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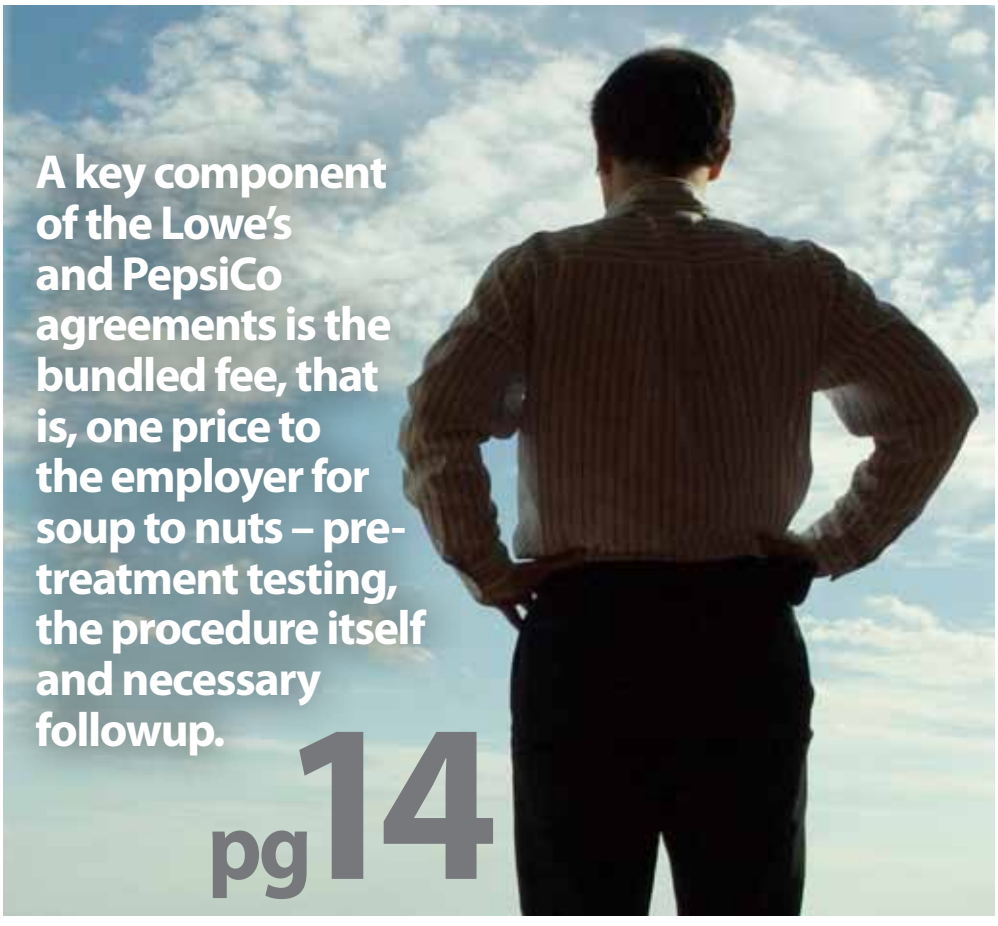

Nurse practitioners: Newest members of the IDN family?

Nurse practitioners are in the public eye; now a growing number are managing their own practices.

When Robert Smithing and a partner sought out bank loans to open their practice in the mid-1980s, they met some resistance. "Nurses don't fit into our model of opening up a practice," loan officers told Smithing and his partner, both nurse practitioners. It wasn't until they met with a loan officer with a family member who was a nurse practitioner, and who understood what nurse practitioners do, that they were able to get the loan and launch their practice. Today, after several iterations, including a spell under the ownership of another corporation – that practice – Family Care of Kent, Kent, Wash. – is thriving, with a staff of four nurse practitioners and several medical assistants and office staff.

"There weren't a lot of nurse practitioner groups in 1985," says Smithing. "We opened our doors to demonstrate that consumers would be interested in seeing a nurse practitioner, even in suburban areas where they had access to other types of care.

"Was it risky? Yes. But from our perspective, we knew nurse practitioners provide excellent care, and that patients would love to see us." Turns out they were right.

In the public eye

There are approximately 150,000 nurse practitioners in the country. Though it is difficult to determine how many own their own practices, signs point to the growth of a new type of customer for med/surg distributor sales reps – the nurse-practitioner-owned and -managed clinic. Here's why.

- The public is more aware of and comfortable with nurse practitioners than ever before, given their presence in hundreds of retail clinics in Walgreens, CVS, Krogers and other retail/grocery outlets.
- Nurse practitioners may be in demand more than ever if, as expected, as many as 30 million Americans enter the healthcare system as part of healthcare reform.
- People appear to be seeking out more personalized care than they typically find with in-and-out, lightning-quick visits with their family doctors, who already find themselves overworked and, in the opinion of many of them, underpaid.

Setting up practice is a popular topic in state and national nurse-practitioner conferences, notes Jill

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Olmstead, MSN, NP-C, who practices in a large multispecialty physician practice at St. Jude Heritage Healthcare, Fullerton, Calif., a ministry of St. Joseph Health System. She is also president of the American College of Nurse Practitioners. "It's a wonderful opportunity."

What is a nurse practitioner?

Nurse practitioners are registered nurses who are prepared, through advanced education and clinical training, to provide a wide range of preventive and acute healthcare services, according to the American College of Nurse Practitioners. They complete graduate-level education leading to a master's degree, and virtually all of them maintain national certification.

The first nurse practitioner program was developed at the University of Colorado in 1965. "Early on, [nurse practitioners] gravitated toward serving more of an underserved population," says Tine Hansen Turton, CEO, National Nursing Centers Consortium, an organization supporting the growth and development of more than 250 nurse-managed health centers. "Just as we're talking about the workforce problem and access to primary care today, we've had that problem for 40 years or more."

The number of nurse practitioners grew as more schools of nursing developed programs. Even today, as many as two-thirds of the Consortium's members are academically affiliated, run by schools of nursing. But the movement toward independent, nurse-practitioner-owned practices is gaining steam. It has only been within the last five or six years that the insurance industry has truly embraced such practices, she says.

The scope of a nurse practitioner's duties depends to a large extent on the state in which he or she practices. In about half the states, nurse practitioners must have a "collaborative physician" of record, that is, a physician who serves as a "quality control" check, and with whom the nurse practitioner consults when questions arise. But many states – approximately 20 – have no such requirement. And today, all 50 states grant nurse practitioners the right to prescribe medications.

The number of nurse practitioners grew as more schools of nursing developed programs. Even today, as many as two-thirds of the Consortium's members are academically affiliated, run by schools of nursing.

According to the ACNP, nurse practitioners take health histories and provide complete physical examinations; diagnose and treat common acute and chronic problems; order and interpret laboratory results and X-rays; prescribe and manage medications and other therapies; provide health teaching and supportive counseling with an emphasis on prevention of illness and health

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maintenance; and refer patients to other health professionals as needed.

Almost half of nurse practitioners focus on family practice, with another 20 percent focusing on adult practice. The remainder specialize in such things as women's health, pediatrics, gerontology, acute care, neonatal care, oncology and psychiatric health, according to the American Academy of Nurse Practitioners.

Metro Medical Direct

Raymond Zakhari, EdM, MS, ANP-BC, FNP-BC, founded Metro Medical Direct in Manhattan three years ago. He graduated in 2003 with a master's degree in the adult nurse practitioner field, and subsequently received a master's in nursing education in health behavior counseling. He completed a post-master's program to complement his family practice training, and completed his boards with the American Nurses Credentialing Center, which is a subsidiary of the American Nurses Association.

An Air Force deployment to Baghdad and work as a traveling nurse gave Zakhari an appreciation of how much medical care could be delivered portably.

An Air Force deployment to Baghdad and work as a traveling nurse gave Zakhari an appreciation of how much medical care could be delivered portably. Living in Manhattan, he sensed an opportunity. "Manhattan is a walker's town; it's not car-friendly," he says. People who live in New York are used to having goods and services, such as their groceries, delivered to their homes or apartments.

While working through a health issue of his own, Zakhari was struck by two things. First was the complexity of the healthcare system. "I can advocate pretty well for myself," he says. But even so, he found the system complex, with doctors and specialists unable or unwilling to communicate and coordinate care.

The other thing? "It takes half a day to go to the doctor's office for an appointment that lasts 10 minutes. It's tiring and time-consuming." Not to mention the fact that in order to see the doctor, typically between the hours of 8 or 9 am and 4 or 5 pm, Zakhari himself would have to cancel his own patients. It's a hardship for any working person.

"So I built a virtual practice," he says. Patients schedule appointments online, and Zakhari goes to their hotel, apartment or home to deliver care, bringing an array of medical supplies and devices, as well as a laptop with a wireless modem. "People don't come to see me to get out of work; they come to see me because they love to work," he says. "You don't have to take off a half day to see me.

"I developed a model that uses the patient's bricks and mortar," rather than incurring the cost of an office of his own, he continues. New York has a well-developed system of home-based medical services, such as imaging, EKGs and other

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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.

diagnostic testing, "so I've been able to work with them." Zakhari supplements home visits with e-mail and web camera sessions.

"It's a convenient primary care option for people in Manhattan, including residents, travelers and visitors, he says. But he prefers the home-based approach for another reason. "I get to see the patient in their context. I can appreciate their struggles of moving around, getting from the bed to the bathroom, for example, which may explain incontinence."

It's a model that many physicians are either unwilling or unable to duplicate. Most physicians who make house calls tend to treat them as an adjunct to their office-based practices, points out Zakhari. What's more, physicians' malpractice insurance costs typically are higher than those of nurse practitioners, so the cost of their house calls are high.

Zakhari provides a broad range of services, including general comprehensive physical exams; geriatric assessment and care plan development; management of chronic conditions, such as diabetes, high blood pressure and high cholesterol, congestive heart failure; anticoagulation management; wound care; men's health; and treatment of a variety of acute medical problems, including flu, infections, sprains, back pain, pink eye, pneumonia, gastroenteritis and sexually transmitted infections.

"My patients text me when they have a problem; we do webcam followups," he says. "They feel they can be in touch with me. And I have a small enough panel, where I actually know them."

Zakhari developed a program called Intensive Primary Care, whose aim is to reduce hospitalization and hospital readmissions, primarily among elderly people with chronic medical issues. Zakhari visits the patient on a regular basis (making sick visits as needed). "The purpose is to identify high-risk times and events that may lead to a hospital admission, and to become sufficiently familiar with the patient's caretakers to establish a good rapport with them, so that subtle changes are picked up sooner and mitigated."

"My patients text me when they have a problem; we do webcam followups. They feel they can be in touch with me. And I have a small enough panel, where I actually know them."

– Raymond Zakhari, EdM, MS, ANP-BC, FNP-BC, founder, Metro Medical Direct

Family Care of Kent

Nurse practitioners tend to pride themselves on their emphasis on health maintenance and patient-centered care. "Nurses practitioners were talking about 'medical homes' 15 years ago," says Turton.

"The captain of our team is our patient," says Smithing. "We listen, we care, and that's why people come to see us. And with chronic illnesses,

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our patients do particularly well, because we use a nursing model of care, which enables our patients to assume more responsibility for their care. They stay healthier."

Studies have shown that the quality of care delivered by nurse practitioners can be as good as or better than that delivered by MDs, and less costly, says Smithing. Patients newly diagnosed with a chronic illness, for example, may see the nurse practitioner more often than he or she would see a doctor, at least initially. But at least one study of congestive heart failure patients showed that even though the cost of ambulatory visits was higher, the patients took fewer medications, had fewer hospitalizations, and had a higher quality of life than those cared for by physicians, he says.

Studies have shown that the quality of care delivered by nurse practitioners can be as good as or better than that delivered by MDs, and less costly.

While primary care doctors feel pushed to the limit to see more patients, nurse practitioners can avoid that treadmill, says Smithing. Nurse-practitioner practice owners have the flexibility to match their practice with their lifestyle choices. "We make sure we schedule time for same-day acutes, so I'm not trying to get 60 patients in my schedule a day," he says. "We plan for that." And Family Care of Kent staggers its shifts, so that two of the four nurse practitioners work on Monday, two on Friday, and all four on Tuesday, Wednesday and Thursday. "We have three-day weekends. That helps us with our home life, and gives us time off to recover."

Reimbursement

Reimbursement has been a challenge for nurse practitioners, but that's changing. Smithing, for example, says that Medicare reimburses nurse practitioners at 85 percent of the physician scale. It's not ideal, he says, but it's something. Medicaid, on the other hand, reimburses nurse practitioners at the same rate as physicians. Most – but not all – insurers do too.

Though the vast majority of his patients have insurance, Zakhari bills them directly. The patient then seeks reimbursement on his or her own. He finds that doing so is not only easier from an administrative point of view, but can actually lead to a better experience for both patient and nurse practitioner. Because they pay Zakhari directly for the care they receive, "they're as incentivized as I am to get a good outcome," he says.

Nurse practitioners typically are directly involved in equipment and supply purchasing for their practices. Olmstead speaks of one colleague who was personally involved in purchasing everything from latex gloves to otoscopes to exam tables.

Like any customers, nurse practitioners value sales reps who look out for their practice. "Don't push us," says Smithing. "Educate us. Provide us with information. We love it. And deliver on what you promise. Follow through. If you can't make it happen, let us know. We get life. **JHC**

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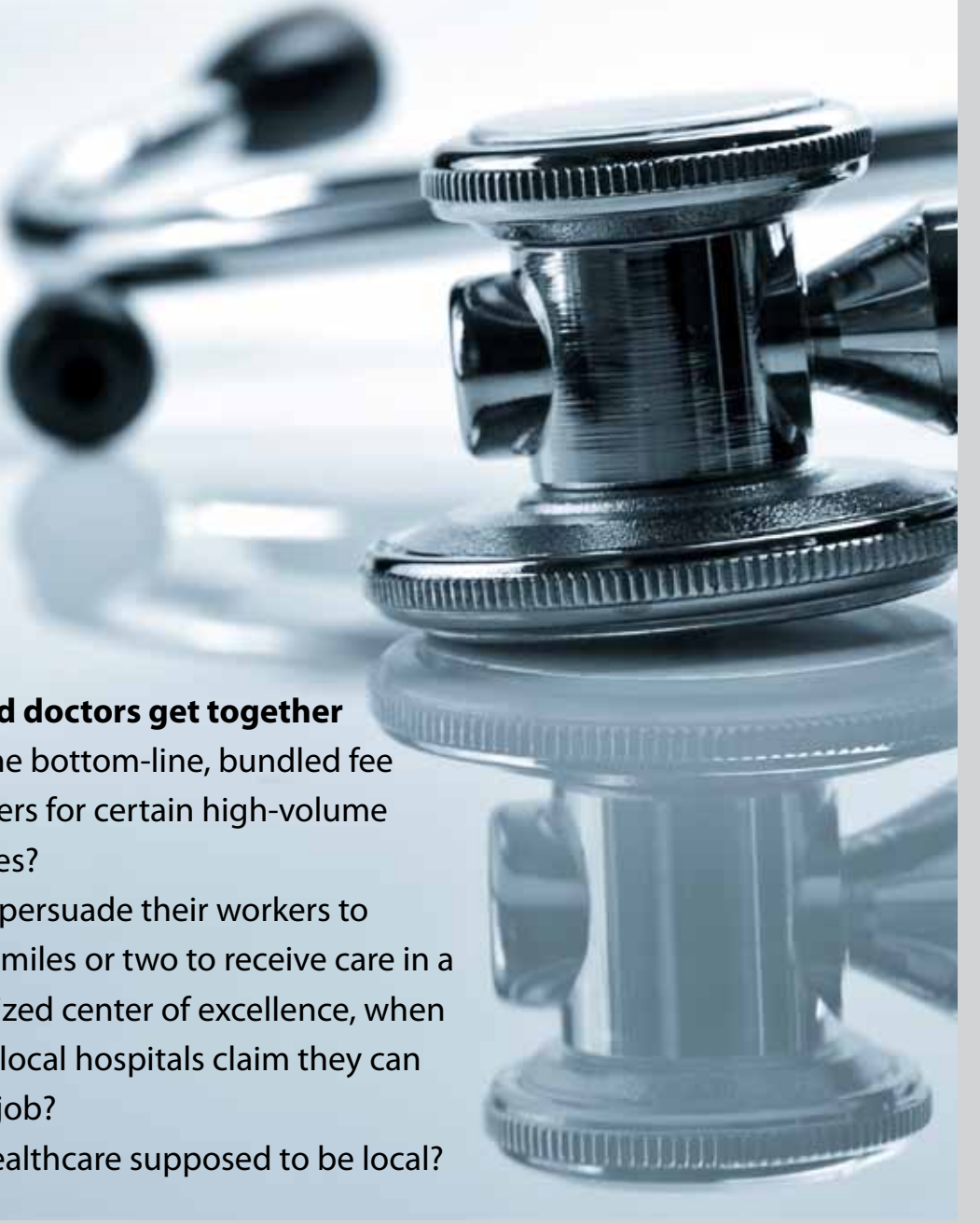
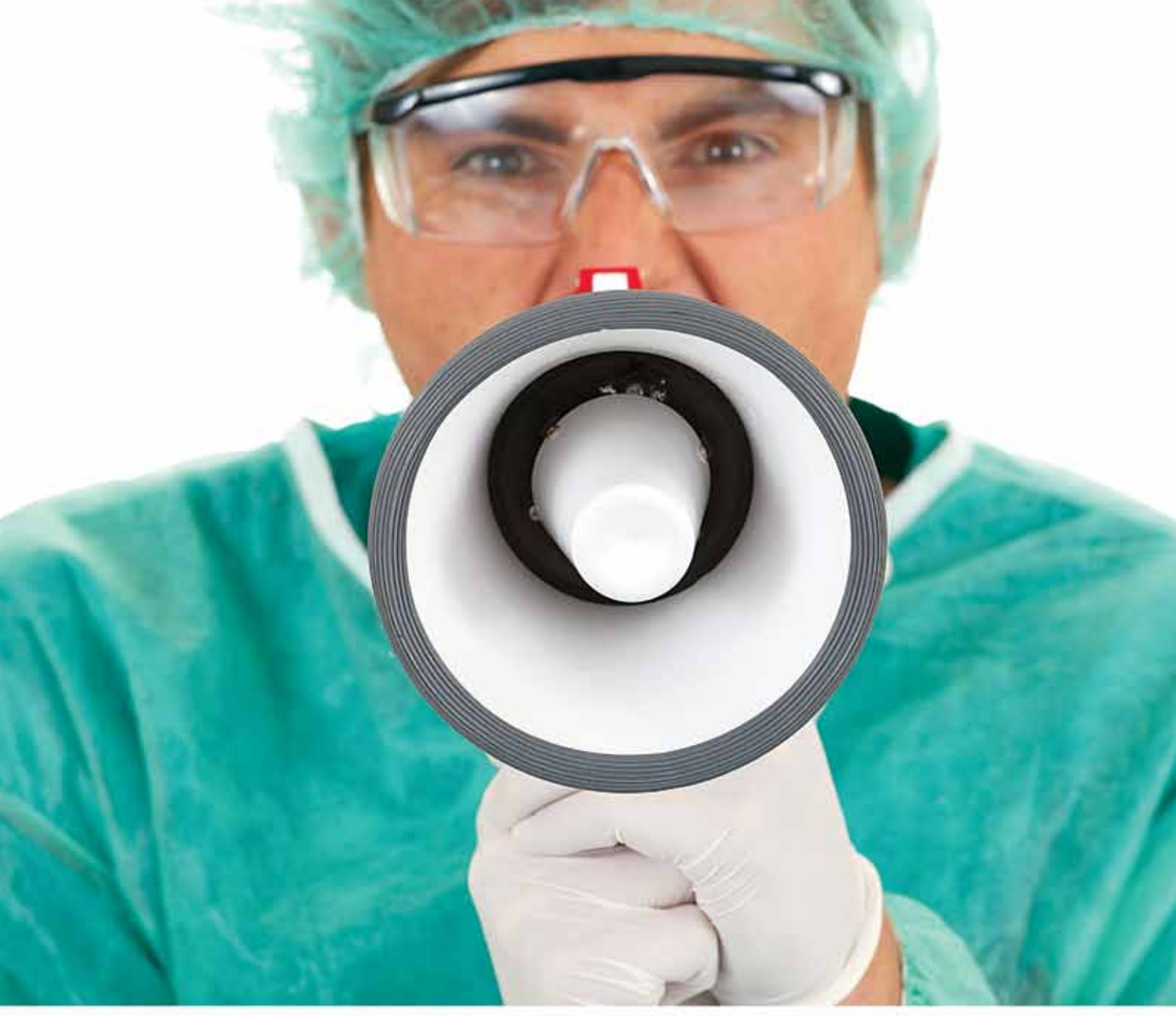


Can hospitals and doctors get together to hammer out one bottom-line, bundled fee to charge employers for certain high-volume surgical procedures?

Can employers persuade their workers to travel a thousand miles or two to receive care in a nationally recognized center of excellence, when those employees' local hospitals claim they can do just as good a job?

And say, isn't healthcare supposed to be local?



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A high profile agreement signed last December between PepsiCo and Johns Hopkins Medicine, signed two years after an equally heralded agreement between Lowe's Companies and Cleveland Clinic, has raised these questions and others.

Johns Hopkins and PepsiCo

In December 2011, Johns Hopkins Medicine signed an agreement with PepsiCo to provide PepsiCo employees the option to travel to Johns Hopkins in Baltimore, Md., for cardiac and complex joint replacement surgeries. PepsiCo, which sponsors its own self-funded medical plan, waives deductibles and coinsurance for those employees who elect to have their surgery at Johns Hopkins. The company also covers the travel and lodging expenses to Baltimore for the patient and a companion. The payment methodology for these procedures is an all-inclusive, bundled rate for hospital and physician charges and certain preoperative testing.

"We're offering their employees some of the best healthcare available, which should mean fewer complications and should result in employees being able to return to work sooner," Patricia M.C. Brown, president of Johns Hopkins HealthCare LLC, the managed care arm of Johns Hopkins Medicine, said at the time the agreement was signed. "At the same time, we're offering PepsiCo predictability regarding cost."

Almost two years earlier – in February 2010 – Cleveland Clinic and Lowe's signed a similar deal, in which Lowe's full-time employees and their covered dependents enrolled in the company's self-funded medical plan could elect to schedule qualifying heart surgery procedures at the Cleveland Clinic in Cleveland, Ohio. Like the Johns Hopkins/PepsiCo program, the Lowe's plan covers all medical deductibles and coinsurance amounts as well as travel and lodging expenses for the patient and a companion, plus concierge services to make the arrangements.

"We believe that having the correct diagnosis, combined with surgery by the undisputed leaders in this field, will produce the highest-quality outcomes for our employees."

– Bob Ihrie, Lowe's senior vice president of employee rewards and services

"We believe that having the correct diagnosis, combined with surgery by the undisputed leaders in this field, will produce the highest-quality outcomes for our employees," Bob Ihrie, Lowe's senior vice president of employee rewards and services, said at the time.

More to come

"Large national employers are saying, 'I have a cost problem and I need to be more creative about solutions and taking on that responsibility directly, on the advice of their payer partners

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and/or HR consultants," says Brown.

"I see more of these agreements in the future," adds Helen Darling, president and CEO of the National Business Group on Health. "The pressures on employers are such and the concerns about controlling cost and improving quality and safety lead them to think in terms of selecting centers of excellence for selected procedures. This isn't across the board, but it is for conditions and procedures that a hospital is particularly good at or experienced in." The National Business Group on Health is a non-profit organization that represents large employers' perspective on national health policy issues.

"All major insurers have various centers-of-excellence programs, which are available to their members," says Eric Grossman, senior partner at Mercer Health & Benefits LLC and a consultant in the company's U.S. health and benefits business. "The primary differences with the Lowe's and PepsiCo model are: very narrow center of excellence (one hospital), travel benefits and services, and the bundled payment methodology." Mercer works on behalf of large employers interested in centers of excellence programs, says Grossman.

The bundled dilemma

A key component of the Lowe's and PepsiCo agreements is the bundled fee, that is, one price to the employer for soup to nuts – pre-treatment testing, the procedure itself and necessary followup. It's a concept that Medicare is pushing, but one that hospital systems and physicians have experienced some difficulty developing.

"One criteria [for bundling] is, 'Is it easy to identify services that should be in the bundle vs. outside it?'" says Peter Hussey policy researcher at the RAND Corp., a nonprofit research organization. Conditions or procedures that are very discrete, and that have clear beginnings and fairly clear end points – such as many cardiovascular and orthopedic procedures – lend themselves to bundling, he says. What's more, surgeons and hospitals already receive global payments for cardiovascular and orthopedic procedures, so it's not much of a stretch to arrive at a bundled fee that encompasses both, he adds.

A key component of the Lowe's and PepsiCo agreements is the bundled fee, that is, one price to the employer for soup to nuts – pre-treatment testing, the procedure itself and necessary followup.

But bundling can be difficult to pull off from a technical perspective, says Hussey. One challenge for providers is the fact that they still handle plenty of fee-for-service claims. "Not every patient is subject to the bundle; not every condition is bundled; not every payer is [seeking bundled-payment agreements]." Providers may find it difficult to balance two different delivery and payment systems simultaneously.

Another issue is the difficulty of convincing providers that cost-cutting measures will not reduce the quality of medical care. This was a point

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that RAND made in a study released last year, of which Hussey was lead author. Can hospital administrators and surgeons work together to reduce the cost of some of the implants used in certain procedures? Will physicians be mistrustful that administration is pressuring them to change the implants they use based on cost rather than clinical outcomes?

Proponents of bundling believe that the approach can lead to better, more efficient care, and might help providers receive compensation for services that might not be accounted for in fee-for-service arrangements. For example, the bundled fee might include the cost of a case manager contacting patients following their procedure to ensure that their recovery is proceeding as planned. Not only can this constitute better care, but it can result in savings too, in that the patient may be less likely to be readmitted for the same condition, says Hussey.

Bundled agreements with centers of excellence often yield higher-quality care at either the same or less cost than traditional fee-for-service deals, says Darling. One reason is that better care can lead to fewer complications for the patient. So even if the actual unit cost per procedure is the same as that of a fee-for-service equivalent, there may be less need for rework or readmissions.

Employers are attracted to bundled agreements with centers of excellence for a couple of additional reasons, says Darling. "There's improved productivity – people are back to work faster," she says. "And frankly, there's a goodwill factor for employees and their dependents, who feel that their company cares so much about them that [the company] is willing to spend extra money upfront – by eliminating copayments, deductibles and travel costs – for their care."

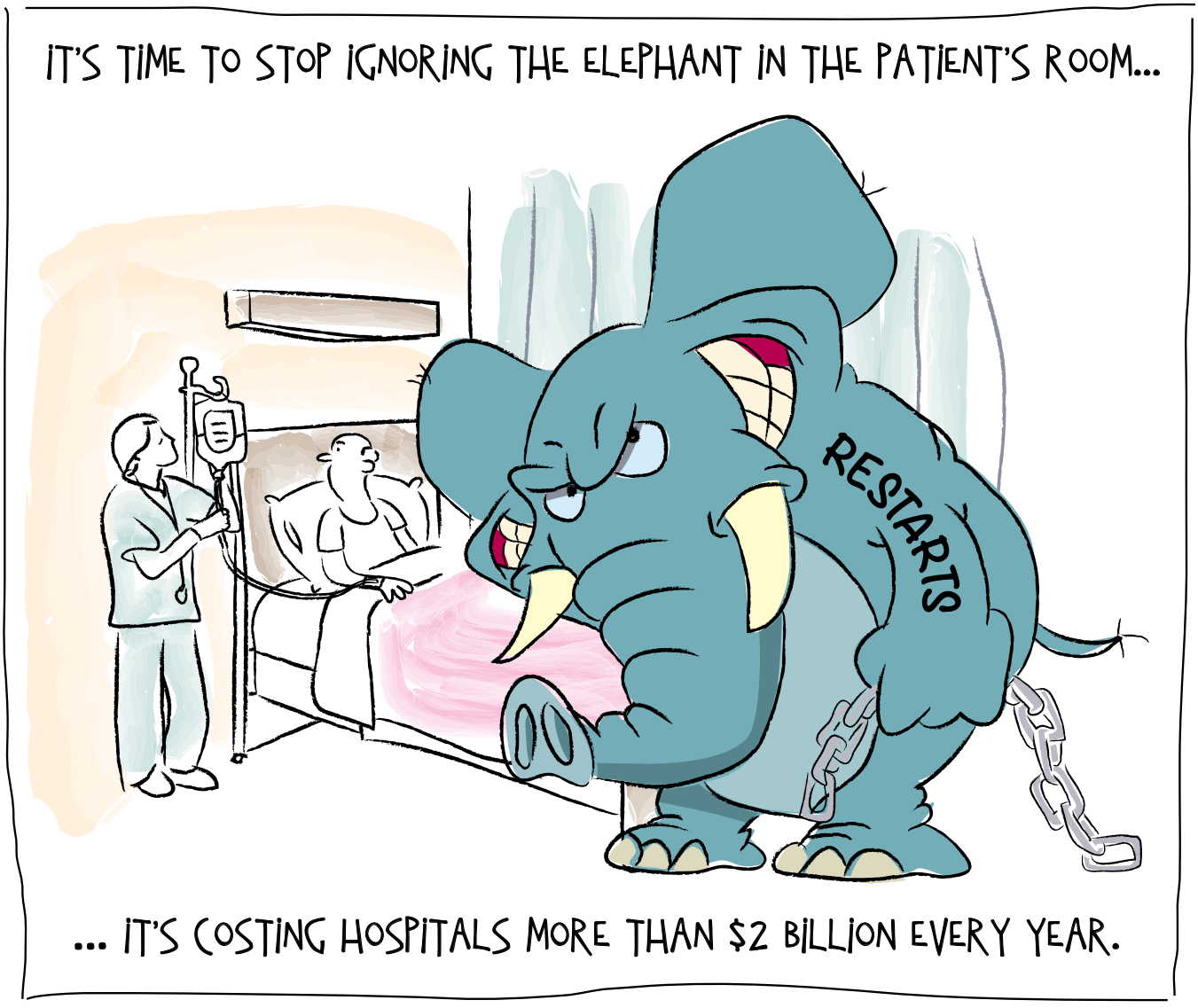
"The good news for IDNs is this: Once they've made the initial investment in training, setting up protocols, and developing expertise in contractual and legal issues, they can usually replicate the procedure with multiple big employers."

– Helen Darling, president and CEO of the National Business Group on Health

Big demands on IDNs

Many IDNs may experience a learning curve developing and marketing bundled-payment deals, particularly if they're going to deal directly with large employers. "Very large employers tend to be very sophisticated purchasers, and they expect a level of service that may not be typical," says Darling. "They feel, 'If we're going to be sending you a lot of patients, we expect a lot of services that aren't routine.'"

IDNs that want to get into this game must develop top-of-the-line customer service, she adds.



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Successful IDNs usually have a team of people in place to handle the issues that arise with direct-to-employer deals. The good news for IDNs is this: Once they've made the initial investment in training, setting up protocols, and developing expertise in contractual and legal issues, they can usually replicate the procedure with multiple big employers, she says.

The success of these programs – both for the hospital system and the employer – lies in correctly pricing the bundled fee. That might not be as big a problem as one might expect.

"We agree [setting up bundled programs] is challenging, but there is very significant activity in this area from all major carriers," says Grossman. "We did not run into significant barriers with developing the bundled payment approach for the center-of-excellence program."

Hospital systems can look to their cost accounting systems to guide them when developing a bundled fee, adds Darling. And they can decide how much they want to add for the additional services that centers-of-excellence programs with employers demand. Meanwhile, employers already have a pretty good idea of how much certain procedures cost, including cardiovascular or orthopedic surgeries. They will use that knowledge in their price negotiations.

Hospital systems can look to their cost accounting systems to guide them when developing a bundled fee. And they can decide how much they want to add for the additional services that centers-of-excellence programs with employers demand.

Being physician-owned, Cleveland Clinic may be ahead of other IDNs insofar as hammering out bundled agreements. But it turns out that Johns Hopkins has a leg up as well.

"We've been in the bundled care business 15 years," says Brown. "It's not unusual for us to entertain these kinds of contracts. Some of the major national payers – United, Cigna, Aetna – have been interested in bundling certain very high-cost procedures, such as transplant, cardiovascular procedures, bone marrow procedures." The fact that Johns Hopkins has its own managed care plan – John

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Hopkins HealthCare – has forced the IDN to develop innovative payment models in conjunction with its physicians. "The unique thing about the PepsiCo agreement is that it is a direct-to-employer deal vs. [an agreement] with a major national health insurer," she says.

Is healthcare local?

Bundling may be a part of the healthcare landscape for some time to come, as illustrated by the fact that the Centers for Medicare & Medicaid Services announced a voluntary national bundled payment initiative in August 2011. And some observers believe that national centers-of-excellence agreements, which include bundled fees, will also multiply in number. But selecting such centers of excellence will always be a moving target.

"If you go back 20 years, you'll see a list of procedures, including cardiac surgery, that have become so routine you don't need a [national] center of excellence," says Darling. "Once that happens, there's no reason to spend extra time and money to [have procedures performed] outside the local community. But the trick is knowing when that occurs."

Is healthcare local? Perhaps not so much as some think. "Many top hospitals get a significant percentage of their surgical patients from outside their immediate service area," points out Grossman.

"I think the answer is still out there," says Brown, responding to the question. "The PepsiCo deal got a lot of attention, but the jury is still out on whether or not it will work." Yes, patients can be assured of receiving care from a high-quality provider, in this case, Johns Hopkins. But will they be willing to get on a plane and travel to Baltimore, when their local hospital is saying it can provide the same service?

"Somebody's going to do something. Costs are out of control, [desirable] quality is not being achieved. Employers – and they're the ones writing the checks. – are saying, 'We're going to see if we can see steer business to providers where we can get the best value.'

"If an employer feels that limiting access, or creating more regional or national access, is a way of reducing cost, they'll pursue that," she says. "There's no doubt that some health systems are really working to differentiate themselves from a value perspective.

"Somebody's going to do something. Costs are out of control, [desirable] quality is not being achieved. Employers – and they're the ones writing the checks. – are saying, 'We're going to see if we can see steer business to providers where we can get the best value.'

"We've only gotten a few referrals since this [agreement with PepsiCo] was signed, which is what we expected initially. It will be interesting to see." **JHC**

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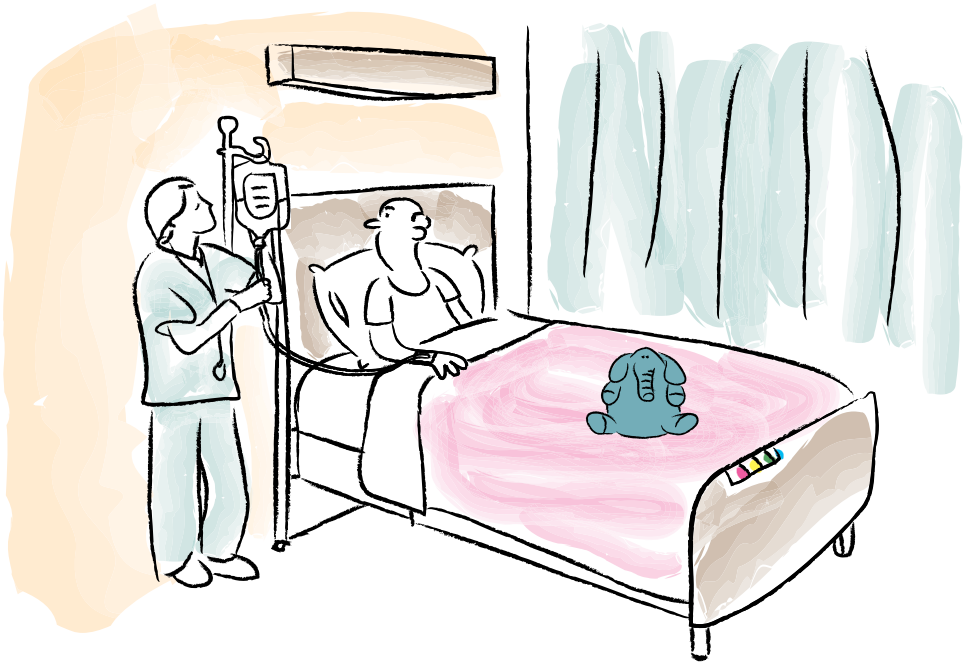

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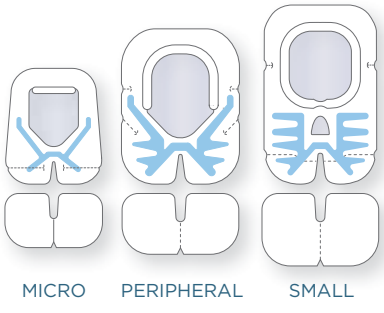

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Are suppliers getting the hang of outcomes-based selling?

Contracting executives are demanding that salespeople go easy on the features and heavy on the – provable – benefits. And suppliers are getting the message.

IDN supply chain professionals are demanding that manufacturers and distributors approach them differently. That's no surprise, given the challenges providers face, including value-based purchasing, penalties for hospital readmissions, all the attention being paid to serious reportable ("never") events, and, of course, never-ending cost constraints.

"I've been in healthcare 25 years, and I don't recall a time when hospitals were under this much pressure, particularly the metrics around value-based purchasing and diminishing reimbursement," says Richard Blackburn, vice president, support services, CaroMont Health, Gastonia, N.C. "Our expectations of distributors and [manufacturers] are evolving, just as the economic environment is evolving. Distributors and manufacturers have to get away from selling on features."

"I believe we are in the beginning stages of a major change, where all supply system members are currently identifying what role we should play in our common purpose of patient-centered care," says Ray Seigfried, senior vice president, administration, Christiana Care Health System, Wilmington, Del. "Materials resources – supplies, medication and clinical equipment – make up between

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15 percent and 20 percent of a hospital's total expense, a significant factor to the operation of every hospital. That's why the [Christiana Care's] Value Institute sees opportunity in redesigning the relationships between manufacturers, distributors, GPOs and hospitals, all of whom serve patients and can make a meaningful contribution to healthcare reform sustainable." The Value Institute designs and studies effective, evidence-based systems of care that deliver better outcomes at lower costs.

Demand-driven

To be sure, Seigfried sees the big picture in healthcare. Perhaps that's not surprising, given his broad areas of responsibility, including the departments of pharmacy, pathology and laboratory medicine, EEG, EMG, clinical engineering, pastoral services, nutrition and food services, textile services, the Sleep Center, not to mention materials management. In addition, Seigfried is a member of the International Society for Systems Science and the System Dynamics Society, an international, nonprofit organization devoted to encouraging the development and use of system dynamics and systems thinking around the world.

"As a supplier of IV products and disposables, we have to work closely with our customers to ensure our products are helping them address the everyday issues they are faced with," including medication errors, clinician and patient safety, and environmental issues."

– Erik Graaf, director of marketing, hospital care, B Braun Medical Inc.

Suppliers seem to be responding to these new realities. "Everyone at Sage is focused on 'simple interventions that yield extraordinary patient outcomes,'" says Steve Anderson, vice president, corporate accounts, Sage Products, paraphrasing the company's tagline. "Measuring the clinical and financial impact of interventions has a real impact on the healthcare-acquired conditions that providers are trying to avoid."

"As a supplier of IV products and disposables, we have to work closely with our customers to ensure our products are helping them address the everyday issues they are faced with," including medication errors, clinician and patient safety, and environmental issues, says Erik Graaf, director of marketing, hospital care, B Braun Medical Inc.

"Change really starts with us, that is, hospital executives," says Seigfried. "That's one reason Christiana Care Health System created the Value Institute. Those of us who have responsibility for materials management believe that clinical technologies need to have value not in and of themselves, but more so, in how they improve patient outcomes."

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— Geoff Brenner, president and chief executive officer, Texas Purchasing Coalition

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Seigfried talks about a new, broader way of looking at provider/supplier relationships, opting to use the phrase "supply system" instead of "supply chain."

"What's the difference?" he asks. "Systems are not the sum of their component parts, like one would understand a series of chain links. They're interdependent, holistic and organic."

Providers have to do their part to turn systems thinking into concrete action, says Seigfried. For example, they need to move from a supply-driven materials process to a demand-driven one. Hospitals have "overplenished" their inventories for years, just in case, he says. "That's our contribution to waste. Now, we must switch to a demand-driven approach. But in order for that to work effectively, all system members must forge a new relationship." Other industries already have become demand-driven, says Seigfried, citing electronics company Apple as a prime example. "That is the model that healthcare needs to learn from, and it will be achieved through a closer relationship between all system members.

"I think we're in the Stage 1 of development. For us to be successful, hospitals like us will have to work with manufacturers and distributors and address questions such as, 'How do we stop overplenishing the system, and what role does the manufacturer, the distributor and the hospital play?' I haven't figured all that out yet. But I'm on the track of asking these questions, and trying to get others to join me in the dialogue."

Big-picture thinking has practical ramifications on how Christiana Care evaluates medical technologies, such as clinical equipment. "Prior to this thinking, we would simply evaluate technology in terms of the acquisition cost and quality," says Seigfried. "Today, the factors are quality, outcome, safety and cost. So in other words, we're not looking at value relative to the technology itself, but value relative to the course of care for the patient." Christiana Care will pay more for a piece of equipment, for example, that can help clinicians reduce the time it takes to make accurate diagnoses, or that can support quicker turnaround times in the emergency department. "The question now is, 'What is the value relative to the patient?' It's a totally different thought process."

"Ten or so years ago, providers looked at the price of products as the primary way to reduce costs. If it was a good product, if the features were there and the clinicians liked it, we would buy it, so long as the price was good."

– Richard Blackburn, vice president, support services, CaroMont Health

Providers' growing demands

Blackburn says that providers' decision-making processes have evolved over the years, with definite implications for suppliers.

Ten or so years ago, providers looked at the price of products as the primary way to reduce costs, he says. "If it was a good product, if the features were there and the clinicians liked it, we would buy it,

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so long as the price was good," he says. Then, providers' thinking evolved. More than just the purchase price, they began investigating the impact of a new product or piece of equipment. "That's the benefit piece," he says. Clinicians, finance, materials and others came together to ask, "What are the actual benefits of this product? What will it do for us?"

Fast forward a couple of years, and providers grew more demanding of the sales reps who called on them. No longer would they accept the rep's claims that a product could, for example, reduce infections. "The reality today is, if a rep walks through the door and says, 'My device will reduce infections or improve quality,' I want hard, empirical evidence that will, in fact, happen," says Blackburn.

Many reps understand this new reality, he says. Others still believe that features-based selling will win, or that they can leverage strong personal relationships with clinicians to push their products into the hospital. But neither approach works, at least not at CaroMont.

"Our clinicians and physicians clearly understand that it's all about whether a product will do three things – reduce cost, improve quality, and improve community or population health," he says. "Every healthcare provider has to be competent at all three things. And when reps come through the door, they need to understand everyone is aligned around these three competencies. We have a lot of reps who get that and who understand it's all about the tangible, quantifiable benefits their products can bring to us."

Many reps understand this new reality. Others still believe that features-based selling will win, or that they can leverage strong personal relationships with clinicians to push their products into the hospital.

In some cases, particularly with new technologies, hard-core proof of outcomes may be hard to come by, says Blackburn. And few hospitals – even teaching and research facilities –are equipped to conduct carefully controlled studies.

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In those cases, the provider has to rely on its clinical team to vouch for the effectiveness (or lack of effectiveness) of a technology.

"Our early attempts at comparative effectiveness were rudimentary for sure, but frequently produced the right outcome, which was the best product at the best price for the clinical need," he says. "Unfortunately, those early efforts almost always ended in purchasing newer technology at a higher cost than current technology.

"Today, we still focus on product price, clinical efficacy, utilization and total cost. However, we no longer accept that buying the latest version or newest product is the only means to achieve quality outcomes. Our clinicians and providers recognize that newer is not always better, especially if the product comes with an unsustainable total cost with little or no incremental benefit for the patient.

"The manufacturer and distributor must present empirical evidence that their products or services directly and quantifiably produce a sustainable, valuable benefit for the organization, patient, and payer. The days of pass-through costs are over, unless the [manufacturers] want to contract directly with payers, such as Medicare, to get reimbursement for their devices. The reality is that hospitals cannot sustain an ever-increasing cost structure. OEMs and distributors must understand that new technology cannot come with a higher price tag and total cost of ownership."

Vendors respond

Sage is serious about developing the evidence to support its product interventions, says Anderson. The company's salespeople are trained to work with accounts to develop and measure the effectiveness of clinical protocols for prevention of a number of conditions, including ventilator-associated pneumonia, heel/sacral pressure ulcers, and surgical-site infections.

Sage recognizes that providers face a difficult transition from the fee-for-service world to value-based purchasing, says Anderson. "There's so much financial pressure on them right now, and they're kind of caught in the middle." Purchase price will always be an issue, particularly for supply chain executives, whose compensation rests in part on cost-savings.

The reality is that hospitals cannot sustain an ever-increasing cost structure. OEMs and distributors must understand that new technology cannot come with a higher price tag and total cost of ownership.

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"Yet the cost of the problem they are addressing – including ventilator-associated pneumonia and pressure-related skin injury – is exponentially larger than their spend on products. The increased focus on data-mining and comparative-effectiveness research is terrific, and it will help the entire market understand the true cost of these infections. We all have a responsibility to tackle them."

B Braun is working hard to develop products that add value, says Graaf. With more factors involved in the product selection process than in years past, the company hasn't strayed from addressing its customers' key issues, he says. One of those issues is safety – for the patient, healthcare worker and environment. Regarding patient safety, the company helps its customers address such things as the prevention of medication errors and the reduction of central-line infections, and even hospital readmissions (due to pain), he says.

"Occupational exposure to bloodborne pathogens, needlestick injuries and dangerous cytotoxic drug exposure are at the forefront of issues that constantly beg us to ask, 'What else can be done?'" says Graaf. The company's "RA advantages" website (www.raadvantages.com) addresses the positive impact regional anesthesia – where indicated for surgery – can have on all the different stakeholders, including administrator, surgeon, anesthesiologist, supply chain executive and patient. Moving away from general anesthesia, which is performed using gas and opioids, to a regional anesthesia approach using peripheral nerve blocks can help reduce PACU stays, readmission rates and potential addiction to oral narcotics following surgery, Graaf points out. "All of these things represent an opportunity to reduce costs, but they also result in reduced patient anxiety and better outcomes. Patients are awake and more alert coming out of surgery, and able to get back to their families a lot sooner."

"Occupational exposure to bloodborne pathogens, needlestick injuries and dangerous cytotoxic drug exposure are at the forefront of issues that constantly beg us to ask, 'What else can be done?'"

– Erik Graaf

"We have known for more than 50 years about this concept of system, interdependency and the need for us to work together as a holistic process," says Seigfried. "Healthcare reform will force this thinking on us. It has to, because we can't continue overplenishing the system. The question is, 'Will we join forces to work out how we can all make this a 'go?'" **JHC**

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By Robert T. Yokl

Taking On Greater Responsibilities

Are you ready for what's ahead?

I'm not going to rehash the winds of change in healthcare. By now, we all know the upside and downside of the Patient Protection and Affordable Care Act. The question I have for supply chain managers – are you ready for what's ahead? Are you ready to take on even greater responsibilities? Communicating and executing your strategic vision? Leading and working with high-powered teams and juggling mixed priorities? I call this "stepping up" to meet the new supply chain challenges in the new healthcare economy – head on!

As I see it, the top of the list of new responsibilities for supply chain managers is to effectively communicate and execute your strategic vision. This is what I hear the C-Suite saying is lacking in many of their own supply chain managers: a clearly articulated vision of what their hospital, systems or IDNs' supply chain should look like over the next few years. Don't wait to be asked. Don't wait for guidance. Don't wait for someone else to do it. Instead, deliver to your C-Suite a clear vision in writing (i.e. supply chain strategic plan) that will guide the execution of your strategic visions over the next three to five years. To do less is to risk being reactive, not proactive, to the massive changes in healthcare that are surfacing each and every week.

Next on my list of new responsibilities for supply chain managers is to close the gaps in your supply expense management.

Next on my list of new responsibilities for supply chain managers is to close the gaps in your supply expense management. Meaning, no purchases should be made (including food, drugs, laboratory and maintenance supplies and purchase services) at your healthcare organization without your direct oversight or consultation. The reason for this declaration is that there has been too much delegation of purchasing authority to department heads and managers at most healthcare organizations and this has cost these same organizations millions of dollars annually in

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unnecessary supply expenses. In the new healthcare economy only supply chain professionals can make these buying decisions, if your healthcare organization is serious about reigning in their supply chain expenses.

Last on my list for supply chain manager's new responsibilities is upping your value analysis game. Too many supply chain managers have delegated this mission critical responsibility solely to their value analysis directors, managers and coordinators with mixed reviews. You might call this leading from behind as opposed to being actively involved in their value analysis program. The most successful supply chain managers I know are leading the charge with their value analysis program, just like a general would with his troops. They are helping to set their team's agendas, problem solving and troubleshooting, teaching, coaching and most importantly bringing new ideas and approaches to their value analysis teams. In short, they are never, ever satisfied with so-so results!

Too many supply chain managers have delegated this mission critical responsibility solely to their value analysis directors, managers and coordinators with mixed reviews.

A new dawn is breaking in healthcare that requires supply chain managers to step up to the plate and take on new challenges, new responsibilities and new accountabilities. To be ready for what's ahead you will need to rethink everything that you have been doing, starting with taking on greater responsibilities than you have in the past. By doing so, you will discover that the road to supply chain success will be bumpy, but not impossible to maneuver for those who decide to be leaders in their supply chain profession by "stepping up" to the new challenges that we all will face over the next few years. **JHC**

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CMS moves back compliance date for ICD-10 by one year

CMS (Baltimore, MD) moved back the compliance date for implementing ICD-10 diagnosis and procedure codes to October 1, 2014 from October 1, 2013. According to a recent survey conducted by CMS, up to 25 percent of healthcare providers believe they would not be ready for a 2013 compliance date. Based on recent industry feedback, CMS believes that larger healthcare plans and providers generally are more prepared than smaller entities. The delay will give organizations more time to prepare for the transition to ICD-10 and conduct thorough testing, allowing them to avoid obstacles and save money. In the Regulatory Impact Analysis (RIA) of this final rule, CMS estimates that there would be a cost avoidance of approximately $3.6 billion to nearly $8 billion. For more information about this final rule, visit www.ofr.gov/OFRUpload/OFRData/2012-21238_PI.pdf.

Joint Commission launches Lab Central Connect

The Joint Commission (Oakbrook Terrace, IL) launched Lab Central Connect™, which will help Joint Commission-accredited laboratories centralize storage of important survey-related documents, and improve safety and quality by helping to maintain continuous compliance with Joint Commission standards. The Lab Central Connect portal can be accessed through The Joint Commission Connect extranet site. Accredited laboratories are asked to enter a small amount of information, including key personnel, cytology workload and annual statistics as well as whether the lab accepts referral testing and the lab's test systems menu. Accredited laboratories must enter certain information mandated by the Clinical Laboratory Improvement Amendment (CLIA) to Lab Central Connect by January 1, 2013.

Commonwealth Fund finds 13% of hospitals participating in ACO

A new report by the Commonwealth Fund (New York, NY), a private foundation that "aims to promote a high performing healthcare system that achieves better access, improved quality, and greater efficiency," found that only 13 percent of hospitals are participating in an accountable care organization (ACO) or plan to do so in the next year. The data comes from a survey of 1,700 hospitals conducted by the Commonwealth Fund. The survey found that more than half of the hospitals that are participating or plan to participate in an ACO call patients within 72 hours of their discharge in order to follow-up, and almost 35 percent arrange home visits by advanced practice nurses or physicians. About 57 percent of the ACOs that hospitals are participating in are joint ventures between hospitals and physicians, and 26 percent are physician-led. About 2.4 million Medicare beneficiaries are receiving healthcare services from 154 ACOs

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NCH Healthcare System joins Mayo Clinic Care Network

NCH Healthcare System (Naples, FL) joined Mayo Clinic Care Network (Rochester, MN) in a move that allows NCH physicians to collaborate with those at Mayo Clinic Health System (Rochester, MN) facilities. It also allows patients to access Mayo Clinic expertise without having to travel far from home. Financial terms of the deal were not disclosed. NCH is the seventh health system to join the network, following New England Alliance for Health (Lebanon, NH), which joined in July 2012.

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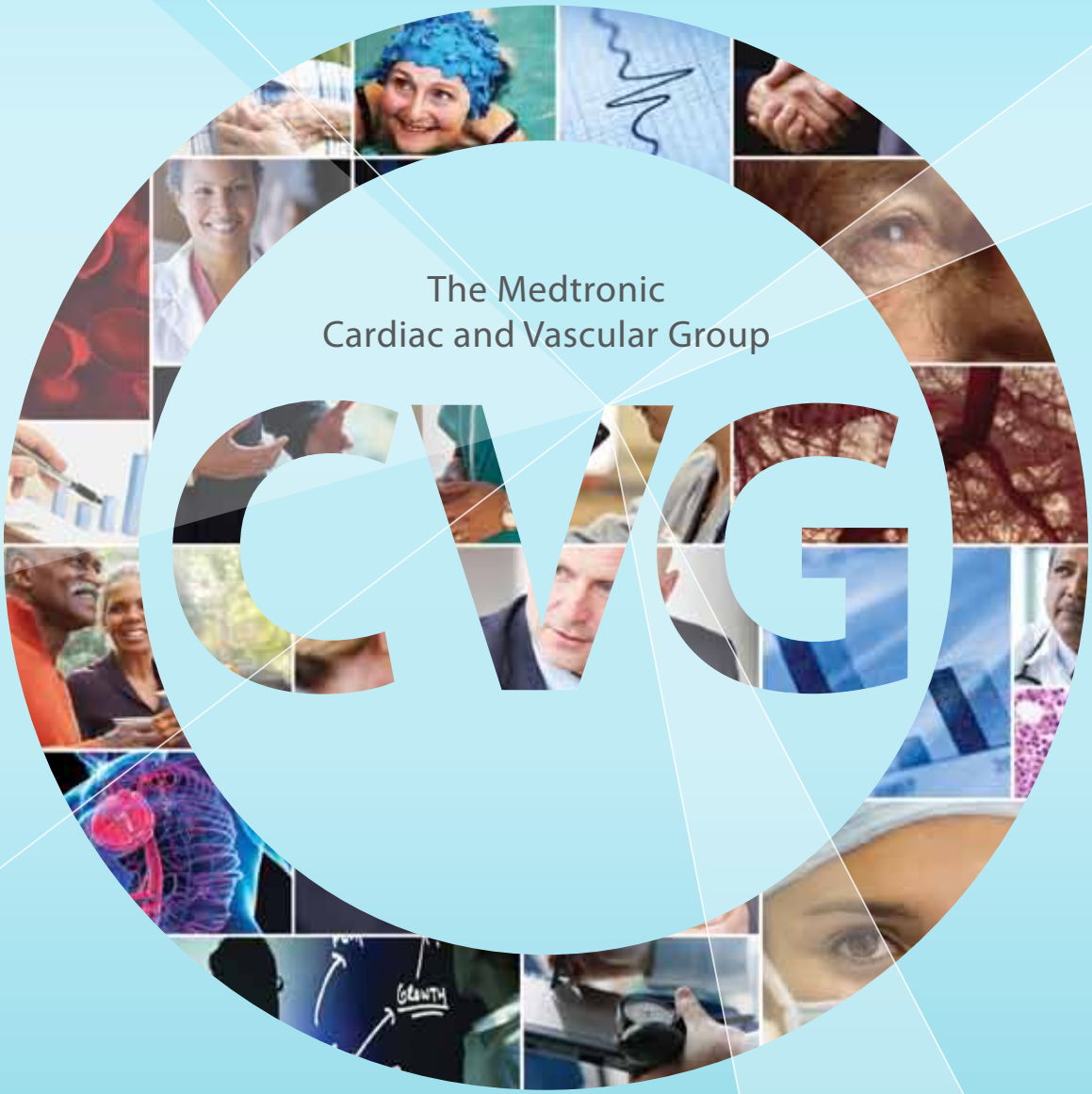

The Cardiac and Vascular Group (CVG) at Medtronic is strategically aligned to address today's changing healthcare environment. Beyond offering the industry's broadest portfolio of technologies, CVG delivers programs and services to drive economic value across the cardiac and vascular care continuum.

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