medical school, residency, or fellowships, yet in practice they are expected to serve as leaders to their teams.

> *"When approaching clinicians, don't start out talking about money. Talk about what matters to them – the vocation and why they became clinicians. Help them improve quality for their patients and then you will have true champions."*
>
> Mike Schweitzer, MD, MBA
> Chief Population Health, Verity Health

If health care organizations want clinicians to serve as champions for CQO initiatives, they must teach them core leadership skills, including project management, change management, and team leadership.

Value of dyad and triad leadership: Many initiatives in health care organizations fail because those driving for change have not engaged the right people. For those initiatives that require clinician engagement, a dyad or triad leadership model works best. Stakeholders should include a clinician leader who spearheads the project and can lead his or her colleagues to change, an executive sponsor who can secure the necessary resources to make it happen, and when possible a performance improvement team to guide, track, and report on the initiative.

Lead with a focus on improving quality: While new payment models have made clinicians more cognizant of the cost pressures facing health care, their priority continues to be the patient.

> *"At Sanford, our culture is very important to us. We have processes in place so physicians know they have a place to go for their needs to be heard. While it is not perfect, it is as fair and consistent as we can make it."*
>
> Doreen Kirkevold, RN, BSN
> Director of Value Analysis, Corporate Supply Chain, Sanford Health

When attempting to secure clinician buy-in for a supply chain initiative, lead with its potential to improve patient care quality, understanding that cost savings will follow.

Align efforts with care redesign: Many leading health care systems and hospitals are engaged in care redesign efforts with the goal of improving quality through evidence-based process and product standardization. This provides an ideal opportunity for supply chain to present data on current product usage and spend, as well as opportunities to share comparative-effectiveness data with their clinician colleagues to help guide their standardization and strategic procurement efforts.

Meaningful and frequent communication: The three keys to successful change management among clinicians are message, method, and frequency. Describe how the initiative will benefit the patient (e.g. improved quality, safety) and the clinicians themselves (e.g. greater efficiency, less paperwork); communicate facts or ideas using a variety of channels (e.g. written materials, meetings, video clips, social media); and do so frequently (eight times, eight ways for each message).

> *"Look at the big picture with care redesign. First, get those easy wins within the hospital and then look at the post-acute space because there is an unbelievable amount of spend in the first 30-60 days after discharge."*
>
> Robert P. Sticca, MD, FACS
> Chair Surgical Services, Sanford Health

Care across the continuum: Value-based payment models are not only driving the need for clinician engagement, but also driving clinicians to be more engaged and focused on care across the continuum – beyond acute care hospitals to non-acute facilities and all the way into patient homes. Therefore, when selecting products, clinicians must consider their impact on cost,

quality, and outcomes throughout the continuum of care. Supply chain is positioned to provide clinicians with information they need to achieve these objectives.

What Clinicians Need to Succeed

The Summit participants recognized that clinicians today are struggling to balance patient care delivery with a growing administrative burden driven by the shift in payment models. They acknowledged that if health system and supply chain leaders want clinicians to go above and beyond their current work to play an active role in CQO initiatives, they must provide them with the following:

> *"In our organization, we recreated the role of physician leader and came up with a different program to get them up to speed, which includes the ability to lead in areas of new payment models."*
>
> Jimmy Chung, MD
> Associate VP, Perioperative Services,
> Providence St. Joseph Health

Trust: In many cases the trust of clinicians has been broken over time so leaders must work to rebuild it before asking clinicians to make changes. Initiatives are far more successful when clinicians trust that the proposed changes will be beneficial to their patients and themselves.

The opportunity to lead: Historically, clinicians have viewed supply chain initiatives as cost cutting measures forced on them by administration. Physicians need the opportunity to own and lead CQO initiatives rather than being asked to implement others' decisions. The role of supply chain should be to provide clinicians with information to help them make the best decisions for their patients – and for their organizations – and work collaboratively to support them in these efforts.

> *"We are not driving change - we are supporting it."*
>
> Doreen Kirkevold, RN, BSN
> Director of Value Analysis, Corporate Supply Chain,
> Sanford Health

Accurate and timely data: Clinicians are data-driven; they want proof that change is required and that the intended changes will have an impact. The Summit participants acknowledged that when it comes to securing the support of clinicians, bad data is worse than no data at all. When a supply chain team presents flawed data, they lose their credibility with clinicians which can be difficult to regain. Lead with an accurate and reliable source of timely data presented in a way where clinicians can quickly understand the intended impact and benefits.

Economic support: The work of clinicians doesn't stop at the patient bedside. They spend countless hours on charting, documentation, and other administrative work. If health care organizations expect clinicians to spend additional time and effort to help with CQO initiatives, then they must offer economic alignment and support.

Greater efficiency: Clinicians, like anyone else, do not want to waste time. They are there to take care of patients but much of their day is taken up by non-value added activities. Supply chain has the opportunity to help clinicians be more productive in their work, and at the same time, improve cost, quality, and outcomes. For example, by improving the integrity of data flowing from the item master to the electronic health record (EHR), physicians can more quickly identify and record products in the patient record, which drives greater accuracy in patient billing, and moves the organization toward a total cost of care model.

> *"We have focused our efforts on making it easier for clinicians to do the right thing for patients, and avoid frustrations during their workdays."*
>
> George Cheely, MD, MBA
> Medical Director for Care Redesign, Duke Health

Introduction & Release

of the 2018 AHRMM CQO Report on the Clinically Integrated Supply Chain

The AHRMM18 Cost, Quality, and Outcomes (CQO) Summit took place on Monday, August 13, 2018, during the AHRMM18 Conference in Chicago, bringing together over 100 individuals representing a variety of organizations across all health care segments.

As in past years, the Summit kicked off with the presentation of the annual AHRMM CQO report: *The 2018 AHRMM Cost, Quality, and Outcomes (CQO) Report on the Clinically Integrated Supply Chain*. The CQO Report is available on the AHRMM website at ahrmm.org/2018-cqo-report. During his welcome address, AHRMM Senior Director, Supply Chain, Michael Schiller, CMRP, explained how the goal of the Summit was to engage in active conversations and to create a collaborative learning environment around the report's central theme.

In presenting the report, AHRMM Board Immediate Past Chair, Karen Conway, MSHCD, CMRP, Vice President, Healthcare Value, GHX, who also chaired the Task Force, highlighted the six case studies contributed by task force members (see page 7 for list). She noted that while each organization is different in its approach to achieving a clinically integrated supply chain, they all have commonalities and fundamental principles that can be applied broadly in health care.

Conway highlighted how the use of data to drive standardization was a common thread throughout the case studies, whether it was standardization in care redesign, sepsis prevention and treatment, spine product selection, physician co-management agreements, or patient experience across the continuum of care.

"While there was a focus on data-driven standardization, at the same time, almost every case study had the opportunity for variation," said Conway. "But it was variation driven on the needs of the patient because that is the only place where variation should take place."

Bob Taylor, CMRP, SVP Supply Chain, RWJBarnabas Health, provided the opening address, presenting the first speaker, Mike Schweitzer, MD, MBA, Chief of Population Health, Verity Health. He also explained how following Dr. Schweitzer's presentation, the attendees would be asked to engage in a discussion and report their findings on the following question:

"What is the single most important change that you believe has to occur to advance the clinical integration of the health care supply chain?"

"While there was a focus on data-driven standardization, at the same time, almost every case study had the opportunity for variation. But it was variation driven on the needs of the patient because that is the only place where variation should take place."

Karen Conway, MSHCD, CMRP
Vice President, Healthcare Value, GHX,
and AHRMM Board Immediate Past Chair

2018 AHRMM CQO Report

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Jane Pleasants
Vice President, Supply Chain, Duke University

AHRMM is looking to build a meaningful repository of case studies, tools, and other resources focused on educating and advancing clinical integration activities across the health care and health care supply chain field. Please contact AHRMM at ahrmm@aha.org if you are interested in participating in this influential initiative.

Physician Leadership
in a Value Analysis Program

Today's Health Care Environment

Dr. Schweitzer began his presentation with a discussion on health care economics, explaining how as costs continue to rise, everyone is looking to those in the room to decrease bottom line expense. He pointed to a number of cost-drivers and growing trends, including:

- An aging population that is driving deficit and debt.
- A shift in spend from professional services to pharmacy and outpatient care; approximately 23 percent of Medicare spend is on post-acute care.
- The decline in "fee-for-service" and the corresponding increase in value-based payment programs and population management, with Medicare Advantage program enrollment more than doubling since 2010.

Mike Schweitzer, MD, MBA
Chief Population Health, Verity Health

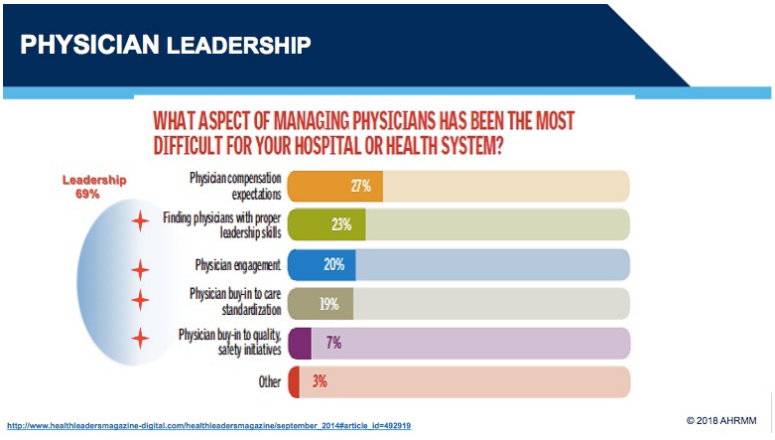
Dr. Schweitzer collaborates with system, hospital, and physician leadership for negotiation and coordination of managed care contracts, risk based contracts, and payor relationships. He leads the development of population health alternative payment models, such as bundled payments, accountable care organizations, and co-management agreements. Dr. Schweitzer also provides leadership in standardizing and streamlining processes for system-wide provider credentialing.

The Need for Physician Alignment

According to Dr. Schweitzer, health system and supply chain leaders must align with physicians culturally, economically, and clinically in order to impact cost, quality, and outcomes.

He cited a survey of hospital chief executive officers (CEO) that found nearly 70 percent of their physician management concerns were related to physician leadership. He explained how physician trust has been broken time and time again in many health care organizations because the C-suite has demanded changes from physicians without taking into account their insights, opinions, and concerns.

Once there is turnover in executive leadership, such as the appointment of a new CEO or chief medical officer (CMO), this new leader typically makes his or her own demands on the physicians. This has resulted in a cultural misalignment between the health system and physicians, with physicians suspicious of C-suite motives and unwilling to get behind, let alone lead, proposed changes.



"I have heard the same concept from physicians who have been around for a while, there has been broken trust in many areas, and we have to rebuild that," said Dr. Schweitzer.

Health systems must also economically align with physicians if they want them to support change. Dr. Schweitzer explained how physicians are already burdened with work beyond clinical care, with many spending nights and weekends on patient charting and other documentation.

Dr. Schweitzer also emphasized the importance of clinical alignment when engaging with physicians for change. When approaching clinicians, do not lead the conversation with cost, he said, but rather explain how the initiative can improve quality outcomes and patient experience, and make life more efficient for the clinicians themselves. Then explain how higher quality care, fewer complications and readmissions, and shorter length of stay often equals lower costs for the organization.

"It's all about engaging your physician and clinician champions and having them work with you to influence change within your community," said Dr. Schweitzer. "Talk about what matters to them – the vocation and why they became clinicians. Help them improve quality for their patients and then you will have true champions."

Change Management

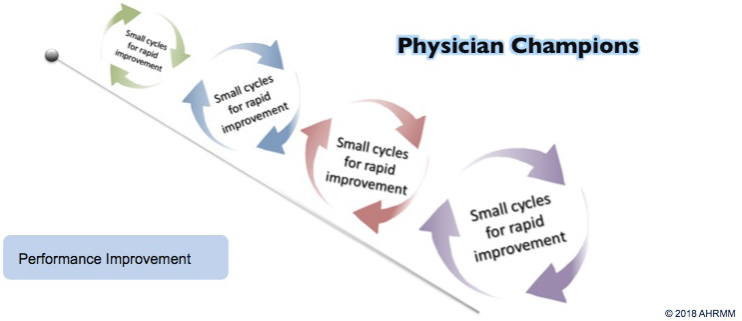
When enacting change in collaboration with physicians, Dr. Schweitzer suggests that health care organizations leverage a dyad or triad leadership model. This team should include a physician leader who spearheads the project and can lead his or her colleagues to change, an executive sponsor who can secure the necessary resources to make it happen, and when possible a performance improvement team to guide, track, and report on the initiative.

When selecting a physician to be a dyad or triad leader, Dr. Schweitzer said he often chooses one of the busiest physicians in the organization because he or she "gets a lot done." An alternative is to select an "up and coming young physician" with a "burning passion" who can be trained to become a successful leader.

"Once you have chosen your physician leader, listen to them or they won't help you for long," said Dr. Schweitzer. "You chose them because you value their opinion, influence, ability to change, and passion."

While health systems and hospitals expect physicians to serve as leaders within their organizations, Dr. Schweitzer reminded the audience that most physicians have no formal leadership training. He recommends health care organizations provide opportunities for physicians to hone their project management, change management, and team leadership skills.

SPREAD THE KNOWLEDGE



"It's all about engaging your physician and clinician champions and having them work with you to influence change within your community."

Mike Schweitzer, MD, MBA
Chief Population Health, Verity Health

Data and Communication Channels

Physician champions must have the opportunity to lead, explained Dr. Schweitzer. When collaborating with a physician leader on an initiative, supply chain should provide them

with data and information early in the process. That way the physician has time to review it, ask questions, and understand it before sharing it with his or her colleagues. The physician champion understands the mindset of his or her colleagues; therefore, he or she should collaborate with supply chain on formatting the data so that it will resonate with the clinical team and truly have an impact.

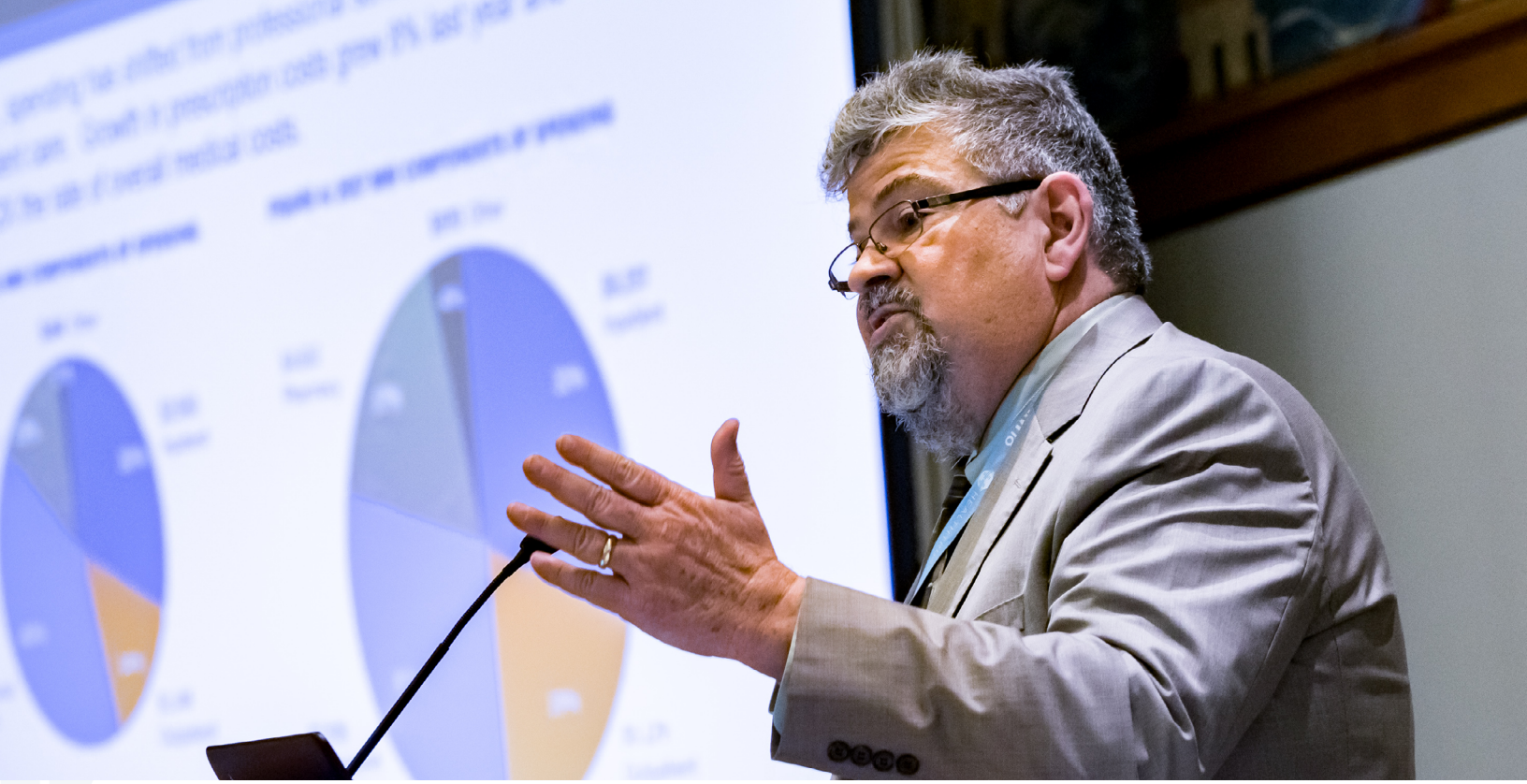
When introducing reports, Dr. Schweitzer suggests educating providers about the purpose of analyses and expectations, stressing the importance of describing the data source, definition, and methodology to avoid distracting from the analytic insights. He described how physicians often like to view information graphically so they can quickly understand the situation and the actions they can take. He added that some physicians will want to dig deeper into the data so supply chain should be prepared to accommodate those requests as well.

According to Dr. Schweitzer, when communicating with physicians, share facts and ideas using a variety of channels to achieve mutual understanding, with the goal of "eight times and eight ways," including written materials (e.g. newsletters, emails, texts, signage in break rooms); meetings with providers, office managers, and one-on-one; or video clips, and social media.

Physician Roles in Value Analysis

Dr. Schweitzer described three ways that physicians can get involved in value analysis efforts to drive positive change through supply chain decisions.

- New product requests: Position clinical leaders to evaluate new product requests based on evidence-based data.
- Reducing unnecessary variation: Establish best practice by leveraging expert consensus to standardize on products through evidence-based decisions.
- Strategic collaboration with vendors: The combined clinical/supply chain team can engage with vendors on patient outcomes-based negotiations, including pricing agreements based on savings/ revenue arising from quality improvement.



Roundtable Discussions

Following Dr. Schweitzer's presentation, the Summit attendees were asked to discuss and report out on the following question:

"What is the single most important change that you believe has to occur to advance the clinical integration of the health care supply chain?"

Below are some key themes that emerged from their discussions:

- Communication: Making sure the lines of communication are open between supply chain and clinicians and both sides understand what is being asked of them.
- Supply chain structure: Having a structure that allows supply chain to connect with clinical teams. Dr. Schweitzer recommends that supply chain engages and works closely with the CMO or chief of quality. Another suggestion was to have a clinician embedded in the supply chain team.
- Physician connections: Supply chain may not know the best way to help physicians, and physicians don't necessarily know how supply chain can help them. Engage in grass roots efforts to bridge these two groups. For example, a supply chain leader could introduce himself or herself to a new physician during the onboarding process to explain his or her role and offer assistance.
- Broader engagement: Don't "hyper-focus on physician engagement." Health care organizations must target all of their leaders – clinical and operational – in order to drive true change.
- Data transparency: Data transparency is key to successful supply chain/clinical integration. A representative from a small hospital noted how data extraction can be very costly and called on larger health systems with greater resources to share information with them.
- Cross-functional alignment: Different groups within a health care organization must build relationships and trust with one another in order to succeed. When stakeholders are fully engaged and understand each other's situations and challenges then they can achieve alignment in a more robust way.

Panel:

Moving Beyond Value Analysis to Clinical Variation Reduction – Supply Chain's Involvement

The final segment of the 2018 CQO Summit was a panel discussion on the need to move beyond traditional value analysis efforts to more advanced clinical variation reduction. Using an evidence-based approach, supply chain and clinicians are collaborating to standardize processes and products to improve care quality, reduce costs, and drive better financial outcomes for their health care organizations.

Moderator Jimmy Chung, MD, led the discussion with the four panelists, and facilitated a question and answer session with the Summit attendees. This document captures the highlights of that discussion and Q&A session.

Moderator: Jimmy Chung, MD, Associate VP, Perioperative Services, Providence St. Joseph Health

Dr. Chung is responsible for collaborative development, integration, implementation, and optimization of the Supply Chain Value Analysis strategy working with physicians and operational stakeholders across the Providence system. He has developed regional, physician-led Value Analysis Teams for evaluating surgical and procedural products and integrated physician leadership into developing strategic plans for Providence-wide standardization initiatives, using physician-specific cost and quality data analytics.

Panelists:

George Cheely, MD, MBA
Medical Director for Care Redesign, Duke Health

Dr. Cheely leads Duke's Care Redesign program, which aims to improve clinical outcomes and reduce waste by supporting more than 40 multi-disciplinary teams to develop and implement evidence-based improvements to care delivery. Impacts include improved patient experience, avoided admissions and readmissions, fewer nights in the hospital or skilled nursing facility, improved team communication, and cost of care reduction.

Jane Pleasants
Vice President, Procurement and Supply Chain, Duke Health

Pleasants has established a supply chain at Duke under a shared service model between the health system and the university. Duke has a robust portfolio of Duke owned contracts for pharmaceuticals, medical supplies, equipment, and purchased services, along with an enterprise-wide materials management system interfaced with Duke's electronic medical record, providing a single source of truth throughout the system.

Robert P. Sticca, MD, FACS
Chair Surgical Services, Sanford Health

Dr. Sticca has practiced surgical oncology and general surgery at Sanford since 2008, where he also currently serves as Chair of Surgical Services and Medical Director of Supply Chain. At Sanford, Dr. Sticca has expanded the UND Medical School's surgery department, as well as developed one of the first rural surgery programs in the U.S. He co-chairs Sanford's Surgical Value Analysis Team and has a strong interest in medical product cost effectiveness, safety, and quality.

Doreen Kirkevold, RN, BSN
Director of Value Analysis, Corporate Supply Chain, Sanford Health

Kirkevold is the Director of Value Analysis for Sanford Health. Sanford Health has 14 Value Analysis Teams supporting 45 Medical Centers, 289 Clinics in nine states, 48 Long-term care facilities, and 1,300 Physicians.

Clinical involvement in supply chain

Dr. Chung noted how most clinicians currently involved in supply chain had no training in this area during medical or business school. He asked the panelists how they became involved in supply chain at their organizations.

> *"When we started this journey there was no standard communication between physicians and the value analysis team – no relationships built, no trust, no transparency. There were just two groups of people that only engaged when they wanted something. We have moved light years past that."*
>
> Doreen Kirkevold, RN, BSN
> Director of Value Analysis, Corporate Supply Chain, Sanford Health

Dr. Cheely explained that with the passage of the Affordable Care Act, Duke Health's senior leadership team intensified the work the organization had been doing to empower clinical teams. Executive leadership chartered the Care Redesign Oversight Committee, which identifies opportunities across the organization to improve outcomes, reduce cost of care, and improve quality.

"I got into this work with a passion on improving the value proposition," said Dr. Cheely. "I help the organization figure out where a small group of industrial engineers, nurses, and physicians can come together to support those clinical experts to help drive change. This includes how to reduce admissions and length of stay and increase patient satisfaction. We look at the cost structure that underpins those episodes to care to understand where reducing variation is the right thing for patients, and where variation in medical devices can increase cost of care relative to what we are seeing among other organizations."

> *"It became clear when initiatives around care redesign started to blossom that there was an element of supply chain. We want physicians to know that we are together in where we are going, this means being thoughtful and cognizant in the care redesign process."*
>
> Jane Pleasants, Vice President, Procurement and Supply Chain, Duke Health

"It became clear when initiatives around care redesign started to blossom there was an element of supply chain," added Jane Pleasants. "We want physicians to know that we are together in where we are going, this means being thoughtful and cognizant in the care redesign process. So if there is a care redesign initiative coming up in three months with the spine team, then we want to tie our supply chain program to that."

> *"Sometimes there is a significant gap between practicing clinicians and supply chain. Prior to my involvement the only knowledge I had of supply chain was when I was in the OR and wanted something but we didn't have it. Now I see it from other side."*
>
> Robert P. Sticca, MD, FACS
> Chair Surgical Services, Sanford Health

Dr. Sticca explained how the health system recruited him ten years ago to rejuvenate the specialized surgery department ahead of a merger. His role with supply chain evolved out of this position. As Sanford acquired other hospitals, there was an increasing need to standardize and integrate supply chain with physicians in order to gain clinical input.

"Sometimes there is a significant gap between practicing clinicians and supply chain," said Dr. Sticca. "Prior to my involvement, the only knowledge I had of supply chain was when I was in the OR and wanted something but we didn't have it. Now I see it from other side. I serve as a liaison between physicians and supply chain and try to generate as much physician involvement as possible. As a result, we have been able to standardize across all four campuses including over 1,000 physicians."

"When we started this journey, there was no standard communication between physicians and the value analysis team – no relationships built, no trust, no transparency. There were just two groups of people that only engaged when they wanted something. We have moved light years past that," added Doreen Kirkevold.

Physician engagement

When asked how they are able to engage physicians in their efforts to reduce variation and create a more predictable patient experience, Dr. Cheely said he frames goals in a way that appeal to the physician leaders, stating:

"We are a competitive bunch and like to use data to inform decisions. If we could make it easier to do the right thing for patients, then we could come to some common terms of agreement and hardwire some of the clinical decisions. At a time when burnout is high among physicians, we have been able to bring together multi-disciplinary groups to talk about what care should look like for their patients."

Cheely explains that when this work began, Duke Health had just gone live with its new electronic medical record (EMR) system. He recognized that if he and his team could help orient the order entry, documentation, and data views for clinicians then it would help drive standardization efforts and make it easier for physicians to get through their work days.

"We knew that by reducing variation cost savings would follow and that has been clearly borne out in the past several years. We have been able to demonstrate to physicians, nurses, and administrators that by focusing on the right thing

for patients we can improve quality, experience, and costs – that has really been powerful" added Dr. Cheely.

Physician-led, supply chain supported

When Dr. Chung asked the panelists to provide examples of where they had truly achieved clinical variation reduction as opposed to more traditional value analysis. Kirkevold and Dr. Sticca described their work with the Sanford OB/GYN departments. Kirkevold explained that when they initially tried to standardize OB/GYN procedure packs five years ago it was, in her words, "a complete failure" because it was led by supply chain and not by the clinicians. She stated:

"We got the teams together, physicians at the table, reviewed what was in the packs and there were obvious standardization opportunities. The clinicians then came to me and asked, 'Are you going to make us do this and can you make us do this?' I said 'no.' They said 'well great this was a fun project 'and they left. Lesson learned – it has to be led by them."

Their latest attempt has been physician led and supported by supply chain. Dr. Sticca explained how Sanford hired an enterprise director of OB/GYN who has been able to get the clinicians in all of the major hospitals to agree to certain practice patterns and product standardization.

In response to Dr. Chung's question, Dr. Cheely described Duke's clinical variation reduction initiative in total joint procedures. Duke's Vice Chair of Clinical Affairs envisioned an ideal episode of care for total joint from the initial clinic visit all the way out through planning for the caregiver who would take care of the patient when he or she leaves the hospital.

> *"A lot has come from surgeons working closely with nursing, anesthesiologists, and administrators to hardwire those changes so the system is systematic and the data points are reliable."*
>
> George Cheely, MD, MBA
> Medical Director for Care Redesign, Duke Health

When Dr. Cheely, Pleasants, and their team broke down the cost components of that episode of care, and looked at the types of implants used across the system, they found the opportunity to clearly define standards. Next they used evidence to develop a contracting strategy aligned with clinical standards.

"We have seen a reduction in cost of care and length of stay, and an increase in patients ready to go home instead of entering skilled nursing facilities," said Dr. Cheely. "A lot has come from surgeons working closely with nursing, anesthesiologists, and administrators to hardwire those changes."

The need for clean, accurate, and timely data

> *"To sustain it, you need data to support it."*
>
> Jane Pleasants
> Vice President, Procurement and Supply Chain, Duke Health

With regards to program sustainability, Pleasants pointed to the need for clean, accurate, and timely data. In 2014, Duke had engaged in a care redesign initiative with its spine group where they standardized products from 13 vendors down to two. Pleasants explains that while they "hit their savings targets in a huge way," they had to find a way to sustain their success.

"The physicians leading it said 'I am doing this one time and you better show me data to prove we have lowered cost,'" said Pleasants. "So we facilitated a data feed on a monthly basis and updated our dashboard so we could show how cost per procedure was going down. Three years later we have not gone back to 13 vendors. And now we can finally get data on cost per procedure and drill down on that data to see what products were used on a patient. To sustain it, you need data to support it."

> *"If physicians are involved in the very beginning to tell us which data is meaningful, then they are much more invested in acting on it."*
>
> Robert P. Sticca, MD, FACS
> Chair Surgical Services, Sanford Health

"It goes back to basic block and tackle fundamentals," she added. "Without these controls you have to send the data off, have someone normalize it, clean it, and then you get it back in nine months. We don't want to look back that far because our surgeons can change that quickly. You need the data in as close to real time as you can get it."

"That has been one of our struggles, not only getting the data from our IT folks but getting data that is clinically significant," said Dr. Sticca. "If it isn't significant, then the physicians will just tear it apart. If physicians are involved in the very beginning to tell us which data is meaningful, then they are much more invested in acting on it."

Advice to others

Dr. Chung closed the discussion by asking the panelists to provide a piece of advice to the Summit participants on how to successfully move beyond value analysis to clinical variation reduction.

Kirkevold cited culture and communication as success factors, while Dr. Sticca stressed the importance of physician involvement, administrative support, and IT support.

Dr. Cheely highlighted the need for communication, including who is asking the physicians to take part in the work, how they are framing the request, and how they are kicking off the initiative.

> *"Cost is something that accrues to someone else's bottom line. We need to frame this type of work as improving care for patients with the recognition that cost will follow. That has been true north for us."*
>
> George Cheely, MD, MBA
> Medical Director for Care Redesign, Duke Health

"I say that having learned the hard way," said Dr. Cheely. "When you lead with cost, cost means to many of my physician colleagues making the care for my patient cheaper. Cost is something that accrues to someone else's bottom line. We need to frame this type of work as improving care for patients with the recognition that cost will follow. That has been true north for us."

Pleasants pointed to the importance of customer service when collaborating with physicians, stating:

"If you are not supporting physicians in their day to day operation – if they are running out of product and are unhappy with supply chain – then when supply chain needs their support those relationships won't be positive. Don't lose sight of the support you provide. The physicians remember back to something that didn't work well before. Don't forget customer service. Our customer is our patient, and then those who give care to patients."

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> Jane Pleasants,
> Vice President, Procurement and Supply Chain,
> Duke Health

Closing Remarks

Bob Taylor, CMRP, SVP Supply Chain, RWJBarnabas Health, closed out the Summit by summarizing those factors needed to facilitate supply chain and clinical collaboration – people, processes, and technology – noting how much of the day's discussions fell into these three categories. He noted that in order to be successful, the health care field must develop different relationships, shift processes for a greater focus on alignment, and leverage technology that drives new data and information for evidence-based decision-making.

AHRMM is looking to build a meaningful repository of case studies, tools, and other resources focused on educating and advancing clinical integration activities across the health care and health care supply chain field. Please contact AHRMM at ahrmm@aha.org if you are interested in participating in this influential initiative.

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