The Journal of Healthcare Contracting

Providing Insight, Understanding and Community

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Putting the Brakes on Treatment

Doctors list tests and procedures to avoid. Consumers will get the message.

ALSO INSIDE:

Reforming the Supply Chain

Payers and providers mix it up

Smartphone Medicine

Breaking Down Silos

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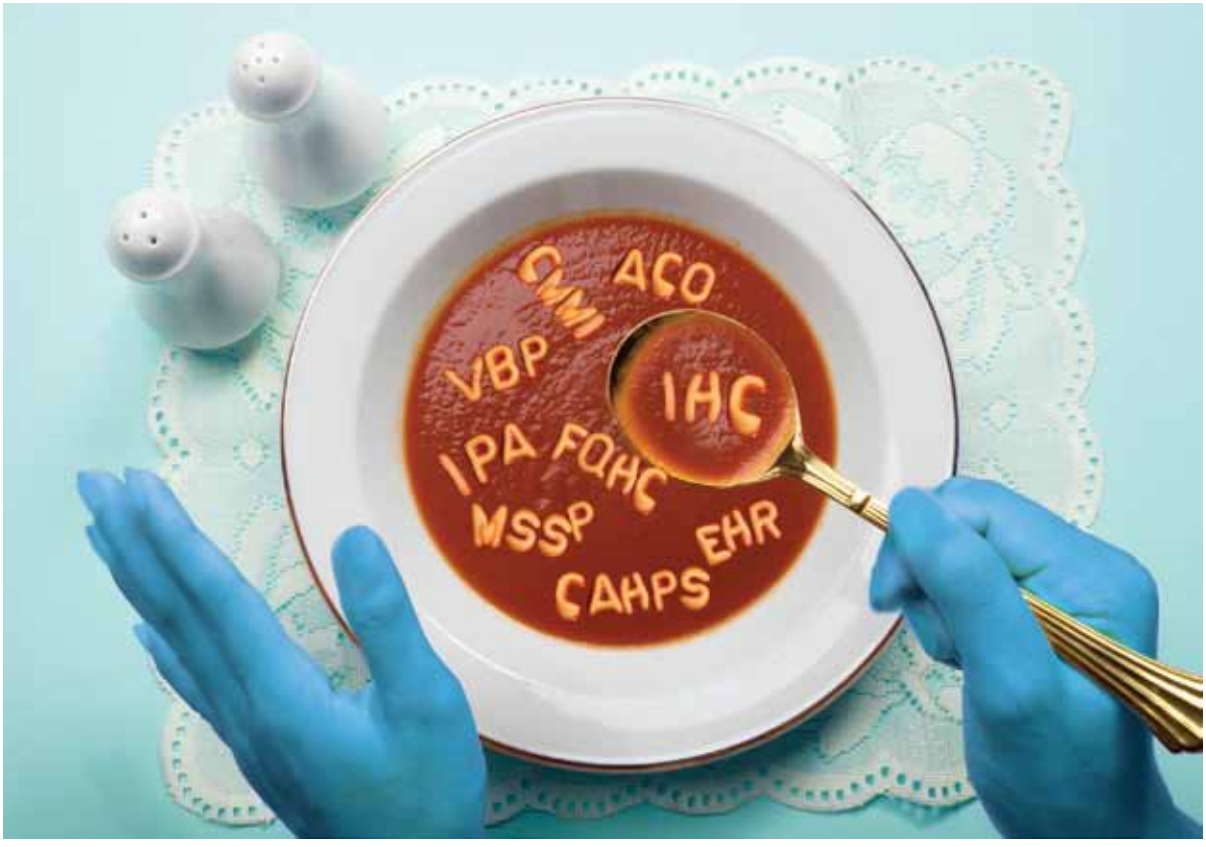

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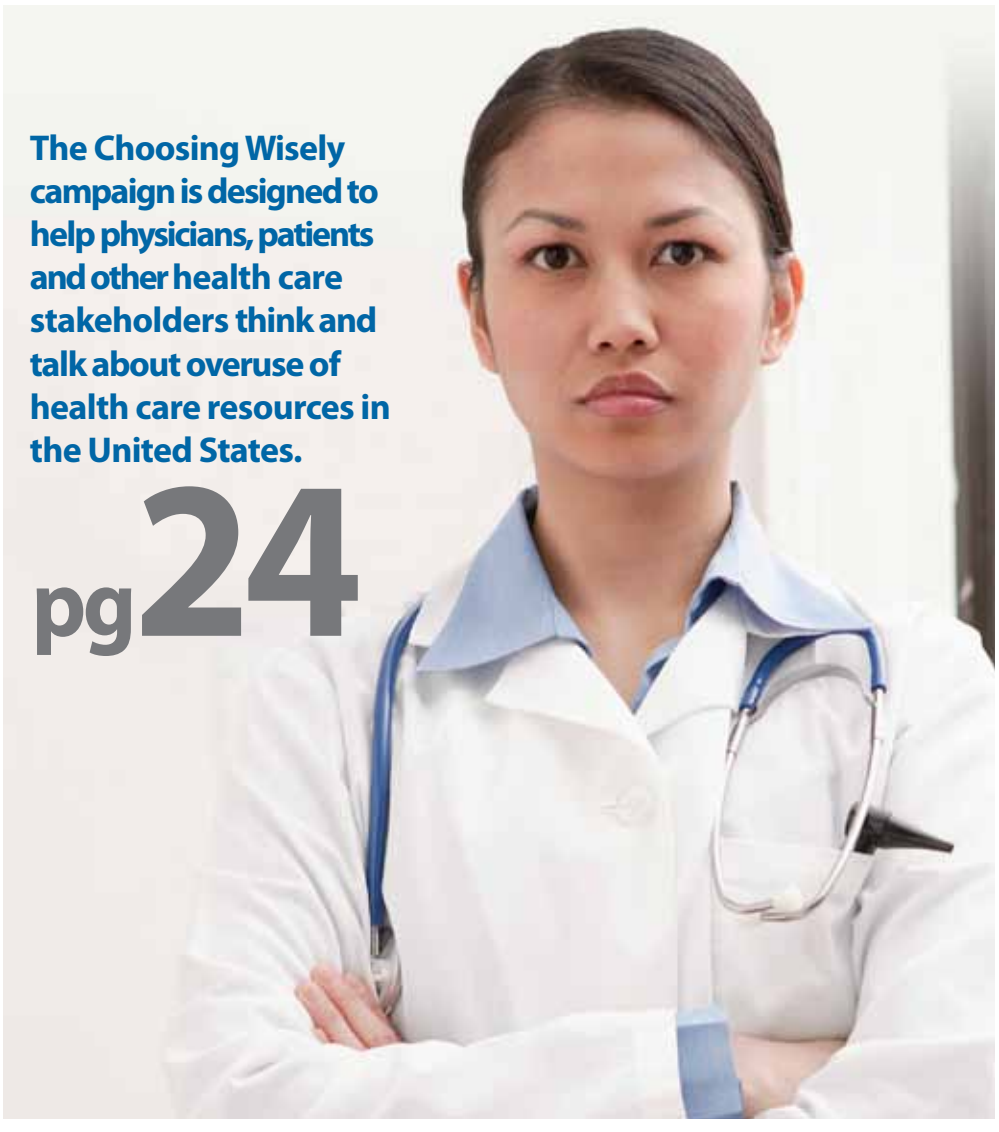
CONTENTS »»» JULY 2012



The Choosing Wisely campaign is designed to help physicians, patients and other health care stakeholders think and talk about overuse of health care resources in the United States.

pg24

4 Reforming the Supply Chain

10 Payers and providers mix it up
Insurers come to the table with hospitals and physicians to improve healthcare quality and reduce expenditures

24 Putting the Brakes on Treatment
Doctors list tests and procedures to avoid. Consumers will get the message.

34 Smartphone Medicine

50 Breaking Down Silos
Is this still a hospital supply chain challenge?

By Harry Kirschner, Managing Director, Supply Chain Solutions at The Advisory Board Company, Washington, DC

Reforming the Supply Chain

Healthcare reform and national demographic shifts have set transformative market changes in motion. While the final Supreme Court ruling on the Affordable Care Act and political instability add some degree of uncertainty, there is little disagreement that growth in healthcare spending must be modulated. Healthcare administrators are squarely focused on initiatives to increase the quality of outcomes while aggressively reducing costs across the care continuum.

Supply and purchased services spend, together representing about half of most hospitals' operating expenses, offer the next attractive targets.

While labor represents the largest expense category for hospitals, future savings on labor costs appear to be diminishing. Labor productivity has been a perennial focus for many hospitals in recent years, yet administrators are growing wary that further cuts may impact reimbursement if getting "too lean" reduces patient satisfaction or worsen outcomes. Real transformation requires restructuring of care delivery, taking years to implement, but leaders must find immediate cost management strategies to mitigate operating margin challenges in the short term.

Supply and purchased services spend, together representing about half of most hospitals' operating expenses, offer the next attractive targets. Supply costs, inflected by both price to the hospital and utilization by clinicians, have undoubtedly received attention across the past decade (particularly on utilization control), but many leaders have kept supply chain at arm's length, relying on traditional tactics to drive only incremental impact. Our price comparison and economic research clearly demonstrates that most hospitals have significant latent price opportunity embedded in their supply costs, findings borne out by the recent General Accounting Office report exposing implant price variation. Through our Strategic Sourcing Management initiative, we've uncovered 10-20% price improvements at institutions that were previously performing in the best price decile. While these savings were exclusive of utilization improvements, a key success factor for any cost containment strategy is increased physician alignment.

On a positive front, reform is driving providers to pursue a variety of physician engagement

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 *Calculations based on these sources; sample calculations available upon request. 1. Computers, Informatics, Nursing: September/October 2009, Volume 27, Issue 5, pages 318-323, Connected Care: Reducing Errors Through Automated Vital Signs Data Upload, Smith, Laura B. MSN, RN; et al. 2. Automated Vital Sign Documentation for Medical Surgical Units: Saving Time and Increasing Accuracy: Fact or Fairytale?, Meg Meccariello, RN MS; Jennifer Johnstone, RN MS, Presented at The Nursing Management Congress 2008 Las Vegas, NV. 3. Vital signs measurement frequency estimates from "Lippincott's Textbook for Nursing Assistants: A Humanistic Approach to Caregiving," Pamela J. Carter, 2007, page 292. 4. Hospital beds (most recent) by country estimates from NationMaster.com, www.nationmaster.com/graph/hea_hos_bed-health-hospital-beds. 5. Population, Source: U.S. Census Bureau, Population Division.

strategies to both capture increased market share and create meaningful incentives for mutual accountability. Whether formally participating in bundled payment initiatives, increasing physician employment, or pursuing co-management agreements, providers are implementing mechanisms to create meaningful financial rewards that spur new levels of collaboration with clinicians. Aligned financial incentives for hospitals and their clinicians will strengthen a sometimes-tenuous alliance, as they share rewards for lower costs and higher quality, or, in some cases, penalties for high costs and low quality.

To achieve transformative change, these themes of collaboration and partnership need to be extended to govern the relationship between providers and suppliers as well. Research with supply chain executives and suppliers alike has demonstrated that negotiations are more often governed by mistrust and a steadfast defense of one-sided priorities. A review of best practices from outside industries demonstrate a more partner-centric approach that values a transparent and data-driven exchange designed to create mutual value. Moving beyond this prevailing "zero-sum" game will require action by hospitals and suppliers alike.

First, supply chain organizations should be thoughtful around providing suppliers with clear visibility into their needs and opportunities to expand business into new categories. Hospitals and their clinicians must partner with suppliers to build efficient, strategically designed sourcing events that create a compelling opportunity for suppliers to be creative and thoughtful around opportunities to drive mutual benefit. They should use strategic sourcing strategies to clearly articulate product, service, legal, and business requirements, taking the guesswork out of supplier proposal development. Hospitals must activate their clinicians and other end-users beyond the level of "engagement" common in committee work, by also building pathways for physicians themselves to lead supply award decisions, with all the relevant price and quality information in hand to make appropriate trade-off decisions. True business partnership with clinicians requires continued access to the supplies that make the hospital their workshop-of-choice, but also control over the sourcing award decisions that will

Research with supply chain executives and suppliers alike has demonstrated that negotiations are more often governed by mistrust and a steadfast defense of one-sided priorities.

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drive the financial gains that reward lower cost.

Suppliers have long been accustomed to serving clinicians' need for information about clinical performance differentiators. As aligned financial incentives merge hospital and clinician interests, suppliers should be prepared to discuss the cost impact of their products with newly-interested clinicians. As hospitals critically examine spend for total value, suppliers should be prepared to articulate the non-price benefits that support their proposals (quality or performance differentials, favorable service terms, stocking requirements, product support, etc.). Suppliers should also push to clearly understand across those targets. As our industry moves into an uncertain future, successful organizations will build true partnerships across the supply chain divide, and capitalize on aligned incentives to build a more efficient supply marketplace, to benefit both buyers and sellers. **JHC**

the hospital and clinicians' broader objectives, moving beyond standard proposals or commitment requirements to propose more creative offers that drive incentives for both parties to achieve all cost and quality objectives.

"Value" has become a buzzword in health care today, but with good reason – it encapsulates both cost and quality, and attempts to rationalize choices

"Value" has become a buzzword in health care today, but with good reason – it encapsulates both cost and quality, and attempts to rationalize choices across those targets.

To better understand the impact of the Advisory Board's innovative approach to sourcing – download a copy of a white paper describing how the Advisory Board helped transform the already-excellent supply sourcing function at a distinguished academic medical center in the Midwest, leading to $1.85 million in savings.

To learn more about what the Advisory Board is doing in the supply chain space more broadly, visit www.advisory.com/Consulting/Strategic-Sourcing-Management/About-Strategic-Sourcing-Management

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Payers and providers mix it up

Insurers come to the table with hospitals and physicians to improve healthcare quality and reduce expenditures

A lot of ink has been shed about hospitals and hospital systems acquiring physician practices. Experts believe that if these two can align themselves, they can coordinate care, avoid duplication of services, reduce costs, and improve the health of patients with chronic ailments and acute conditions. In other words, if the fee-for-service system – which many blame for excessive healthcare costs – is ever to be eliminated, these two must get their act together.

But there's another player elbowing its way to the table – insurers.

With years of experience monitoring and paying claims, insurers have developed the management expertise and databases to affect how – and what – care is delivered, to whom, and with what results. They are starting to exercise their strength in the market, either by acquiring or merging with providers, or forming strategic partnerships with them.

"Whether it's a contractual relationship, a joint venture, or a full merger, all of these options are being discussed with those who are willing and wanting to have that discussion," says a spokeswoman for Highmark, which announced an affiliation with West Penn Allegheny Health System in July 2011.

It is difficult to predict the impact these developments will have on product and equipment selection. But one thing is certain: These new entities will undoubtedly emphasize delivering care more efficiently and effectively. That could boil down to fewer supplies and equipment used.

Not the first time

This isn't the first time insurers and providers have joined forces. Louisville, Ky.-based Humana, for example, once was one of the country's largest owners of for-profit hospitals. It launched its own insurance plan in 1984. Three years later, VHA began its own insurance operations. Humana long ago shed its hospitals, while VHA shed its insurance operations years ago. But today, things appear to be different.

"Insurers want to set themselves up to be in a position to try to control costs upfront," says Minoo Javanmardian, partner, Booz & Company. In other words, they want patients to get care early, before chronic or acute conditions progress to the point where hospitalization is needed.

And what can insurers bring to the table? A long-range view of patients' care, from symptom to treatment to recovery and long-term monitoring. "The payer has the full picture of the patient, whereas the providers just have the picture of the episode they were engaged in," says Javanmardian.

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"We are in a rapidly changing health care environment," says Brad Lotterman, spokesman for Optum, a division of UnitedHealth Group. Optum recently acquired the management arm of Monarch HealthCare, a multispecialty physician association in southern California comprising 2,300 physicians. "As health care evolves, we are committed to helping physicians with more support in the form of better technology, better information and population health management expertise, so they can enhance their practices and expand upon the top-quality, cost-effective care they give to their patients."

It's catching on

Many major insurers have gotten into the act. Some examples:

- **Cigna.** In January 2012, Cigna and the Weill Cornell Physician Organization – an 850-member multispecialty group practice in New York City – launched what they are calling a "collaborative accountable care initiative" to achieve what Cigna calls the "triple aim" of improved health outcomes, lower total medical costs and increased patient satisfaction. With the addition of Weill Cornell, Cigna is now engaged in 17 similar initiatives in 15 states, encompassing more than 170,000 Cigna customers and more than 1,800 primary care physicians.

- **WellPoint.** In August 2011, WellPoint announced the completion of its acquisition of CareMore Health Group, which offers Medicare Advantage plans and Special Needs Plans designed for the chronically ill in select California, Nevada and Arizona markets. CareMore focuses on improving the health of its 54,000 Medicare members through a variety of means, including 26 neighborhood care centers staffed with physicians, nurse practitioners, medical assistants, podiatrists, physical therapists, nutritionists, psychologists and case managers. WellPoint says it would like to expand CareMore's model both within existing CareMore markets and to WellPoint markets across the country.

- **Highmark.** In June 2011, Highmark Inc., an independent licensee of the Blue Cross and Blue Shield Association, announced its intention to pursue an affiliation agreement with the financially ailing West Penn Allegheny Health System in Pittsburgh, Pa. The IDN comprises five hospitals and a number of outpatient facilities. Highmark is making a financial commitment of up to $475 million over four years. The agreement was expected to be approved by Fall 2012.

- **UnitedHealth.** The insurer explains that its acquisition of the management arm of Monarch Healthcare will provide Monarch's primary care and specialty physicians with administrative support and access to advanced information technology, data and provider collaboration solutions.

- **Humana.** In December 2010, Humana completed its acquisition of Addison, Texas-based Concentra Inc., for close to $800 million in cash. Concentra delivers occupational medicine, urgent care, physical therapy and wellness services to workers and the general public from more than 300 medical centers in 42 states. In addition to its medical center locations, Concentra serves employer customers by providing health advisory services and operating more than 240 worksite medical facilities. On its website, Concentra says that it is "actively seeking opportunities to acquire medical practices providing urgent care, occupational health, family practice and wellness services."

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Misaligned incentives equal costly care

"There is tremendous pressure on healthcare," says Javanmardian, whose firm, Booz & Company, publishes an annual report on payer/provider relationships in the healthcare industry. For example, there's the question of access, that is, how patients gain access to healthcare providers. Then there are questions concerning quality of care. Finally, there's the question of affordability. "The trend as it is today cannot continue, because it will make healthcare unaffordable for a big part of the population," she says.

In today's fee-for-service system, doctors and other providers are paid based on activity, not outcomes, says Javanmardian. As a result, the healthcare system is fragmented. "There is no one person or no one system in charge of the care of the patient. The result is patient dissatisfaction and very costly delivery of care." Services are duplicated, and patients may fail to get the care they need at the correct facility and the correct time. "So what's right for the patient vs. the way it gets paid is not aligned, and misaligned incentives result in the affordability issue."

"Many people believe that payer and provider collaboration, or at some point, integration, will help solve the problem, because you're bringing incentives and care delivery together, which will allow you to deliver care more effectively and efficiently." She points to Kaiser Permanente in California as an example.

At the center of the transformation is the so-called "patient-centered medical home," or "accountable care organization," says Javanmardian. In these scenarios, the patient has an "anchor" in a medical home, often, a group of primary care physicians and nurse practitioners. That explains why some insurers are pursuing affiliations or acquisitions of primary care practices. "They can incentivize the physician to provide the right care for the patient and to manage them end to end, so the patient doesn't end up in the hospital, which is a high-cost facility.

The "productization" concept can be applied to virtually any medical episode that has a beginning and end, such as coronary artery bypass and even, on an outpatient basis, LASIK surgery.

Productization

That goal is what Booz calls "productization" of healthcare. An example of a "product" might be a knee replacement. In today's system, a patient in need of a knee replacement would visit his primary care doctor, then an orthopedist, then a surgeon, then a rehabilitation specialist. Various activities are conducted, and perhaps duplicated, each of which generates a charge.

"What productization does is this," says Javanmardian. "From the minute that patient goes to the orthopedist until he comes out of rehab, a whole host of things need to happen for him to have a functional knee. The 'product' here is the surgery and then the ability to walk out after rehab with a functional knee. That's what the patient is going to buy, and that's what the insurance company will pay for." And the patient's care is coordinated and managed end to end.

The "productization" concept can be applied to virtually any medical episode that has a beginning and end, such as coronary artery bypass and even, on an outpatient basis, LASIK surgery, she says.

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But insurers can't develop "products" like this on their own, says Javanmardian. They're not doctors. "What's important is to get everybody at the table – physician, hospital and payer." Together, they have to learn what is important to consumers, and then they have to spell out the financial incentives for all the players and how they will affect the affordability of the product.

The insurer is an indispensable part of the picture. That's true not only because of the fact that they will pay for the care provided, but because they have that long-range view of the patient. "The only way to manage the cost and quality of care is to engage patients and [get them to] change their behavior," says Javanmardian. "And the only way you can do that is if you have full information on them, and the payer is the one who has that information."

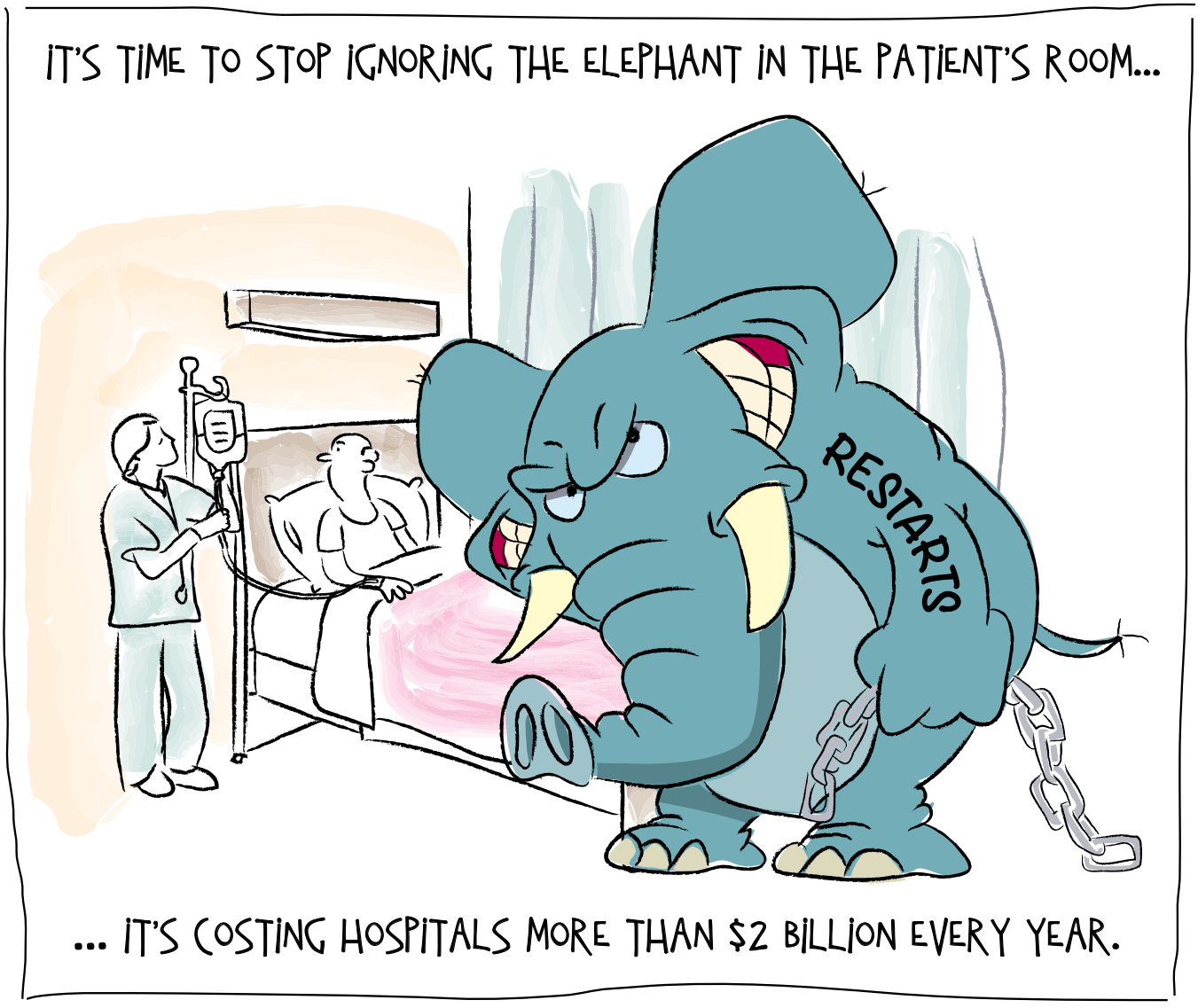
In January 2012, WellPoint announced a program that, it says, "will fundamentally change its relationship with primary care physicians by significantly increasing the company's investment in their practices and in the health of their patients."

WellPoint

Indianapolis, Ind.-based WellPoint appears to be following the game plan. "The CareMore acquisition exemplifies our strategic plans to capitalize on new opportunities for growth in the senior market as baby boomers become eligible for Medicare and the company prepares for this significant demographic shift," says Jill Becher, spokeswoman. "CareMore's model is focused on disease management programs that provide Medicare recipients with a hands-on approach to care coordination and intensive treatment of chronic conditions. Their goal is to understand seniors' medical needs and help members better understand their needs and navigate the system.

"The physicians, nurse practitioners, medical assistants, podiatrists, physical therapists, nutritionists, psychologists and case managers who staff the CareCenters do not replace an individual's primary care physician or specialist, but rather, provide care management and personalized health planning that ensures members, especially those with chronic conditions, receive the individualized attention they deserve, and are able to navigate the healthcare system and better manage their health. CareMore's physicians, nurse practitioners, and extensivists follow members through inpatient, outpatient, skilled nursing and, when appropriate, hospice care." The company remains committed to improving the lives of senior citizens through preventive care and screenings, and intensive care management of the frail and chronically ill, she adds.

In January 2012, WellPoint announced a program that, it says, "will fundamentally change its relationship with primary care physicians by significantly increasing the company's investment in their practices and in the health of their patients." WellPoint says it will make a major investment in primary care by increasing revenue



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Unscheduled peripheral IV restarts cost hospitals over two billion dollars every year! Some experts peg it at double that amount. Facts to consider:

- 90% of all patients receive a PIV during their hospital stay
- There are an estimated 128 million unscheduled restarts per year
- Inserting and troubleshooting a peripheral IV averages $23 in nursing labor costs
- US hospitals spend an average of $2,800 per bed on unscheduled restarts
- IV complications are one of the top causes for patient/hospital lawsuits
- IV restarts are one of the main reasons for patient dissatisfaction

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opportunities for participating primary care physicians, enhancing information sharing, and providing care management support from WellPoint clinical staff. The new program will also incorporate best practices from the company's multiple medical home pilots.

Participating physicians will be able to earn additional revenue in the following ways, according to the company:

- An increase to the regular fees paid to physician practices for specific services.
- Payment for "non-visit" services currently not reimbursed, with an initial focus on compensation for preparing care plans for patients with multiple and complex conditions.
- Shared-savings payments for quality outcomes and reduced medical costs.

"Patients most likely to see the immediate benefits of the program with Weill Cornell are those who need help managing chronic conditions, such as diabetes or heart disease."

– Cigna

Primary care physicians who maintain or improve quality may earn 30 percent to 50 percent more than they earn today through the shared savings model, says the company. WellPoint estimates the program will improve quality and member health, and reduce overall medical costs by as much as 20 percent by 2015. The company's goal is to implement the program across its primary care network by the end of 2014.

"Our medical home pilots have proven to make a meaningful difference in patient quality, outcomes and cost," said Harlan Levine, M.D., WellPoint executive vice president, Comprehensive Health Solutions, in a statement. "Some of our pilots have experienced an 18 percent decrease in acute inpatient admissions and a 15 percent decrease in total ER visits while improving compliance with evidence-based treatment and preventative care guidelines."

Cigna

Cigna is no stranger to healthcare provision, having operated its Cigna Medical Group in Arizona since 1982, when Connecticut General (CG) merged with INA to form Cigna. (Today, the group comprises over 30 health centers and 200 clinicians in metropolitan Phoenix.) But its so-called "collaborative accountable care" programs, such as that recently launched with Weill Cornell, offer a new twist.

The company launched its first such program with Dartmouth-Hitchcock in New Hampshire in 2008. The IDN comprises hospitals, physician groups and a variety of outpatient programs and services. Today, Cigna has a number of so-called "patient-centered initiatives," encompassing more than 170,000 customers and 1,800 primary care physicians. It plans to increase the number of such initiatives significantly in 2012.

Patients most likely to see the immediate benefits of the program with Weill Cornell are those who need help managing chronic conditions, such as diabetes or heart disease, says Cigna. Weill

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Cornell Physician Organization – which comprises 71 primary care doctors – will monitor and coordinate all aspects of an individual's medical care. Registered nurses, employed by Weill Cornell, will serve as clinical care coordinators and help patients with chronic conditions or other health challenges navigate their health care system.

"The care coordinators will enhance care by using patient-specific data provided by Cigna to identify patients being discharged from the hospital who might be at risk for readmission, as well as patients who may be overdue for important health screenings or who may have skipped a prescription refill," according to the company. "The care coordinators will contact these individuals to help them get the follow-up care or screenings they need, identify any issues related to medications, and help prevent chronic conditions from worsening." The care coordinators will also help patients schedule appointments, provide health education and refer patients to Cigna's clinical programs, such as disease management programs for diabetes, heart disease and other conditions; and lifestyle management programs, such as programs for tobacco cessation, weight management and stress management.

"We believe that initiatives such as this will help transform the way medicine is practiced in the United States – from a system that's focused mainly on treating illness and rewarding physicians for volume, to one that's patient-centered and emphasizes prevention and primary care," said Alan Muney, M.D., Cigna's chief medical officer, in a statement. "We've already seen very promising early results in locations where we've implemented this type of program, and we believe these initiatives ultimately will lead to a healthier population and lower medical costs."

"We've already seen very promising early results in locations where we've implemented this type of program, and we believe these initiatives ultimately will lead to a healthier population and lower medical costs."

– Alan Muney, M.D., Cigna's chief medical officer

Highmark

Highmark's affiliation agreement with West Penn Allegheny Health may have been driven by the peculiarities of that situation, but the company believes the agreement can lead to a new kind of healthcare delivery system.

West Penn Allegheny was on the verge of collapse when Highmark stepped in. (The IDN's outlook remains cloudy.) What's more, observers suspect that Highmark's decision to affiliate with the IDN may have been prompted by what some have called a "feud" between the insurer and West Penn Allegheny's competitor, the University of Pittsburgh Medical Center, over the terms of a new contract. All that notwithstanding, Highmark expects the West Penn Allegheny deal to lay the foundation for a new provider strategy.

"Highmark is engaging all players in Western Pennsylvania and other markets to discuss where they are in terms of their particular strategic objectives and how we can assist in helping to make sure that their community's needs are met," says Aaron Billger, Highmark spokesman. "We are looking to form a relationship to help make these needs happen."

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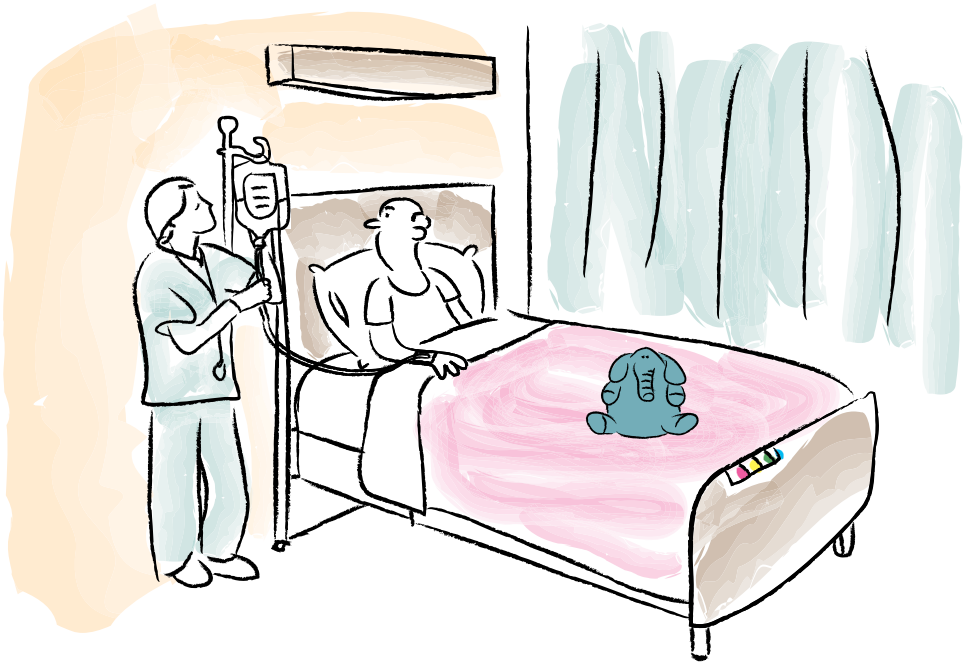

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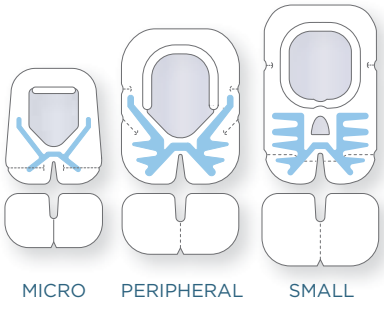

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[1] Flippo, P, Lee, J (2011). Clinical Evaluation of the SorbaView SHIELD Securement Device Used on Peripheral Intravenous Catheters in the Acute Care Setting. *Journal of the Association for Vascular Access*, 16(2), 2011, 95.

[2] Bausone-Gazda D, Lefaiver CA, Walters SA (2010). A randomized controlled trial to compare the complications of 2 peripheral intravenous catheter-stabilization systems. *Journal of Infusion Nursing*, 2010, Nov-Dec; 33(6):371-84

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The insurer is pursuing relationships in primary care, pre-acute-care (such as urgent care and ambulatory surgery), acute care, post-acute-care (such as rehabilitation), and home care and palliative care, he says. "Our provider strategy model will incentivize all of these players in the health care system through the alignment of a payment system that is focused on the patient and outcomes; not a system that is focused on maximizing revenue and encouraging physicians, through incentives, to do more procedures and interventions that may be dangerous and harmful to patient care. This is an important opportunity to transform health care delivery in our communities."

Highmark's delivery systems "will be different than other traditional systems by including innovative clinical technologies, new care management models and advanced analytics and insights," he adds.

UnitedHealthcare

UnitedHealth Group's Optum division, based in Golden Valley, Minn., "has affiliations and supports local care providers in many different ways, with a wide range of capabilities," says spokesman Brad Lotterman. "We have a strong history of helping care providers expand their service areas and open new locations, recruit new physicians, better serve people with limited mobility and in rural areas with advanced telemedicine tools, and improve patient choice by adding new health care payer partners," says Lotterman.

We have a strong history of helping care providers expand their service areas and open new locations, recruit new physicians, better serve people with limited mobility and in rural areas with advanced telemedicine tools, and improve patient choice by adding new health care payer partners."

– Brad Lotterman, spokesman, UnitedHealthcare

In 2008, the company acquired Sierra Health Services in Nevada, which includes Southwest Medical Associates, a multispecialty group. Today, Optum provides that group and others a variety of tools, says Lotterman, including:

- Technologies that enable physician collaboration and access to critical information.
- Actionable intelligence tools that provide comprehensive patient information in real-time.
- Health management and clinical expertise to support better outcomes and help patients make more informed decisions about their care.
- Administrative support.

Will it work?

The big question is, can providers and payers work together to transform the healthcare delivery system? It may be too early to tell, but it seems clear, they're going to try.

"Providers are preparing for a world where access (to doctors and diagnostics, primarily), care management, and cost control will matter more to their overall success and financial health than having a hospital in every part of the market," say the authors of the Booz report, "2012 Healthcare (Payor/Provider) Industry Perspective," of which Javanmardian was one. "Furthermore, as care management and cost control have become increasingly important, so too has the need to forge new relationships with payors." **JHC**

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1. López-Huertas HL, Polcari AJ, Acosta-Miranda A, et al. Metallic ureteral stents: a cost-effective method of managing benign upper tract obstruction. *J Endourol.* 2010;24(3):483-485.

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Given continuing concerns about healthcare cost and quality, questions such as these are likely to crop up with greater frequency in the months and years ahead. To be sure, *Journal of Healthcare Contracting* readers won't be charged with coming up with the answers. But they will have a front row seat to some of the greatest debates around. And the outcome of those debates will influence what and how many supplies and equipment are brought into the IDN.

Campaign launched

In April, nine leading physician specialty societies launched their "Choosing Wisely" campaign by publishing a list of 45 tests or procedures (five from each specialty society) that they say are commonly used but not always necessary. The lists of "Five Things Physicians and Patients Should Question" are said to provide specific, evidence-based recommendations that physicians and their patients should discuss to help make wise decisions about the most appropriate care based on their individual situation.

Unlike many evidence-based recommendations, which receive a day or two of screaming national coverage, never to be heard of again, the recommendations in "Choosing Wisely" are expected to have legs.

The "Choosing Wisely" concept was originally piloted by the National Physicians Alliance, which, through an American Board of Internal Medicine Foundation "Putting the Charter into Practice" grant, created a set of steps physicians in internal medicine, family medicine and pediatrics could take in their practices to promote the more effective use of healthcare resources. These steps were first published in the Archives of Internal Medicine.

Since then, the movement has grown. The nine organizations releasing lists represent nearly 375,000 physicians. They are:

- American Academy of Allergy, Asthma & Immunology.
- American Academy of Family Physicians.
- American College of Cardiology.
- American College of Physicians.
- American College of Radiology.
- American Gastroenterological Association.
- American Society of Clinical Oncology.
- American Society of Nephrology.
- American Society of Nuclear Cardiology.

And the heat will only mount. In April, ABIM announced that eight additional specialty societies were joining the "Choosing Wisely" campaign. They were expected to release their lists this fall.

These recommendations will have legs

"Choosing Wisely" follows by two years the launch by the American College of Physicians of its "High Value, Cost-Conscious Care" initiative. That initiative was created to assess benefits, harms and costs of diagnostic tests and treatments for various diseases. At the time of its announcement in 2010, ACP quoted a Congressional Budget Office estimate that 5 percent of the nation's Gross Domestic Product – or $700 billion a year – is spent on tests and procedures that do not actually

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improve health outcomes. "ACP contends…that savings can be achieved by reducing inappropriate utilization of services and by encouraging clinically effective care based on comparative effectiveness research," the College said at the time.

Unlike many evidence-based recommendations, which receive a day or two of screaming national coverage, never to be heard of again, the recommendations in "Choosing Wisely" are expected to have legs. That's because Consumer Reports, with more than 8 million subscribers, has agreed to partner with the specialty societies and ABIM to address the value and quality of various diagnostic tests and medical procedures, just as it does cars, toothpaste and vacuum cleaners.

The Choosing Wisely campaign is designed to help physicians, patients and other health care stakeholders think and talk about overuse of health care resources in the United States.

In fact, the magazine announced that 11 consumer-oriented organizations would join "Choosing Wisely" to help disseminate information to the public. They include the AARP, Leapfrog Group, the National Business Group on Health, and the Service Employees International Union.

Overuse of healthcare resources

"Many experts agree that the current way health care is delivered in the U.S. contains too much waste – with some stating that as much as 30 percent of care delivered is duplicative or unnecessary and may not improve people's health," said the ABIM in a statement announcing the "Choosing Wisely" campaign. "In fact, such unnecessary care may harm or hinder patients' health.

"The Choosing Wisely campaign is designed to help physicians, patients and other health care stakeholders think and talk about overuse of health care resources in the United States. By creating and releasing [the] lists, the groups aim to stimulate discussion about the need – or lack thereof – for many frequently ordered tests or treatments, many of which are requested by patients. The groups also hope to support physician and patient relationships by encouraging specific conversations about appropriate individualized testing and treatment plans."

Following are just a few of the nine specialty societies' lists of overused tests and procedures. (For the full text of all lists and their rationale, go to www.choosingwisely.org.)

- Don't order sinus computed tomography (CT) or indiscriminately prescribe antibiotics for uncomplicated acute rhinosinusitis.
- Don't diagnose or manage asthma without spirometry.
- Don't do imaging for low back pain within the first six weeks, unless red flags are present.
- Don't use dual-energy x-ray absorptiometry (DEXA) screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors.
- Don't order annual electrocardiograms or any other cardiac screening for low-risk patients without symptoms.

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- Don't perform Pap smears on women younger than 21 or who have had a hysterectomy for non-cancer disease.
- Don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms, unless high-risk markers are present.
- Don't perform annual stress cardiac imaging or advanced non-invasive imaging as part of routine follow-up in asymptomatic patients.
- Don't perform stress cardiac imaging or advanced non-invasive imaging as a pre-operative assessment in patients scheduled to undergo low-risk non-cardiac surgery.
- Don't perform echocardiography as routine follow-up for mild, asymptomatic native valve disease in adult patients with no change in signs or symptoms.
- In the evaluation of simple syncope and a normal neurological examination, don't obtain brain imaging studies (CT or MRI).
- Don't obtain preoperative chest radiography in the absence of a clinical suspicion for intrathoracic pathology.
- Don't do imaging for uncomplicated headache.
- Don't image for suspected pulmonary embolism without moderate or high pre-test probability.
- Don't do computed tomography (CT) for the evaluation of suspected appendicitis in children until after ultrasound has been considered as an option.
- Don't recommend follow-up imaging for clinically inconsequential adnexal cysts.
- Do not repeat colorectal cancer screening (by any method) for 10 years after a high-quality colonoscopy is negative in average-risk individuals.
- Do not repeat colonoscopy for at least five years for patients who have one or two small (< 1 cm) adenomatous polyps, without high-grade dysplasia, completely removed via a high-quality colonoscopy.
- For a patient with functional abdominal pain syndrome, CT scans should not be repeated unless there is a major change in clinical findings or symptoms.
- Don't use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status, no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anti-cancer treatment.
- Don't perform PET, CT, and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis, or early breast cancer at low risk for metastasis.
- Don't perform surveillance testing (biomarkers) or imaging (PET, CT or radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent.
- Don't perform routine cancer screening for dialysis patients with limited life expectancies without signs or symptoms.
- Don't place peripherally inserted central catheters (PICC) in stage III–V CKD patients without consulting nephrology.
- Use methods to reduce radiation exposure in cardiac imaging, whenever possible, including not performing such tests when limited benefits are likely. **JHC**

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Smartphone Medicine

Talk about disruptive innovation. The cellphone – now smartphone – has changed the way people access information and communicate with each other. And it's not all small talk.

In November 2011, Pew Internet, a project of the Pew Research Center, reported 29 percent of surveyed adults who have downloaded an app to a cellphone or tablet computer reported downloading a health app. Pew estimates that this translates to about 11 percent of all adult cellphone users.

True, many of those apps are designed to help people track calories consumed, calories burned, miles run, etc. But increasingly, devices and accompanying apps are helping people – particularly those with chronic conditions – monitor their health and communicate with their caregivers. The implication for physicians and physician office traffic could be huge.

Some examples:

- A blood pressure monitor from Withings, a French firm, calls for the user to wrap the cuff around his or her arm, plug it directly into their iPad, iPhone or iPod, and, with the Withings app in place, begin measurement. Results are stored on the mobile device or the user's computer (on their personal Withings webpage), and can be e-mailed to a doctor or anyone else using an automatic sharing feature. Cost $129.
- The iBGStar™ Blood Glucose Monitoring System from Salem, N.H.-based AgaMatrix (and distributed by Sanofi U.S.) was the first blood glucose meter to be FDA-cleared (in December 2011) for use with the iPhone and iPod Touch. The device measures the amount of glucose in the blood and transfers the data to the mobile device, for storage or transmission. Estimated cost: $80.
- Bethesda, Md.-based Telcare received FDA clearance to market its Telcare Blood Glucose Meter in August 2011. The meter has a built-in cellular chip that automatically sends all test results to MyTelcare.com's secure server, which can be viewed by the patient or anyone else, with the patient's permission. MyTelcare.com can be accessed with an iPhone app. The cellular connection can be used to send the patient messages about the readings, if necessary.
- Though not yet cleared by the FDA for sale

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in the United States, a credit-card-sized wireless device from Oklahoma City, Okla.-based AliveCor can reportedly turn an iPhone, iPad or Android device into a ECG recorder. The device sells for about $100 in Europe.

- San Diego, Calif.-based HealthInterlink says its software platform can incorporate any FDA-approved, Bluetooth-enabled device. One platform can fulfill a variety of remote health management needs, according to the company, including oxygen saturation, blood pressure, blood glucose, weight, temperature, peak flow, etc. The main HealthInterlink gateway device collects data from devices and routes it through the company's platform to the appropriate care provider. Examples of existing tablets and mobile gateway devices are Samsung Galaxy Tab tablet, Motorola Xoom tablet and most Android-enabled smart phones.
- AirStrip Technologies, San Antonio, Texas, says its AppPoint software platform can securely send critical patient information, including waveform patterns, bedside alarms and other patient data, to clinicians anywhere. The platform is said to be available with virtually any cell carrier and mobile device, including smartphones, iPhones, BlackBerrys, Android-based tablets, Windows Mobile devices and iPads. In February 2012, hospital company HCA announced a collaboration with AirStrip that includes expanded use of AirStrip's mobile patient monitoring software and a financial investment in the company.
- Although not intended for consumers, Redmond, Wash.-based Mobisante's MobiUS™ SP1 is a smartphone-based ultrasound imaging system. Cleared for marketing by the FDA in February 2011, the system allows the practitioner to archive or share images using a cellular network, WiFi or direct connectivity to a personal computer. Cost is about $8,000.

To fully exploit the potential of smartphones, however, physicians and care teams need to work actively with patients to help them collect and interpret data, and then act on it accordingly.

Well-established trends

"The trends are already being established," says David C. Kibbe, MD, MBA, senior advisor, American Academy of Family Physicians, and consultant to the AAFP's Center for Health Information Technology. Smartphones are compatible with testing and monitoring equipment. "They are also 'ever present,' and are showing promise for automated alerts and reminders, helping patients remember when to take medications, or interactively querying and replying to patients who need to monitor the side effects of medicines very closely." Smartphones are capable of linking people in social networks and making healthy behavior a part of online games and competitions, he adds. "And cameras on smartphones extend a person's ability to

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visualize their bodies and to communicate images to healthcare providers remotely."

To fully exploit the potential of smartphones, however, physicians and care teams need to work actively with patients to help them collect and interpret data, and then act on it accordingly, says Kibbe. And that education process has already begun. "There are home monitoring programs in some larger institutions already, and it's often the nurses or case managers who handle this education, working in concert with primary care doctors," he says. "Nurses in small practices all over the country have instructed new diabetic patients in home monitoring for decades. So we do have models."

Welch Allyn is exploring the use of smartphones and tablets in healthcare, including so-called Health applications, says Scott Gucciardi, executive vice president, chief marketing officer. "It is clear these mainly consumer-oriented devices are here to stay, and their usage in professional settings, including healthcare, continues to grow. We already see iPads, iPhones and Android devices being used to do a number of things to support workflow in both the hospital and physician office settings, including integration with various health information systems and EHRs. Whether, or to what extent, they will be used to acquire and process diagnostic data will depend on the workflow fit and preference of providers.

"A major consideration is whether smartphones and tablets are really capable of displacing 'purpose built' devices, such as vital signs monitors, that are designed to meet the needs of healthcare delivery environments," he continues. "Those needs include reliability, durability, and human factors including the ergonomics of repetitive motion and ensuring safeguards in the user interface to meet regulatory standards."

"When we decided to use mobile phones for part of our program development a couple of years ago, the adoption of [smartphones] among our population was about 10 percent, so we decided not to build apps."

– Joseph Kvedar, MD, founder and director of the Center for Connected Health

Just-in-time messaging

"The beauty of mobile devices – and what they are doing to revolutionize healthcare delivery – is that they are always in [your pocket], and that allows for just-in-time messaging," says Joseph Kvedar, MD, founder and director of the Center for Connected Health. "Wherever you are with your phone, I can reach you." The Center for Connected Health was founded in 1995 by Harvard Medical School teaching hospitals. Its mission is to develop strategies to move healthcare from the hospital and doctor's office into the day-to-day lives of patients, leveraging information technology.

"When we decided to use mobile phones for part of our program development a couple of years ago, the adoption of [smartphones] among our population was about 10 percent, so we decided not to build apps," says Kvedar. "So we used text messaging as an important tool to encourage behaviors that are health-improving." Patient

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Today, the Center uses a home hub-type mobile device from a firm called MedApps, which accepts short-wave wireless signals from sensors, then sends that to the cloud, where caregivers at the Center pick them up to make medical decisions or educate patients on next steps. But Kvedar is confident that smartphones will play a larger and larger role in medical delivery in the future.

That's true for several reasons, he says. First, smartphones allow caregivers to send messages to the patient with confidence that the patient will receive the message quickly. Second, they can accept data from medical devices, such as sphygmomanometers and glucometers, and feed them to the cloud. "Third, and perhaps most interesting, is that mobile phones as display devices enable mobility for doctors," says Kvedar. In other words, doctors can view a patient's EKG or X-ray on their cell phones, or they can videoconference with patients when necessary. In fact, doctors are using smartphones as much or more than other professionals, he says.

"Every time I can help keep a patient in a low-cost setting instead of a higher-cost one, there will be cost savings."

Lower cost?

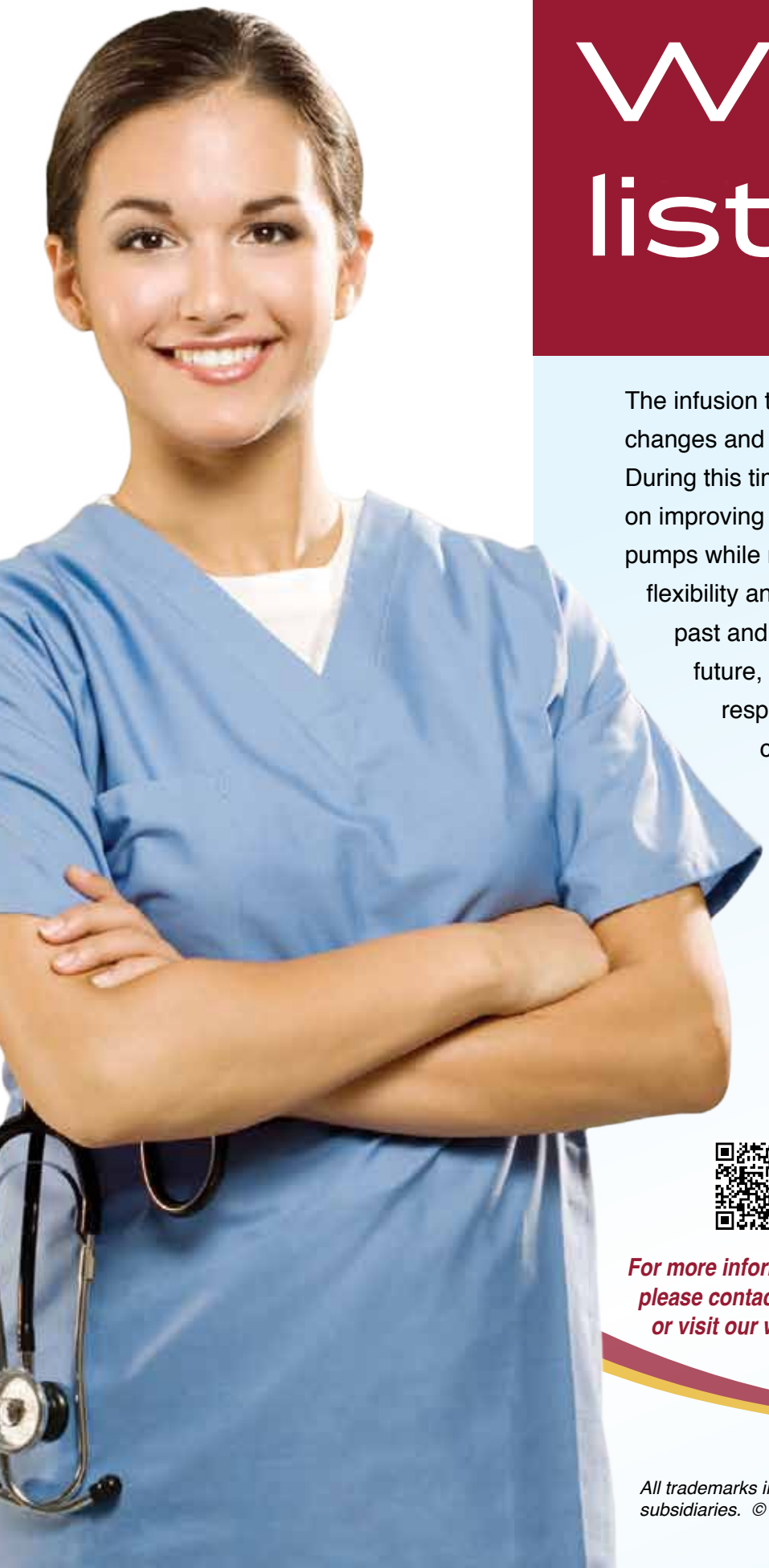
Better patient care aside, proponents believe smartphone technology can lead to reduced healthcare costs. "Under the right payment incentives, there's no question that home monitoring can help reduce healthcare costs," says Kibbe. "Every time I can help keep a patient in a low-cost setting instead of a higher-cost one, there will be cost savings." In Hawaii, Kaiser Permanente used e-mail with patients to reduce the number of face-to-face primary care visits by 20 percent. That meant lower costs for Kaiser and for patients, who were spared the cost of taking time off to drive to the doctor's office. "There's no question about it: Better communications informed by better information saves healthcare dollars."

But reimbursement – or the lack thereof – does pose some problems. "As long as doctors are paid per visit in a piecemeal fashion, and patients don't have accountability for the cost of their care, there isn't any gain from device monitoring," says Kibbe. "However, change the nature of the payment system to create a win-win-win for doctors, patients and the organizations used for care delivery, through shared savings arrangements, bundled payments and gainsharing – and then it becomes obvious that device monitoring can save time, energy and avoid duplication of services.

"So, I'd say, as I always do, that payment reform has to happen first, or at least parallel to the best and most meaningful uses of these new technologies." The American Academy of Family Physicians has been very active in prompting payment reform, he adds.

Avoiding information overload

There's no doubt that the rising incidence of home monitoring, work monitoring and smartphone-anywhere monitoring will generate lots of new data from patients, says Kibbe. That's the good



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news. But that data collection must be well-managed in order for the care team to avoid information overload, or even information chaos, he says.

"Physicians and care teams need to work actively with patients to help them collect and interpret these data, and then act on them accordingly, if we're going to make body monitoring via these devices efficient as well as a means of improving quality of care. In other words, I'm advocating for a participatory approach to this kind of device monitoring, in which patients and their providers – including physicians, nurse practitioners, nurses and pharmacists – are all on the same page with respect to the reasons for monitoring, the value to be achieved, and the improvements in care that are expected."

"The systems that help us interpret these data need to identify trends and signal when the data show something worrisome."

– David C. Kibbe, MD, MBA, senior advisor, American Academy of Family Physicians

Of course, not all the data collected by smartphones is meant to be reviewed by a doctor, nurse or other healthcare professional. Rather, devices can be programmed to sound alarms or otherwise signal caregivers when readings stray outside agreed-on parameters.

The question becomes, "Where should these new streams of data go, and how can you optimize their collection and interpretation so as to achieve the desired improvement in care?" says Kibbe. Caregivers have a generation of experience with home monitoring of blood pressure, blood sugar and, to a lesser extent, weight, he points out. "The systems that help us interpret these data need to identify trends and signal when the data show something worrisome. I'm a big proponent of dashboards and filtering systems that use dynamic presentation layers, like green-yellow-red coloring, to indicate safe and non-safe levels."

Patients directly benefit from the trending data that home monitoring provides, says Derek Kosiorek, senior consultant, Medical Group Management Association. For example, someone monitoring LDL cholesterol can see where they are today vs., say, three months ago. They can see that even if LDL is still high, perhaps it's trending downward. "If the data [demonstrates the need for medical] attention, the doctor will proactively schedule an appointment with the patient. But if it's normal, [the doctor] won't take any action. If we're scheduling a visit or test, it's because we have documented proof that the patient needs assistance. So I'm not concerned about information overload."

And when the patient does come to the office, the physician will have much more information to draw on prior to seeing him or her, he continues. "They'll have accurate and timely information, and they'll be able to make more effective decisions because of it."

"Healthcare is prejudiced toward doing things to people," says Kvedar. "It's something patients and providers gravitate to. There's something a little creepy about Watson [the IBM computer which, famously, competed successfully on the

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game show Jeopardy] being your doctor, even if Watson could do a better job."

But the fact is, "the science and implementation of analytics is way, way, way ahead of healthcare," he says. Retailers like Target and Amazon analyze millions of data points about consumers in order to create better advertising profiles. "We can do that with healthcare data, though we haven't done it more than the first level." Medical software can easily filter out normal from abnormal readings. "We won't overwhelm doctors with meaningless data," he says. "It will get better and better, and more automated. Fifteen years from now, people will get comfortable with that."

Doctors who fail to embrace technology – including smartphone medicine – may lose relevance in the near future.

Tradition

Doctors who fail to embrace technology – including smartphone medicine – may lose relevance in the near future. The Pew study, for example, showed that 30-to-49-year-olds were just as likely as 18-to-29-year-olds to have download a health app. But adults age 50 and older lag behind.

"If you walk into a bank and they pull out a paper ledger, my guess is you'll find another place to keep your money," says Kosiorek. Similarly, physician practices that lack electronic patient portals or that fail to offer remote monitoring may find themselves squeezed aside by more aggressive competitors.

"Many of the doctors I have worked with are concerned they will have to spend time on activities usually performed by their support staff," says Kosiorek. In addition, physicians may find they have more direct contact with their patients outside the office. Messaging is, after all, a key component of portals. "In their mind, they're doing more work.

"But it's hard to argue that this innovation isn't going to make a difference in the patient/doctor relationship – a positive difference when it comes to communication," he adds. Well-managed, it can lead to a more efficient workflow. Support staff can triage patient requests, handing to the doctor only those requests that truly demand his or her attention.

"And doctors shouldn't forget that responding to e-mails is much more than providing great customer service," says Kosiorek. "Via this method of communication, doctors and their patients will be able to form stronger relationships. When you get an e-mail from your doctor, it's like getting e-mail from a celebrity," he says, only half-joking. "Interaction with patients improves their healthcare. And doctors have to understand that the communication they have with their patients provides more than comfort. This type of communication helps to strengthen the doctor/patient relationship and could ensure that the patient remains a life-long client."

The FDA's role

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and perhaps lead, say experts. "There's no question the FDA is constantly looking for the appropriate way to interact with this technology and its clinical components," says Kibbe. "I wouldn't be surprised at all if we find a somewhat stronger position from the FDA as smartphones begin to do things that make them more like medical devices."

The FDA may get more involved with regulating the software used to transfer, store, convert and display medical data than with the hardware, says Kvedar. "What if the software on your mobile phone has a bug and doesn't expose high blood-pressure readings, so you're going along thinking you're fine, and your blood pressure is [abnormally high] 10 days in a row?" The agency wants to ensure that remote systems are sound, does what they say they will do, and protect patients' privacy.

"It is clear the FDA is moving to regulate mHealth applications, and this will only raise the bar for players planning to enter and make this new market," says Gucciardi. But the challenges of making smartphone medicine part of the healthcare landscape are broader than that.

"Smartphones and tablets are already utilized in the home for consumer healthcare applications," says Gucciardi. "The question is, again, whether and to what extent these devices will be used to record and transmit diagnostic data, not only for the personal consumption of the patient but also as a part of the provider's management of the patient's care. While there are hurdles to overcome for both the patient, including simplicity and cost (consider the demographic and their tech-friendliness), and for the provider, including workflow and reimbursement, very gradually these hurdles are being overcome. The final solution may or may not include consumer devices, because other technology solutions may better lend themselves to meeting the complex needs of this new care paradigm.

"The hurdles indeed include regulatory and payer/reimbursement issues, and the technology needs to be mindlessly simple to realistically enable deployment on any significant scale in the target home demographic."

"The question is, again, whether and to what extent these devices will be used to record and transmit diagnostic data, not only for the personal consumption of the patient but also as a part of the provider's management of the patient's care."

– Scott Gucciardi, executive vice president, chief marketing officer , Welch Allyn

What's next?

"One thing is clear," says Gucciardi. "Smartphones and tablets will continue to get smarter, smaller, lighter, faster and cheaper, and will continue to proliferate so that nearly every individual will have one, much the same way the cellphone market evolved. What will be exciting is that the technological innovation will continue to amaze us.

"A recent example is Apple's Siri on the iPhone 4S. While subject to some criticism in its beta version, just imagine the possibilities as this technology gets smarter and eventually perfected. Some day your smartphone/tablet may anticipate your every need, including healthcare needs, such as managing your conditions, meds, vital signs, diet, exercise, provider interactions, etc. And perhaps this will all be done without you lifting a finger." **JHC**






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By Robert T. Yokl

Breaking Down Silos

Is this still a hospital supply chain challenge?

"(Breaking down silos) of constituent politics – the bringing together of the various stakeholder groups – and guiding them toward a common mission," as stated by Michael J. Dowling, Harvard School of Public Health, is still a big challenge for hospital, system and IDN supply chain executives. This situation has gotten significantly better over the last few years, but not good enough for the healthcare challenges we face now and in the future.

Too often supply chain executives shy away from these conflicts and misalignments, but handling constituent politics is the key to your success in the new healthcare economy. As we move from the notion that it's OK for some clinicians, surgeons, and department heads that are politically connected to buy almost anything they want, to an era when all constituents must be accountable for what they buy, these silos must be broken down.

Every hospital, system and IDN has their silos that are holding back progress because these constituencies believe they have all of the answers.

If your senior management won't support you in these "breaking down silos" efforts, then you must take on this challenge

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yourself or risk becoming irrelevant. One way I have found to be very effective in doing this was to build personal relationships with these politically connected constituents by getting on committees (e.g, infection control, surgical, capital, etc.) that they chaired or on which they were members. This way I could interact with them as a peer and then relate to them as individuals.

as team leaders on value analysis teams. One time we did this with a director of surgery who wasn't keen on our PPI initiative, and who turned out to be one of the biggest supporters of our value analysis program. Why? Because he called the shots and was in control of his destiny!

What I just talked about is a reality at every healthcare organization in the country.

I remember one IT director who tried to stand his ground on a questionable software purchase, and who had to give in to the majority rule when he couldn't figure out a reason why he shouldn't bid this purchase.

These interactions enabled me to get them to answer my phone calls or schedule appointments to discuss burning issues.

The second way I was able to break down silos was to appoint these individuals to value analysis teams, where they had to value justify their purchases to their peers. I remember one IT director who tried to stand his ground on a questionable software purchase, and who had to give in to the majority rule when he couldn't figure out a reason why he shouldn't bid this purchase. There is nothing like peer pressure to break down silos.

Lastly, another way I found that works to smooth the road is to appoint these individuals

Every hospital, system and IDN has their silos that are holding back progress because these constituencies believe they have all of the answers. Our job as supply chain executives is to break down and chip away at these silos until they are permanently removed.

If your senior management won't help remove these obstacles to your success, don't believe for a moment that this same management still won't hold you accountable for the cost and quality issues that are being blocked by these politically connected individuals. Be proactive vs. reactive to avoid this unpleasant "Catch 22" scenario that could be coming your way! **JHC**

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