



LEADERS & Luminaries

Empower Healthcare

Reaching the C-suite

CSCO leadership
pokes through
top brass ceiling



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MISSION & VISION

Launched in late July 2007 by a group of influential veterans in the healthcare supply chain industry, Bellwether League Inc. operates as a 501(c)(6) not-for-profit corporation that identifies and honors men and women who have demonstrated significant leadership in, influence on and contributions to the healthcare supply chain.

Bellwether League's Board of Directors, a veteran group of industry advocates, evaluates and validates professionals submitted for consideration in its three award programs: Bellwethers, Future Famers and Ammer-Level Healthcare Supply Chain Organizations.

The Board selects deceased, retired and currently active professionals with a minimum of 25 years of exemplary


service and leadership performance in supply chain operations that meet its criteria to be publicly recognized as Bellwether Class Honorees. Those honored demonstrate their qualifications by advancing the profession through work experience and performance and active participation in professional organizations and their communities.

Honorees include professionals from hospitals and other healthcare providers, manufacturers and distributors of healthcare products and services, group purchasing organizations, consulting firms, educational institutions and media outlets.

Future Famers represent supply chain professionals early in their healthcare careers who do not yet qualify for Bellwether consideration, but have contributed to the healthcare supply chain profession in a meaningful way.

Departmental recipients of Bellwether League's Dean S. Ammer Award for Supply Chain Excellence demonstrate superior performance achievement in their daily operations.

To date, Bellwether League has honored 104 innovators, leaders and pioneers in healthcare supply chain management in five distinct categories: Education & Media, Supply Chain Management, Group Purchasing, Supplier and Consulting Services. Bellwether League also has recognized 21 Future Famers and two highly designated Ammer-Level organizations.

The Hall of Fame for Healthcare Supply Chain Leadership is funded by six Founding/Platinum Sponsors – Halyard Health, HealthTrust, Owens & Minor, Premier, Vizient and VIE Healthcare – and a host of additional sponsors. 

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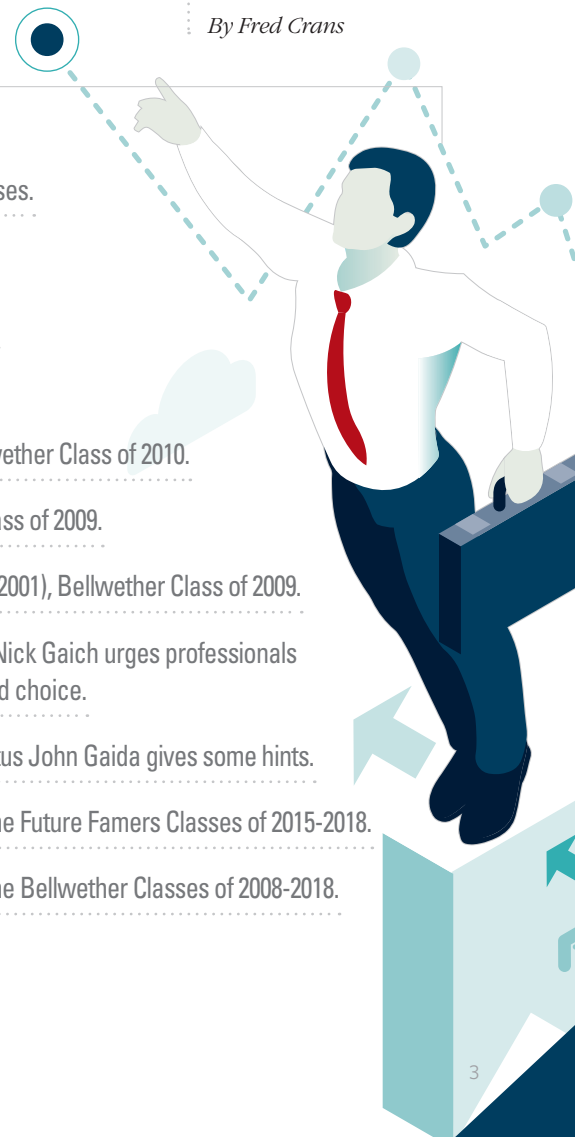
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HOW, WHY SUPPLY CHAIN MUST CUT

By Rick Dana Barlow

For a profession on the verge of earning a C-suite berth, based in part on its influence over a large chunk of a healthcare organization's budget – estimates have Supply Chain's non-salary expense stream surpassing Labor costs as the largest budget bracket within a few years – it's somewhat ironic that the biggest attribute it should shed is attitude and ego.

Historically known for its basement sequestration and perceived proximity to the loading dock and the morgue, Supply Chain and its leaders have struggled to gain recognition, respect and reverence for what they accomplish in providing valuable services to clinicians and administrators.

Alas, some of it may be self-inflicted.



Amy Chiappa, Future Famers Class of 2018, dispatches the "woe-is-me"

stereotype and urges others to do the same.

"Don't let being in the basement – or closet or trailer – define your relativity," she said. "Don't let new team members be defined by it either."

"Stop accepting things as they have always been and then lament over what everyone else needs to do or what else has to happen first before we/I can do something," Chiappa added.

"So many leaders are held back by yesterday's hospital business practices," observed



Donna Van Vlerah, Future Famers Class of 2015.

"For example, traditional supply chain/material management activities do not wholly encompass facilities, [operating room], construction, [information systems] or pharmacy and more. They are too focused on orthopedics and cardiology – not to say these are not important, but there are so many other critical areas. Most OR inventory and pharmacy make the supply chain spend look small!"

Jimmy Henderson, Future Famers Class of 2016, concurs.



"We all have to evolve with the current market,"

he noted. "You can't do what you have always done in today's marketplace or you will get left behind."

Mike Switzer, Bellwether



Class of 2015, punctuates it this way: "If you go to a new facility or system, don't always say, 'the way we did it at my last job was...'"

Sacred cows should be



avoided, agreed **Kristine Russell**, Bellwether Class of 2017. "Lose the 'this is the way we've always done it' attitude as a skill set just because it's repetitive,"

she insisted. "Being proficient with one method, may close off the opportunity to try something new that may open up better opportunities."

As the trickle of more experienced and tech-savvy supply chain professionals flows to meet up with the encroaching wave of anticipated prominence and responsibility, the profession should check self-centered ambition at the door, too, Bellwethers and Future Famers recommend.

"I have never been a fan of individuals with large egos," admitted **James Francis**,



Bellwether Class of 2017. "Healthcare is a mission-driven profession, and most organizations that provide care have desired institutional values. Demonstrating your ego is typically inconsistent with values such as teamwork, respect, stewardship and showing compassion.

I also don't find it helpful in achieving any advantage in discussions or negotiations and often find it had the opposite effect."

Dale Montgomery,



Bellwether Class of 2014, wholeheartedly agrees, pointing to the attitude of

"always knowing what is best as being unworthy." "When working in group you must leave your suspect attitude at home and bring the attitude of cooperation

to the table," he noted.

The belief that their way is the only one rarely turns out the way you expected or wanted, and runs afoul of effective teamwork, according to



Jason Hays, Future Famers Class of 2015.

"I [may] get so focused on 'my methods' that I [may] miss the obvious alternative that is much easier to execute and has a better long-term outcome," he said.

The "zero-sum" mentality in negotiations can be toxic,



too, emphasized **Nate Mickish**, Bellwether League Secretary and Future Famers

Class of 2015. "While both parties ought to adopt a 'trust but verify' attitude, there are better ways to get what you want than seeing the negotiating table purely as sport," he said. "All parties need to win something in order to keep coming back and that takes more time, patience and skill than merely trying to get one over on the next person."

Ted Almon, Bellwether Class



of 2010, makes a political reference in rejecting "the idea or attitude that the 'art of the deal' involves a winner and a loser, or that effective deal making is essentially adversarial. In fact the most

beneficial and enduring deals are win-win,” he added.



Eric Tritch, Future Famers Class of 2015, points to respect for suppliers as a key business strategy. “I think if supply chain leaders have an attitude that suppliers are the enemy, then this attitude should be lost, because in order to stay relevant it is key to get suppliers aligned in the supply chain to deliver more value and evolve,” he noted.



Dee Donatelli, Bellwether League Board Member and Bellwether Class of 2015, concurs that it’s high time to shed the concept of winner and loser in relationships with suppliers. “You will be much more successful with a win-win attitude. Suppliers are not our enemies but rather should be trusted partners with whom we establish mutual goals and collaborate for success,” she urged.

Supply Chain leaders need to lose aggressiveness, but



not assertiveness, according to **Jane Pleasants**, Bellwether Class of 2015. “The perception that you have to be aggressive in order to get good ‘deals’ is not the reality,” she emphasized. “In fact, it can have the counter effect. Often you have to put your ego in your pocket and bring folks along with you.”



Such a philosophy also applies to how you treat your own team, too, noted

Deb Templeton, R.Ph.,

Bellwether League Treasurer. “The deployment of ‘command and control’ is no longer a very effective management approach,” she said. “People will be much more engaged if they feel involved and understand why things are being done drive the collaboration needed for successful outcomes. If people feel a part of the mission and solutions to drive the vision, everyone celebrates and is successful.”

Another tip: Avoid a focus on price, which can stem from attitude, experts insist.

“They should lose their approach to ‘pricing first’ in every negotiation and look at ways to move beyond the transactional nature of reverse-auctions, bids, high-pitched demands and other techniques and build solid supplier relationships, especially with key suppliers,”



recommended **John Strong**, Bellwether Class of 2011.

“Although they get lip-service, ‘value analysis,’ ‘total cost of ownership’ and ‘quality’ often get overlooked in favor of a best price-first mentality that fails to serve organizations well over the long run.

“Banal statements during negotiations like ‘we’re such-and-such a hospital/health system, and you have to give us a better deal than anyone else’ have no place in today’s negotiations because there are more than 100 large integrators of care out there, all of whom are important business targets. You look like an idiot saying things like that.”



Mary Starr, Bellwether Class of 2018, agrees that price can be an issue.

“Yes, it’s tangible, but it’s such a small part of a real supply chain leader’s ability to impact the success of their organization,” she noted.

Having a singular focus on price won’t generate the impact necessary to drive costs down, according to



Jody Hatcher, President, Sourcing and Collaboration Services, Vizion

Inc., Founding/Platinum Sustaining Sponsor of Bellwether League.

“Our industry is transitioning from being price-focused to being utilization-focused,” Hatcher said. “For years, we have been hard-wired to focus on price. To advance beyond that, we must consider that sometimes the best cost-saving measure is not using some products at all. In order to understand which products you should use – or not use – you need clinical insights to understand how products are performing, how physicians and clinicians are using those products and how those usage patterns affect clinical variation and practice. To see true cost savings, you have to integrate all those aspects to help hospitals understand why and how they need to behave differently.”

Don’t fret about physician contact either, according to



Bill Donato, Bellwether Class of 2013. “[Lose] the fear of working with and debating the physicians,”

he advised. “An effective healthcare supply Chain requires physician integration!” That means emerging from a comfort zone.



“Stop hiding,” encouraged **Jean Sargent**, CMRP, FAHRMM, CRCST, Bellwether

League Board Member 2010-2015.” Get out and speak to your customers and staff. Understand where the road-blocks are and change what you can. Also, speak to the C-Suite and let them know what you are doing to address these concerns.”

Supply Chain’s approach should be “customer-centric or framed effectively with



the end users in mind,” according to **Troy Compardo**, Future Famers Class of 2018.

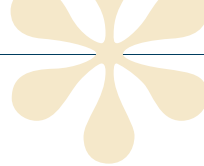
Finally, don’t over-rely



on logic and analytics, recommended **Nancy LeMaster**, Bellwether Class

of 2015. “We always talk about the importance of data and that physicians are scientists,” she said. “But if you don’t create trusting relationships all the data in the world won’t move people. People are moved by a combination of logic and emotion. You need some of both to be effective.”





Oh! My Gosh!

SUPPLY CHAIN CALLS OF THE RILED

Getting phone calls from colleagues and customers praising you or your department for superb contributions or service certainly evoke smiles. Who doesn't want, seek – let alone, need – a pat on the back every once in a while, a little encouragement that justifies what you do and encourages you to keep doing it?

It's those other phone calls (and emails) that vex us. And rightly so. **Leaders & Luminaries** asked Bellwethers, Future Famers and Bellwether League Board Members and Sustaining Sponsor executives to share their actual experiences or hypothetical perceptions on that one work-related phone call they'd prefer not to get. Maybe some of these sound familiar...too familiar.

Seriously?

Jamie Kowalski

Bellwether League Co-Founder and Founding Chairman, Bellwether Class of 2017

"This is Dr. _____. I am telling you [to] come to the OR right now, to see for yourself what is going on and to take corrective action."

Peggy Styger

Bellwether Class of 2016

"The call I got at 2 a.m. from Cedars-Sinai Medical Center [was] an employee in Patient Transportation accidentally switched the toe tags of a Hispanic youth and an elderly Orthodox Jew. The latter was transported and cremated prior to discovering the error. The Orthodox Jewish faith does not permit cremation."

Tom Hughes

Bellwether Class of 2012

"Where's the stuff that I ordered?" As a supply chain leader, if that gets to your office it may be too late. Much of your credibility may be lost by then. Supply chain cannot be managed from your office. Get out and make rounds to even the more complex customers like the OR and Radiology.

Bill Donato

Bellwether Class of 2013

"We had to cancel the case."

Dee Donatelli

Bellwether Class of 2015

"You are no longer needed."

Dick Perrin

Bellwether Class of 2014

"We are out of scrubs... Oh God, it is the Chief of Surgery, and he is standing in the reception area of the OR in his BVDs saying, 'Do you expect me to operate like this?' On a more serious note, it was the call at 2 a.m. regarding critical supplies for the OR, and we sent a police escort to the off-site warehouse to retrieve a box of the critical care items. The procedure went ahead, and the patient was okay. In the morning we found out that the needed supplies were in the OR, but had been moved prior to the procedure so that they would be available and then somehow were overlooked. Major apologies [came] from the OR staff for the oversight and difficulties created, but [also] appreciation for the rapid response to get additional supplies."

Brent Johnson

Bellwether Class of 2014

"CEO/COO calling to tell me to back off of pressuring the physicians to standardize products."

Jim Francis

Bellwether Class of 2017

"Our primary distribution center has suffered some type of disaster (e.g., flood, tornado, fire, etc.) and it is completely off-line."

Jason Hays

Future Famers Class of 2015

"I know it is Friday afternoon, but I am out of _____. Can you help me?"

John Strong

Bellwether Class of 2011

"There is a mass casualty event arriving in 10 minutes. Get ready."

Jimmy Henderson

Future Famers Class of 2016

"Your overnight order didn't ship out."

Dale Montgomery

Bellwether Class of 2014

"The phone call on reduction of force."

Troy Compardo

Future Famers Class of 2018

"I don't have what I need to take care of a patient, why?"



y!

Kristine Russell

Bellwether Class of 2017

“Where is _____?”
And it’s not available
because my system
failed.”

**Jean Sargent,
CMRP, FAHRMM, CRCST**

*Bellwether League Board Member,
2010-2015*

“The call from the boss
who says, ‘I just heard
_____ Why didn’t
you tell me so I was
prepared to respond?’”

Mike Switzer

Bellwether Class of 2015

“You never want to get
the call that informs you
of the death of one of
your workers, or their
loved one. You can try
to do your best to be
there for them, but you
can’t bring them back.”

Deborah Templeton, R.Ph.

Bellwether League Treasurer

“One of the worst phone
calls is hearing that one
of your employees has
passed away. Whether
due to an expected
outcome, or totally out
of the blue, the sense
of loss is palpable, and
leading the team through
the loss is difficult.”

Eric Tritch

Future Famers Class of 2015

“Working in the Midwest,
it’s never fun to get
the ‘Call’ when a wild
snowstorm hits and it is
all-hands-on-deck to get
staff and supplies to meet
the needs of care while
we dig out from the storm,
but in general we are in
supply chain because
we like solving difficult
operational challenges,
and savor the fact the
organization looks to us
when times are tough.”

Nate Mickish

Future Famers Class of 2015

“‘I haven’t heard
back from so-and-so.’
Responsiveness is
an act of respect and
servanthood. I try
my best to model this
personally. While far
from perfect in doing
so, I also expect folks
on my team to do the
same – be it with an
internal customer
or a supplier.”

Pat Carroll

*Bellwether League Treasurer,
2007-2011, Secretary, 2013-2018,
Bellwether Class of 2018*

“A complaint regarding
customer service! The
phone call would indicate
I was not in touch with my
customers and anticipating
issues they may have.”

Help

Donna Van Vlerah

Future Famers Class of 2015

“I hate hearing that a
member of the team did not
provide excellent collab-
orative support either to a
patient, customer
or co-worker.”

Mary Starr

*Bellwether League Treasurer, 2012-
2016, Bellwether Class of 2018*

“A patient’s well-being
was impacted by
something supply chain
did or didn’t do.”

Nancy LeMaster

Bellwether Class of 2015

“You never want to get the
call that says we are out of
a supply and therefore the
case/procedure is going to
be canceled. Supply stock-
outs, especially when there
are limited substitutes, are
painful for everyone.”

Vance Moore

*Bellwether League
Board Member 2010-2015*

“Anything that relates to
a significant bad event for
a co-worker or customer.
You get really close to folks
that you work with day-to-
day, and my heart drops
when I hear of some form
of setback. I never know
what to say, but it hurts me
to know they are hurting.”

Jody Hatcher

*President, Sourcing and Collaboration
Services, Vizient Inc., Founding/
Platinum Sustaining Sponsor
of Bellwether League*

“This is the legal
department and we
have an issue...”

Jane Pleasants

Bellwether Class of 2015

“You have [a] bad
product in your supply
chain, and it has
caused patient harm.”



Oops!



WHEN QUESTIONS LEAVE MARKS

By Rick Dana Barlow

Supply Chain

Bellwethers and authentic leaders fancy themselves as problem-solvers – strategic thinkers over tactical navigators, so to speak – whether that's showing people the way or merely supporting them to find it on their own.

When you develop a reputation as a solver of problems – or as a provider of products and services – you may field a slew of questions from administrators, clinicians and department heads. What follows are some of the leading contenders faced by Bellwethers, Future Famers, and Bellwether League Board Members and Sustaining Sponsor executives, in addition to costs, expenses, pricing and savings expectations.

“A frequent and frustrating question was ‘what is supply chain going to do to reduce supply costs?’” said **Nancy LeMaster**, Bellwether Class of 2015. “I’d always respond

most clinicians and customers wanted a quick pricing fix, but at the same time clinicians typically accuse and dismiss Supply Chain for only being concerned about price.

“It’s hard not to over-generalize, but I’ve found that clinicians can be resistant to standardization and reducing variation,” LeMaster noted. “Even when Supply Chain is saying ‘we aren’t asking you to use the cheapest product, just don’t use four,’ they will come back with, ‘well, just get the same price for all four and then we don’t have to choose.’ The key is to have the cost/quality discussion up front prior to starting any project. The challenge is to define quality and get agreement prior to the review of any products how decisions will be made.”

Amy Chieppa

Future Famers Class of 2018

“Why can’t I/we/you just... [insert the rest]?” Change a description, change a product, override a decision, not RFP, let me just have..., etc. “I don’t understand why X is so complicated...”

Brent Johnson

Bellwether Class of 2014

“Why is Supply Chain getting so much attention? You aren’t caregivers.”

John Strong

Bellwether Class of 2011

“I can get that ream of paper at Staples for \$2.95 this week, but you are

expensing me \$3.00. Can’t you do better?”

Jim Francis

Bellwether Class of 2017

I would have to characterize it under the general heading of “Why?” “Why do I have to follow that policy?” “Why am I required to do a RFP or get a competitive bid?” “Why does it take so long to get a contract done?” “Why is the institution standardized on that supplier or why can’t I use my preferred orthopedic implant?” I could go on, but I think you understand.

Jamie Kowalski

Bellwether League Co-Founder and Founding Chairman, Bellwether Class of 2017

“Why should I/we do things the way you have defined?”

Deborah Templeton, R.Ph.,

Bellwether League Treasurer

“Why can’t we be like Walmart?” Walmart was an early leader in recognizing that value of investing in supply chain. It set the impression that all supply chains should work in the smooth and efficient way that Walmart did. However, lack of investment in technology, lack of true product standards for ease of processing and communication and often lack of visibility at point of use make product forecasting difficult has made healthcare supply chains much more challenging to manage.

Nate Mickish

Future Famers Class of 2015

In my current role it’s “how much money are you saving us?” Despite all of the other value that a supply chain team brings to an organization, it’s still about savings at the end of the day.

Pat Carroll

Bellwether League Treasurer, 2007-2011, Secretary, 2013-2018, Bellwether Class of 2018

For senior management, it would be “what is effective supply chain and what should I expect from my supply chain department?” For supply chain leaders, it is most often “what can I do to get more support and respect from the C-suite?” From clinicians and departments, it is “why cannot I receive better service from supply chain?”

Eric Tritch

Future Famers Class of 2015

Because I’m fortunate to have a robust supply chain team and operation, we are most often asked how we can extend what we do to our partners in the marketplace. As a result we’ve developed an affiliate model that is part of the pitch and generates a lot of interest when we talk with other organizations about partnership opportunities.

Continued on next page...

“It’s a team sport and we are going to work together to go beyond looking at just the price of the product to looking at utilization and the total cost of ownership.”

It was an uphill battle since most everyone wanted a quick pricing fix.”

Tinged with hypocrisy, what’s noteworthy is that

SUFFERING FROM FOOT-IN-MOUTH DISEASE?

The art of cowering behind incompetence, deflecting blame, initiating “plausible deniability,” justifying artificial boundaries or uttering orders with an attitude of superiority may be accepted in politics but it doesn’t work in the customer-centric field of healthcare supply chain management. While providing service to clinicians, administrators or even patients, Supply Chain professionals may be tempted to say the wrong thing.

But when you say the right thing, you have nothing left. Here’s what Bellwethers, Future Famers and Bellwether League Board Members and Sustaining Sponsor executives admit you never should say at work or tell colleagues and customers. Leading the list: “It’s not my job!” and “We can’t/don’t do that.”

Pat Carroll

Bellwether League Treasurer, 2007-2011, Secretary, 2013-2018, Bellwether Class of 2018

For colleagues in Supply Chain, you never say anything derogatory towards a customer even if they are being a pain in the posterior. The customer may not be right, but they are always the customer.

Troy Compardo

Future Famers Class of 2018
“I can’t. We can’t.”

Dee Donatelli

Bellwether Class of 2015
“We only buy the stuff,” or “That is not our job.” Never, ever diminish the role of Supply Chain!

Bill Donato

Bellwether Class of 2013

“This is impossible...we can’t help you...I don’t care what the physicians want.”

Derwood Dunbar Jr.

Bellwether Class of 2011

The right thing to always say is, “I understand we have a problem here. Let’s solve it together.” The worst thing to say is “That’s not my job.”

Jim Francis

Bellwether Class of 2017

“It’s not my job!” This phrase is prohibited in our supply chain operation. I advise staff that it is not important what the request is or whether

The worst thing to say is

“That’s not my job.”

it is part of your job duties and responsibilities as much as it is how you respond to it. All supply chain employees are expected to respond favorably to a request, be the first line of defense for all inquiries and make sure the customer’s request is resolved even if handed off to another supply chain employee.

Jody Hatcher

President, Sourcing and Collaboration Services, Vizient Inc., Founding/Platinum Sustaining Sponsor of Bellwether League

“Mission accomplished.” A Supply Chain leader’s work is never done.

Jason Hays

Future Famers Class of 2015

“I have learned my lesson, and we are never changing that product again.”

Jimmy Henderson

Future Famers Class of 2016

“I don’t care; use it anyway.”

Brent Johnson

Bellwether Class of 2014

“It’s all about the money.”

Jamie Kowalski

Bellwether League Co-Founder and Founding Chairman, Bellwether Class of 2017

“There is no solution to that situation/problem.”

Nancy LeMaster

Bellwether Class of 2015

There are a lot of things we should never say but I think the worst is “it’s not my job or it isn’t my fault.” We are there to help solve problems, and although an “I told you so” would feel so good in the short run it will ruin the relationship. It’s better to

Continued on next page...

“I’m too busy.”

When Questions Leave Marks continued...

Jason Hays

Future Famers Class of 2015

“Why do we have to change to that product/vendor?”

Troy Compardo

Future Famers Class of 2018

“How can we automate and simplify our processes

to drive more value across the organization?”

Dee Donatelli

Bellwether Class of 2015

“How much have you saved us this week?” Which is frankly sad as supply chain is or should be so much more than savings.

Vance Moore

Bellwether League Board Member 2010-2015

“Now what have you done?” Hey, I never said I was a great employee.

Jody Hatcher

President, Sourcing and Collaboration Services, Vizient Inc., Founding/Platinum Sustaining Sponsor of Bellwether League

“Who performs best and why?”

SUFFERING FROM FOOT-IN-MOUTH DISEASE? | *Continued*

lead with “let’s see what we can do.”

Nate Mickish

Future Famers Class of 2015

“It’s not my job.” Not only is that statement distasteful, it’s foolish. Providing support and value in areas technically “out-of-scope” opens doors for future opportunities to expand the influence and efficacy of the supply chain function.

Vance Moore

Bellwether League Board Member 2010-2015

We should never use the word “you.” We are all in this thing together and we are collectively accountable for performance. “We” must solve problem, and not “You” have a problem.

Kristine Russell

Bellwether Class of 2017

“We chose to purchase this product because it’s cheaper.” This only supports the myth of what supply chain does.

Jean Sargent, CMRP, FAHRMM, CRCST

Bellwether League Board Member, 2010-2015

“We don’t do that.”

Mary Starr

Bellwether League Treasurer, 2012-2016, Bellwether Class of 2018

“It’s all about saving money.”

John Strong

Bellwether Class of 2011

“I’m too busy.” “We won’t be able to get to your request for at least two weeks.” “We don’t have the bandwidth.” “That’s not my/our job.” “We can’t do that.” Pick any of these.

They will kill the desire to use your services in supply chain faster than anything else you can dream up.

Deborah Templeton, R.Ph.

Bellwether League Treasurer

I would never tell anyone that things will never change. Change is inevitable and comes much faster and far more often than ever before. Fueled by rapidly developing technologies, the business of healthcare and supply chain are constantly changing. How we communicate, acquire and deliver product will not look the same in five years. What used to take decades to transform, can now happen almost overnight to drive much different relationships and processes.

Eric Tritch

Future Famers Class of 2015

Supply Chain leaders should never tell colleagues/co-workers/customers that we’ve squeezed all the juice out of a particular orange, because we should always be focused on continuous improvement. That doesn’t mean we shouldn’t focus on juicier opportunities for added value, but it’s important to keep in mind that there is always opportunity to improve.

Donna Van Vlerah

Future Famers Class of 2015

The word “No.” As the master negotiator for the health system we should be in a position of influence and steer individuals/groups internal and external to the organization. Sometimes, I talk about leading the



mule to the water – the mule is stubborn, and you can’t make it drink, so one must demonstrate leadership skills

and navigate to achieve the right direction and outcome (when mule goes to the water and drinks).

RISE OF THE CSCO/CPO: PROGRESS' PRIVILEGE

How is the 21st century *reshaping* healthcare supply chain leadership?

By Rick Dana Barlow

Since the early 1900s, healthcare organizations have witnessed a rash of changes among those who procure products, services and equipment for their facilities – including breadth and depth of responsibilities, skills, titles and even C-suite influence.

- **Golden Age, 1910-1950s**
- **Silver Age, 1960s-1980s**
- **Modern Age, 1990s-2010s**
- **Post-Modern Age, 2020 and beyond**

In fact, the titles and responsibilities may have elevated and grown, respectively, but the skills and C-suite influence seem to have settled into an inverted bell curve. Early on in the Golden Age, they appeared to be highly regarded and influential within a more primitive healthcare business model. During the Silver Age, however, and as the healthcare business model evolved into something a bit more complex, they seemed to fall from favor and grace, relegated to the basement of tasks from the ivory tower of ideas. Two healthcare reform movements during the Modern Era, along with the repercussions of managed care and reimbursement controls, now seems to be pulling what we call Supply Chain to loftier heights to facilitate communications and collaboration as well as function as problem solver and resource well.

From cooperative buying and purchasing agents during the Golden Age to materials/materiel managers during the Silver Age to resource managers and supply chain managers in the Modern Age, this profession and those who lead it are positioning themselves at the dawn of a new era – one that heralds the emergence of an experienced motivator, resource and strategic thinker responsible and accountable for the majority of

a healthcare organization's expense stream and a considerable portion of its revenue stream.

But are we *really* on the verge of the next phase of progress for Supply Chain executives and professionals?

Straddling the healthcare supply chain's Silver and Modern Ages from 1987 to 1996, American Express promoted its charge card with the catchy and familiar marketing slogan, "Membership has its privileges."

Two decades later, a small but growing number of Supply Chain executives are finding that leadership has its privileges, too, but, in hearkening back to that old Silver Age Smith Barney ad, Supply Chain leaders gain and generate C-suite influence the old-fashioned way: They earn it.

Check in with the key executive rosters at some of the leading hospitals and healthcare systems around the nation these days and chances are you'll find someone's name with "Chief Supply Chain Officer," "Chief Purchasing Officer" or "Chief Procurement Officer" in close proximity.

For some of them, the CSCO/CPO designation augments an Executive Vice President or Senior Vice President title; for others the designation stands alone as its own title – the proverbial key to the C-suite.

This relatively new phenomenon raises three fundamental questions: How did we arrive here through the "ages," what unites leadership through the ages and why does it really matter?

Post-healthcare supply chain retirement, three reputable veteran leaders recall fondly their decades of service along the way.

With a healthcare supply chain career that spanned two of the ages and multiple categories, **Bob Simpson**,



Bellwether Class of 2012, recognizes that healthcare comprises many different types of businesses, research

facilities, services and surgery centers with hospitals representing the largest of the lot. Historically, Supply Chain leadership in healthcare started at the bottom.

"When I started to work in this profession in the mid-seventies you needed to go to the lowest level of the building you worked in to make your way around and through pallets of supplies and low overheads filled with all the pipes that feed the building," Simpson told *Leaders & Luminaries*. As he advanced in his career, he remembered "working all kinds of hours, 24/7, on call all the time and leading by example," all areas that extended beyond the traditional functions.

"What I learned during this time is that any success you have is very much tied to the team you surround yourself with and how you train them to ensure their success as well as yours," Simpson said. "During the early '80s I joined my first health system at the Boston University Medical Center as the Director of Purchasing. Being responsible for working and training a team that negotiated all purchasing contracts for this multimillion-dollar operation was a huge challenge, and I quickly realized I could not be successful on my own. To gain the confidence of senior management and members of the medical staff was a must, and it had to be addressed every day by the full team of this department."

Simpson attributed the success the team achieved to regular and frequent verbal and written communication, emphasizing the need to “always keep your word and always keep any commitments you make.”

Recognizing the important role suppliers play in fulfilling the needs of healthcare providers and the trust that supply chain executives must develop with them to succeed remains another important part of the equation, according to Simpson. Successive executive positions with a regional purchasing group and a supplier taught him about “the ability to accept ‘no’ and come back to a ‘yes.’”

Simpson fully sees Supply Chain Management as being “accepted as a valuable asset to health systems nationwide.” In fact, “leaders in these positions are very much in demand with the right qualifications,” he added.

“Supply Chain Management is an area that requires total focus and substantial training to be successful,” Simpson continued. “Other industries spend large amounts of money and time to focus on the success of this area of expertise. There is much discussion about what influence this position has on the overall budgets of the facilities they support. Many would suggest it is as high as 80 percent. The titles of CSCO/CPO bring focus on these duties and responsibilities. In addition, these titles send a very clear message to all department heads about the importance of working closely with the CSCO/CPO as part of their efforts to control cost.”



Spanning the first three ages, **Charles Housley**, Bellwether Class of 2008, expresses sincere hope he can contribute to the fourth.

He reflected on starting his healthcare career in 1956 at a small, 44-bed hospital in Tennessee where they “reused needles and OR packs made of cloth” before disposable options emerged in the next decade.

Housley recalled his hospital administrator handing him an Army logistics book “to study and implement some of the techniques and policies,” he said. “That was the start of a great career. Over these many years, I have experienced many improvements in healthcare supply chain management,” a profession that emerged from “Stores” to “Purchasing,” including “CSR, then SPD,” followed by “Materiel Management” to today. “In the early years, most supply processes were decentralized with the various departments managing their own,” he said. “I have managed hospital and healthcare systems in Tennessee, Ohio, Michigan and Kentucky, and I have seen a lot and done a lot. I am very proud of my accomplishments to this very important area of healthcare management.” Currently, Housley serves as Professor of Health Care Administration at Midway (KY) University.



Lee Boergadine,

Bellwether Class of 2008, remembers entering the field in the early 1960s when “nursing staff would

leave their units and bring a requisition to the Central Supply department to obtain all needed supplies and equipment,” he said. “Obviously, this was not the best use of highly trained professional staff.”

Some “visionaries” recognized during this time the automotive industry’s logistics operation where workers on the auto assembly line received parts from logistics staff and not vice versa, according to Boergadine. This motivated them to flip the healthcare model and have staffers from what would become materials management stock the storeroom and bring the supplies to the nursing units, he indicated.

“As the percentage of a healthcare institution’s budget continued to grow, healthcare officials began to realize that increased recognition was needed for the staff member charged with overall responsibility for the supplies and equipment in the facility,” he said. “The

position of Chief Supply Chain Officer was created to give authority to the staff member charged with this significant portion of the budget.

“By having a C-suite member overseeing supply chain functions, there is greater opportunity to align the goals of supply chain with the goals of clinical and other administrative staff members,” Boergadine continued. “As such, a C-suite member, the Chief Supply Chain Officer, would enjoy the privileges that come from such a position – higher salary and benefits, better office location and increased support staff.”

Strategic Signal



The CSCO title sends a signal, according to **Erik Walerius**, Future Famers Class of 2016, and Chief Supply Chain Officer, UW Medicine.

“Forward-thinking healthcare organizations see the value a CSCO provides,” Walerius said. “Organizations are beginning to grasp the connection in regards to the massive spend under the oversight of the Supply Chain team and the financial health achievable by elevating the focus of Supply Chain. A ‘Chief’ designation signals to the organization the investment being made into and value of an effective Supply Chain. Additionally, recognition is building regarding the beneficial impact a Supply Chain being led by a talented leader can have on total cost of patient care and patient outcomes.”

Healthcare service providers need a CSCO at the executive table to



help forge strategic decisions, insists **Raymond Seigfried**, Bellwether Class of 2012, and a former healthcare system Supply Chain executive.

“Supply chain services must be understood as a primary part of the healthcare integrated operational system,” said Seigfried, currently a Healthcare

Administration Faculty Member at Arcadia University's School of Global Business. "COOs are focused on the integrated operating system as a whole in support of their mission. CIOs and/or SVPs are all focused on their departments' effectiveness in support of patient care. CSCOs need to provide predictability in materials, equipment and people. This requires drive of continuous improvement. In my experience the 'privilege' of being part of the executive team is in the responsibility to demonstrate your contribution to effective strategic decisions."

Paul Powell, Bellwether Class of 2009,



concur: The title should provide focal points for the purchasing and distribution specialty and for suppliers to contact. "It is not so much privileges [involved], but obligation to properly serve vendors as well as company interests," he added.

The CSCO title should suit the appropriate required accountability, which amounts to managing a healthcare organization's total non-labor expense budget that typically reaches 45 percent to 50 percent



of the organization's total expense stream, according to **Nick Toscano**, CEO, Julicon Advisers LLC, Bellwether Class of 2018.

"The CSCO must have complete accountability and oversight to all non-clinical support and shared services," Toscano said. "In a matrix organizational structure, the line manager of a support service (i.e., biomedical services) typically has a dual reporting relationship to the CSCO and the COO. A VP of Supply Chain differs in ways that are more narrowly focused and accountable for the more traditional supply chain services (i.e., purchasing, distribution)." Toscano previously served as CSCO, Virtua Health. Such a high level extends beyond transactional and tactical decisions and into strategic influence, according to Toscano.

"The CSCO must be a 'Strategic Thinker' driving a vision and environment for

creating systems and structures for organizational transformation, continuous improvement and cost effectiveness," he noted. "The privileges associated with the CSCO role enable the CSCO to be a member of the healthcare organization's C-suite leadership team. She or he is on a level that allows for strategic dialogue and influence with her or his peers over the strategic direction of the health system. The CSCO also has the authority and ability to collaborate with the clinical staff in developing clinical integration strategy and direction."

Strategic Symbol



For **Tom Lubotsky**, former CSCO, Advocate Health Care, a Bronze Sustaining Sponsor of Bellwether League, the title is symbolic.

"An appointment of a CSCO/CPO role would be acknowledgement of the strategic relevance, understanding and impact supply chains have on healthcare organizations going forward and begin to emulate mature supply chain organizations found in automotive, retail or manufacturing," he noted. "There are very few healthcare C-level executives today that have embraced this shift toward elevating these roles inside their organizations."

What makes the elevated CSCO/CPO at a different level than the various VP posts is that it's "more fully entrenched in setting the strategy and direction of the supply chain that aligns with the healthcare corporate vision and key strategic imperatives," Lubotsky continued. "These roles would also have broader boundaries of interaction among key corporate functions. For example, these roles would be engaged with elements of digital strategy formation in conjunction with IT and Marketing/Communications, providing input into cash and budget planning with Finance, Disaster and Emergency Planning, or developing corporate partnerships as part of its community relations and philanthropy efforts. Most importantly, the strategies

toward driving clinical effectiveness among the use of its products, equipment, technologies and services would be paramount and require the full engagement with its medical staff leadership, clinical operations and hospital management."

Certainly, the CSCO should be empowered with the "immediate authority to set the operating procedures and policies of the Supply Chain," according to Lubotsky, unlike the VP roles that "usually require hospital or region leadership buy-in on the establishment of standard operating procedures.

"While this leadership engagement is a healthy approach, speed-to-execution becomes a real issue in advancing the supply chain," Lubotsky noted. "In the instance of appointing a CSCO/CPO role, they would have the power to set these standards of operation based on their knowledge and expertise, a more efficient manner of moving the supply chain toward elevated levels for meeting customer demand and service. Other privileges that may accrue to this level of position would be setting the supply, drug, food and purchase services general ledger budget for the corporation or safety standards that prevent serious events from emerging."



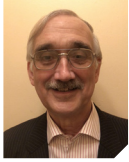
Winifred Hayes, Ph.D.,

Bellwether Class of 2018, questions whether health-care organizations are equipped to "plan for and respond nimbly and effectively to a rapidly changing environment" if someone at the CSCO level didn't exist.

"Sourcing is global, often disrupted by natural disasters and political and economic disruption," Hayes said. "The health care regulatory environment, with a growing emphasis on quality and value, demands new delivery and reimbursement models. Succeeding in this environment requires a strategic supply chain capacity with its leader having a seat on the Executive Team. Digital technology expertise, strategic planning, value- and evidence-based decision making and innovation are critical attributes

for this role. This role demands that the CSCO earn the respect and engagement of the clinical leadership in their enterprise.”

Australia-based **Br. Ned Gerber, OSB, CPA, CGMA**, O’Connell Advisory, Bellwether Class of 2010, remains somewhat sceptical about the issue beyond status.



“I am frankly unsure if a healthcare organization needs a CSCO/CPO,” he said. “Some are eager for the status that such a title may confer. I prefer results. When we produce consistent, cost-effective, high-quality results the status – and respect – will follow. Historically, having VP in a person’s title was considered a mark of status. Perhaps having the word ‘Chief’ in a title is now equivalent. But if so, I suggest it is not yet universal, and does not seem to be widely used outside America, e.g., in Commonwealth countries.”

Jim Olsen, CSCO, Atrium Health, Bellwether Class of 2015, counters that the loftier title clearly denotes the decision maker.



“It is a designation that is needed to point people – internal or external to the organization – to the head of the Supply Chain,” Olsen said. “Other titles do not communicate the specific authority in the organization. The privileges and burdens are the ability to contribute significantly to the organization’s success and long-term viability. The burden is to make difficult decisions that are not universally popular, and to work with the appropriate users. You cannot reduce cost, [but] never change products and give everyone what they want. You can reduce cost, give users what they need and understand the cost of change.”

For an industry emphasizing and promoting team-based care across a care continuum, it only makes sense for the executive/senior leadership team of officers overseeing those efforts to include a supply chain officer in the form of a CSCO,

according to **Rand Ballard**, Chief Customer Officer, Vizient Inc., a Founding/Platinum Sustaining Sponsor of Bellwether League.



“It would seem fundamental, actually, that the executive who is accountable for the second- largest area of expense and asset management across the organization and its full continuum of care would also be an officer,” he noted.


“The CSCO should be a part of the C-suite team,” Ballard emphasized to **Leaders & Luminaries**. “The CPO at Caterpillar sits in the C-suite. The same with Ford. That’s because this is the second-largest area of expense. Non-labor expenses represent where levers are. I can’t imagine then why they wouldn’t be at the table.

But he’s quick to point out that these titles may vary by organization even as the level of authority within the leadership structure may be equivalent.

“The truly defining attribute that the other chief officers share is that they report directly to the CEO,” Ballard said. “Also the CSCO’s role, like the other officers, would include having an executive presence and accountability to the organization’s board of directors... as well as directly participating in and contributing to the development of the organization’s strategic plan and benefits from the insights gained through those activities.”

Ballard cautions that the CSCO/CPO may not be applicable to everyone.

“The facility type really shouldn’t matter for the C-suite team model that includes the CSCO with the CEO, CFO, COO, CMO, CNO and others,” Ballard insisted. “You just have to find the right individual to occupy the office. It can be hard to find that individual to fulfill that strategy. You may not be able to walk in right away and have that credibility. You may not be able to appoint any administrator or administrative type to that position. But it’s an exciting development to see.”

Editor’s Note: For more details on the nine Bellwethers here, read their respective Bellwether career profiles at BellwetherLeague.org. 



SUPPLY CHAIN LEADERSHIP THROUGH THE AGES

Gazing back through more than a century of progress experienced by healthcare supply chain leaders, you might be challenged to find how the earliest pioneers could link to their more contemporary professionals.

Bellwethers, Future Famers, Board Members and Sustaining Sponsor Executives share their thoughts about the characteristics shared by Supply Chain leaders from the past to the present that weave a colorful tapestry through the Golden, Silver and Modern Ages.

Strong values, collaboration and entrepreneurship.

Rand Ballard | Chief Customer Officer, Vizient Inc., Founding/Platinum Sustaining Sponsor

Across all the ages, the successful supply chain leader has had to have the one trait of being willing to innovate and be creative. The reason that Supply Chain has been so successful in rising from the basement to the C-suite is that new and appropriate concepts were developed and instituted to provide good to the organization.

Lee Boergadine | Bellwether Class of 2008

- **Ability to grasp the big picture:** Not relying on one supplier or plant without alternatives just in case of a crisis; recognizing that the acute care model of healthcare is shifting to clinics, outpatient centers and community/home settings.



- **Ability to tackle the difficult:** This includes complex, high-cost medical equipment and systems, public-private partnerships for new construction, recruiting clinical, financial and legal expertise when needed.
- **Ability to anticipate the unexpected:** This includes preparing for “black swan” events, such as pathogenic epidemics/pandemics, natural disasters and man-made disasters.

Br. Ned Gerber | *Bellwether Class of 2010*

All ages are linked by one central and absolutely essential function – obtaining the supplies (equipment, disposables, devices, implants, diagnostics, drugs, etc.) that clinicians and other supporting personnel must

use to prevent disease, promote health, diagnose disease, cure disease and provide supportive healthcare.

Winifred Hayes, Ph.D.

Bellwether Class of 2018

Leadership is setting common, large goals for the organization and looking at the total picture. Management is the carrying out of activities to achieve these goals. In my opinion, leadership without management is dead; leadership with management is the answer.

Charles Housley

Bellwether Class of 2008

- **Social Leadership:** Ability to influence, collaborate and have the interpersonal awareness that advances collective goals of the supply chain.
- **Agility:** Being adaptable, curious and innovative especially when there are conditions of ambiguity and risk.
- **Energy:** Vitality, resilience and drive for achieving in spite of obstacles.

Thomas Lubotsky

Former CSCO, Advocate Health Care, Bronze Sustaining Sponsor

- A sincere desire to improve patients’ health.
- Fundamental respect for the other people involved in a question: Doctors, nurses, suppliers.
- Objectivity in decision making; not “I want you to stop doing business with your friend and start doing business with my friend,” but “this product/supplier is better for us because they provide a better value for the patient.”



- I also believe that very little is achieved by screaming, yelling, cursing or jumping up and down unless there are lives to be lost.

Jim Olsen | *Bellwether Class of 2015*

I would say the one skill in common to leaders from all ages is their innovation in supply chain. Innovation in practice, span of control and technology all had a very important contribution to advancing quality patient care.

Ray Seigfried | *Bellwether Class of 2012*

A highly trained leader with a passion for the job who is willing to sacrifice his time with family and friends to work towards success.

Bob Simpson | *Bellwether Class of 2012*

I believe the one skill or approach that is common and links leaders of all the “ages” is that they all had or have “The Courage of their Convictions.”

Nick Toscano | *Bellwether Class of 2018*

I see two essential analogous traits: Optimism and resiliency/grit, a perspective that pushes through regardless on the size of the challenge and provides vital motivation during good times and reassures during difficult times.

Erik Waterius | *Future Famers Class of 2016*

THREE'S COMPANY: VIEWS FROM THE TOP OF THE CHAIN

A Bellwether Q&A with Chairmen Kowalski, Gaida and Gaich

By Rick Dana Barlow



Launching an organization can be an invigorating exercise, a notable accomplishment and a noteworthy achievement. When a group of health-care supply chain industry veterans decided to take the plunge and create an independent Hall of Fame for

Healthcare Supply Chain Leadership in the summer of 2007, many felt it was “about time” and “the right thing to do.”

Unfortunately, unwrapping the finished product, Bellwether League Inc., while trying to build interest and attract interest and corporate and professional sponsorship just as the stock market crashed and the nation succumbed to the “Great Recession of 2008,” raised more than a few eyebrows.

Then again, isn't that how industry Bellwethers are defined?

Leaders & Luminaries Executive Editor Rick Dana Barlow met with Bellwether League's first three chairmen to draw out their reflections and impressions on the development and launch of the organization as well as its growth and progress to date. Jamie C. Kowalski served as the Founding Chairman (2007-2013), John B. Gaida succeeded Kowalski (2014-2016), followed by Nick Gaich (2017-2022).

Q More than a decade ago as the nation was sliding into a major economic recession, a group of veteran supply chain advocates, evangelists and observers launched Bellwether League as an independent Hall of Fame to recognize and honor professional leadership and innovation. They had lofty goals, but a vision and mission to carry them out. Looking back through the years, how would you characterize

Bellwether League's progress? Is it now where you originally thought it might be 10 years down the road?

KOWALSKI: In many ways, Bellwether League is further along than I expected. It is a bit behind in industry-wide recognition but making notable promise, every year. Those who know Bellwether League realize the value of the service it is providing by finding those who deserve Bellwether status, since it gives credit where credit is due, raises awareness of the importance and accomplishments of Supply Chain and its leaders, and achieving its Bellwether status serves as a goal for Supply Chain leaders to which to aspire.

GAIDA: I believe our progress has been about a “B+.” Sure, I would have liked us to be further along in terms of size and financial support, but all in all we have survived a difficult time in healthcare – downsizing, merger mania, and everyone worried about financials. We depend mostly upon supplier support even though we have developed a few minor income streams. Much credit to our support has been an Executive Director who watches the finances closely and Board Members who have likewise been prudent in the expense side of our business. So, 10+ years later, we are financially sound and aggressively pursuing opportunities to grow our financial support and potential revenue streams.

GAICH: Our progress has been one of continuous growth, and well on track in fulfilling the mission and purpose of our charted goals to the point that it has truly exceeded the early expectations of our founding Board members. As Bellwether League's third chairman I am overwhelmed with a sense of pride and humility to carry forward

their vision. We have a decade of operations behind us and more than 100 Bellwethers and Future Famers recognized for their contributions. This now serves as constant reminders to our current Board of Directors to stay true to our pledge of service as leading advocates for the next generation of Supply Chain professionals and next decade of operations.

Q What's your impression as to how the industry – providers and suppliers alike – has reacted to Bellwether League's mission, vision, debut and deliverance?

KOWALSKI: It was remarkable how many got on board immediately, stating this was long overdue and how glad they were that finally someone did it. Plus, they put their money where their praise was – they became sponsors because “it's the right thing to do.” And, those who got it from the beginning have stayed with Bellwether League via sponsorship and attendance at the Annual Induction event. Mostly, those that have not continued the relationship with Bellwether League were acquired by another company. Yet even many of those acquired companies have continued that support. Providers seemed to “get it,” too. Many attend the event on their own dollar. Many submit nominations for Future Famer and/or Bellwether recognition. Many providers invested their own time to support Bellwether League



Jamie C. Kowalski



John B. Gaida



Nick Gaich

by serving as Board members and working committee members.

GAIDA: It has taken a little while for the industry to recognize us and our mission, but I believe we are now pretty well-known and appreciated. Of course, it was a select few who “got it” immediately and came to our support, which allowed us some running room to further our vision. We determined early on that we needed to broaden our recognition to not only those who have long since gone before us, but also to acknowledge a limited number of professionals who were very near the end of their careers, but yet still active in the business. They were Bellwethers – just not quite done with their careers. We needed to showcase what we were all about and recognizing more current Bellwethers was the ideal way to do it. We still have many more individuals to dig out from the past and recognize for their accomplishments – we will continue to do so, along with a “sprinkling” of more current individuals.

GAICH: I truly believe the Vision, Mission and Values have from Day One resonated with all stakeholders. As with any newly introduced idea, delivering on one’s Vision becomes the turning point for engagement and adoption. Bellwether League has not only established a strong foundation of acceptance through continued support and endorsement, we continue today to assemble an incredible coalition-partnership of growth within our community of practice signifying to me we are well positioned in the hearts and minds within our industry.

GA **If someone were to rewind time and hit the reset button, what would you do differently to create, develop and grow Bellwether League?**

KOWALSKI: Growth may have been quicker if Bellwether League had been able to find at least one mega-sponsor to provide the seed money for doing many things to gain recognition, find candidates for nomination, etc. Instead Bellwether League has been something of a bootstrap operation; not anything to be ashamed of, but rather proud of based on how far we’ve come.

It also would have helped if we had all the administrative work completed prior to start-up; policies, criteria for nomination and selection, etc. But, as a purely volunteer-run organization, that was not really feasible.

GAIDA: The easy answer to that would be to start it sooner! Rick Barlow and Jamie Kowalski had the vision, but it was only around 10 years ago. I think if we had begun, say, 10 years sooner, it would have been a bit easier in terms of attracting supporters. Plus, the more time that has gone by, the harder it has been to search out those worthy individuals from the past. Each year it gets a little harder, but we are dedicated to our mission.

GAICH: This is a hard one to answer because from the beginning our mission and vision deeply resonated with all industry colleagues. At many levels an “all-hands-on-deck” mindset generated a ground swell of initial inertia, serving as a jump start for the formation of the Bellwether League. However, if I had a reset button I believe commissioning our beginning Bellwether Honorees to serve as a prominent source of “community advocates” to enlist and spread our network of supporters would have served as an accelerator for both growth and program development.

GA **As Bellwethers inducted into the Hall of Fame for Healthcare Supply Chain Leadership and as Chairmen of the Board of Directors of Bellwether League, what would each of you say is Supply Chain’s weakest link within healthcare financial and operational transactions and within clinical care services and why?**

KOWALSKI (Bellwether Class of 2017): Supply Chain still is way behind in gaining the stature and recognition for what it can and should do for healthcare providers. Some of that is a lack of strong leaders; the equivalent of COOs or CFOs in education, skills and rank in the provider organization.

Senior execs are still unable or unwilling to elevate the role and position of Supply Chain leaders because they do not understand what Supply Chain really is and can be/do for the organization. They don’t yet know what a provider spends on supply chain, because of

IT limitations and archaic approaches to setting up systems that track and analyze supply chain operations, from a cost-accounting perspective.

GAIDA (Bellwether Class of 2018): The weakest link has always been access to good data. Back in the old days, it was access to usage information to better allow purchasing professionals to negotiate contracts. IDNs made it more difficult gathering information from multiple locations and multiple info systems (or lack thereof). Today, I think we have come a very long way to access usage data and cost, but currently lack the data showing product benefit – patient outcomes related to which product is used vs. another. Many today are pursuing various strategies in this quest, but a universal approach and standardized outcomes are still some time away. Clinicians will always have preferences, but we must help them understand how those preferences affect patient care – positively or negatively. Data is the only way to achieve that goal.

GAICH (Bellwether Class of 2013): I would express my thoughts more from a perspective of what stands before us in terms of exposures and what lies in front of us as opportunities to pursue and overcome. I believe our greatest exposure is our inability to maintain continuity and alignment within all three of the disciplines stated earlier, which in turn sub-optimizes both our value and impact as significant contributors in the healthcare ecosystem.


GA **How challenging and time-consuming is it to fix either?**

KOWALSKI: VERY!!! A comprehensive and holistic supply chain philosophy, approach and operation almost always requires a major change in an organization’s culture. That is lengthy and very hard work. And, it is essential for organizations to realize that is what is needed.

GAIDA: Healthcare has invested many millions of dollars in recent years to create computerized patient records across health centers and the care continuum, but little has gone into the need for advanced computer systems needed to track patient

outcomes by product. I certainly hope that some of the funds used to finish those computerized health records can now be directed to product outcome information. It will be a hard sell and very challenging to have health systems devote large sums of money in the direction we need.

GAICH: Our greatest exposure will also serve as our greatest opportunity. Although many may see this as a grand challenge that will require an overriding burden of time and resources to overcome, I believe it's in our grasp. As we stand today Supply Chain executives are better equipped with not only advanced technology capabilities and educational backgrounds transcending traditional supply chain competencies, they are better prepared with organizational leadership skills, which in turn serves as the connective tissue that within the next five years of service will propel us over the top of the grand challenge.


 **Healthcare Supply Chain professionals today enjoy unprecedented access to an array of high-end technologies conceivably to do their jobs better. But arguably, digital prowess doesn't – and perhaps shouldn't – overshadow analog wisdom gleaned from years of experience. What are some foundational/fundamental mores that can't be replaced or supplanted by technology and why do they matter?**

KOWALSKI: There are many supply chain IT developments have been made in the last decade or two. Almost any task that can be automated now is. Almost any analysis that is needed is available. However, supply chain in healthcare is still technology under-invested. The EHR/EMR (mandated by the federal government) and the Enterprise Resource Planning (ERP) system investments have been enormous and have frequently shut out any timely opportunity for providing Supply Chain with what it needs in today's environment. For some, that actually means even the most fundamental IT tools.

Strong Supply Chain leadership is what is needed much more than IT prowess. This includes people skills, communication (listening as well as talking), strategic thinking/planning and action, analysis, judgment, action orientation, customer focus, reliability and common sense. There are many skills others that help leaders be effective leaders.

GAIDA: The talent to negotiate has, in my opinion, always been at the top of the list of skills needed by Supply Chain leaders. Our job has always been to convince others – selling, if you will, our plans and strategies for reducing costs and improving care in the support of clinical staff. Having the data is very important, but if you cannot then use that data to convince others of change, it is of little value. Likewise, negotiating with manufacturers, distributors, and others is a cornerstone of what we do in supply chain. The skill that comes from artfully and professionally bringing divergent parties together for a common goal is something that can never be replaced by a computer.

GAICH: Certainly there is no question that high-end technologies, as well as sophisticated data science modeling, are growing at an exponential rate. However, to truly harness its power human interventions will remain as a vital component to maximize return. To successfully grow and sustain a future where 'high-tech/high-touch care' becomes the standard, we must continue to grow leadership capabilities in the areas of critical thinking, strategic awareness/planning and human-centered design.


 **At this point in your career – whether active, semi-retired or fully retired – knowing what you know, having logged years of experience, and interacted with the “next generation,” how would you characterize your outlook on the healthcare supply chain? Dim, bright or somewhere in between and why?**

KOWALSKI: Lots of untapped, unfulfilled potential! What is needed is a universal “burning platform.” The industry and the

population can't wait another day of frittering away resources that become scarcer every day. Supply Chain can bring so much value – quantitative and qualitative – to each provider and supplier that does business with those providers, that each day delay of doing what can and must be done, can mean unnecessary spending (a.k.a, wasting) of tens to hundreds of thousands of dollars. No business or industry can survive that lost opportunity. Optimizing supply chain management performance is not an option; it is THE mandate.

GAIDA: I believe the greatest weakness today in Supply Chain is the every growing need for well-rounded and experienced leaders to replace those individuals retiring. I've said multiple times when us “old timers” grew up in the business, we were more likely to be trained in the many areas of supply chain (purchasing, distribution, central processing, etc.). Today, I think there are more specialists who do not really know all these areas. Make no mistake, we certainly have many talented folks in healthcare supply chain, but I just don't see the breadth of experience and leadership that I think we need to tackle not only the basics, but the ever changing healthcare landscape, such as alternate sites of care, contracting with entities outside of just manufacturers, and other 21st century demands on supply chain. I'd also add that I've seen a growing number of talented supply chain leaders move into other areas of healthcare management which, of course, is wonderful, but does reduce the continued growth of those leaders in supply chain roles.

GAICH: Without question the future is bright!!! Although there will always be a degree of uncertainty as healthcare continues to evolve and mature, Supply Chain stands well-positioned to serve as pivotal contributors, leaders and innovators in the decades to come.

 **For Supply Chain to succeed and thrive in the future, what are the top three behaviors/skills you believe leaders will have to grasp and practice? Why?**

KOWALSKI: Strategic Thinking – needed for determining what has to be done, in what sequence and time, and what to expect for the outcomes.

Communications (Listening, Talking and Writing) – so it is possible to persuasively and collaboratively work with physicians, clinicians, executives, suppliers and all others that the Supply Chain interacts with.

Analysis – needed to avoid the “I did this at the last place I worked, so it must be a fit here,” or to determine what are the quantitative and qualitative (quantified) of a change, a plan, a decision or a selection.


GAIDA: Mentoring – we owe it to not only our organizations, but to the people who currently work in supply chain. We need to be sure we are training every individual for his or her future professional growth. We need to give them the freedom to grow and learn new things.

Negotiating skills – this talent is critical. Leaders need to convince not just administrative staff at the highest levels of their needs, but also those clinical leaders who must view them as partners and not adversaries (as I am afraid is still the norm in some places).

Inclusion of clinical staff into supply chain – many have incorporated clinicians into supply chain for years, but I believe we need to advance that pace. I’ve always said it is much easier to teach the clinician the art of supply chain than it is to teach a supply chain person the skills of a clinician. We need to be closer together and merge our resources/goals in order to be successful for the future.

GAICH: As we all strive not only to succeed but thrive in a future state world, boiling it down to three behaviors or skills one must acquire may be self-limiting. To answer your question, I believe our greatest challenge first is to recognize and accept that Supply Chain will continue to evolve into a greater contributing role within the healthcare ecosystem, and to thrive and excel we must adopt a “growth mindset” – a belief that change is a constant force and possible. This shift in mindset is a table setter that allows us to see the future as a natural evolution of change. It also negates

a fear of breaking with traditional thinking, and most importantly, allows us to recognize as leaders that we must continue to improve ourselves as well as the individuals we are leading. If I dare to stare in the looking glass two characteristics/behaviors surface as the underpinnings of future success: Resilience and a fail-forward perseverance both attribute to developing a growth mindset.


 **How will the working relationships between providers, suppliers and payers have to change to meet the demands of the care continuum, population health and consumer-driven healthcare services?**

KOWALSKI: At the risk of sounding trite, all have to be looking out for the good of the industry, the community, the greater good, looking to develop win-win-win approaches, plans, system and deals. Of course, these principles need to be followed within a capitalistic society and economy, in which capitalism is not a dirty word.

GAIDA: Unfortunately, a large part of that continuum is only interested in making money (profits) while the other is focused on improving patient care. I think both goals can be realized, but it will be critical to see some of the existing barriers broken down. The expression “aligning incentives” has probably been over-used without being achieved. Unfortunately, I don’t have an answer how to do that! I think there will have to be some risk taking on both sides to effect the change needed.


GAICH: As the healthcare sector continues its upward climb towards value-based care two significant challenges present themselves: Recognizing the intersectionality between the care continuum, population health and consumer-driven healthcare while embedding the inseparable link between clinical quality and operational effectiveness within its design. The movement from a “diagnose-and-treat” to a “predict-and-prevent” shift in mindset is no easy task. I believe we have seen provider, supplier and payer relationships struggling to adjust conventional thinking – a re-calibration of working relationships – that is understandable based on the high-level of uncertainty that still lies

ahead. However, breakthroughs are occurring, and successful models of change have revealed a possible forward-looking path based on four key principles: Trusted environment where collaboration is possible; incentivized payment model that aligns clinical quality and affordability; shared data that involves collection, analysis and evaluation; and a patient-centric foundation encompassing personalized population/community-based services.

 **If you were to share your parting words – or shots – with the industry, what would they be and why?**

KOWALSKI: Bellwether League was formed to make known and fill a need in the healthcare supply chain management profession. To date, it has met most of its objectives and goals, and in some ways, exceeded them. But, there is a long way to go and a lot more to do. As long as the healthcare supply chain profession, and especially those who have been instrumental in the founding, guiding, operating, supporting/sponsoring and growing Bellwether League in reputation and accomplishments (finding, evaluating and inducting Bellwether-worthy [based on Supply Chain having at least met the criteria/qualifications]), the industry can count on Bellwether League to serve as the beacon to the profession, shining the guiding light for those who strive to, one-day, become Supply Chain Bellwethers.

GAIDA: Good luck, of course! I’m confident that things in healthcare will continue to improve – the question is really how long will it take and what happens in the meantime?

GAICH: Having the privilege to contribute in an industry where the principal aim is to serve others first is humbling. I would end my thoughts by sharing a note of optimism and excitement. I’m optimistic in that lessons learned from both past and current Supply Chain innovators will not only sustain the test of time but evolve to greater heights by our upcoming Supply Chain executives. I’m excited to bear witness and play a role in the continued evolution and advancement of Supply Chain contributions. 

GOSSETT CONSISTENTLY GAVE BACK

By Rick Dana Barlow



You may know him by name – and perhaps name only – but not necessarily by face, accomplishments or reputation.

If you had the privilege of working with him, befriending him or otherwise associating with him in the late 1950s through early 1960s, you most likely remember him as a devout Christian and devoted family man with a genuine and generous heart and a selfless, servant-oriented attitude that dominated his spirit.

George R. Gossett,

who embarked on his abruptly shortened but endearingly meaningful supply chain career as a purchasing agent for Cleveland's Polyclinic Hospital in 1957, led with a sense of honesty, integrity and professionalism that should define any supply chain worker's behavior and role today. Along the way, his supply chain acumen helped the renowned Johns

Hopkins Hospital in Baltimore and venerable Mercy Hospital in Pittsburgh. And he was one of the founding fathers of what's now known as the Association for Healthcare Resource and Materials Management.

To emphasize Gossett's industry relevance and stature, AHRMM Past President Ray Moore once commented, "His face is on AHRMM's one-dollar bill."

Gossett's oldest son Kim C. Gossett, fondly remembered his father as he accepted his father's induction into Bellwether League's Hall of Fame for Healthcare Supply Chain Leadership eight years ago.

"When my dad went into this field his heart was for people."

Kim Gossett

"As a young boy my dad always told me, 'son, if you're ever going to be a leader someday you'll be a servant first because it's those who serve that give the example to others to follow upon which now they can lead others in that way,'" Gossett said. "My father was a God-fearing man. His faith was in the Word of God. He raised us in the family to always have our faith and our trust in the Lord."

George R. Gossett was inducted into the Bellwether Class of 2010. Gossett and wife Liz had three children – sons Kim and Jim and daughter Bethanne.

Gossett answered Polyclinic Hospital's call to become its new purchasing agent in 1957 as a way to serve others.

"When my dad went into this field his heart was for people," Gossett said. "He would go in and see the incredible need. He always wanted to make sure that any person – whether it be a husband, a wife, a child, a family member – that anyone who walked into a hospital would have gotten the best healthcare that they could get. If it was from the bed linens to the best beds to the nurses or the doctors having the equipment that they needed, he worked diligently to make sure that the people who walked through the doors would walk out well and healed.

"The healthcare industry itself was more than just a business," he added. "It was for people. That was his heart."

At the age of 8, Gossett recalled his father getting a call from Johns Hopkins Hospital.

Executives there had heard about how Gossett had helped Polyclinic establish and improve solid business and purchasing operations without sacrificing patient care and service. They wanted to know more.

George Gossett spent a week at Johns Hopkins, freely sharing his expertise and insights with the hospital, akin to what a high-priced management consultant would do today decades later.

Two months after Gossett returned home, however, Johns Hopkins called again, this time offering him a permanent management position in purchasing.

"He and my mom prayed about it and felt that this is where we were to go so we moved to Baltimore from the Cleveland area, and for the next couple of years he did incredible work with Johns Hopkins Hospital," Gossett said.

Because George Gossett knew what it was like to be poor, his life continued to be about people, Kim Gossett emphasized.





◀ Kim C. Gossett accepting George Gossett's Bellwether League beacon from Jamie Kowalski.

During Thanksgiving every year, Gossett would fill the family car with frozen turkeys and with his two sons in tow, head to a place outside of Baltimore where the impoverished lived called the “shanties.”

Gossett would go up to the door, knock and ask the complete stranger who answered the door if he had food for Thanksgiving. “He’d come back and have my brother or I take a frozen turkey and present it to a family that we had never seen before and would never see again,” Kim Gossett remembered. “As a young boy I’ll never forget the look on their faces when a stranger walked away and they now had food for Thanksgiving.”

The Gossett trio did something similar during the Christmas season with the clothes they had outgrown. “We would fill the car and once again go back to these shanties outside of Baltimore,” Kim Gossett said. “We would go to the poor and give them blessings for their children to be kept warm. This was the heart of George Gossett.”

In the early 1960s, executives at Mercy Hospital in Pittsburgh learned of Gossett’s work at Johns Hopkins. They called for his help, and the Gossetts headed northwest to the facility where he would finish his short but reputable supply chain career.

George Gossett gently emphasized the importance of caring, compassion and understanding to his sons. “He would always share with us as young boys,

‘if you’re having a bad day, son, someone’s having a worse day. If you’re having a hard day, someone else out there is having a harder day. If you’re hungry, someone out there is hungrier. And if you’re ever lacking, someone’s lacking more,’” Kim Gossett said.

“My dad was a man that if he had but a nickel in his pocket he would have given it and walked away knowing that he touched someone. That was the life of George R. Gossett,” Kim Gossett noted.

For many, George R. Gossett represents a name on an association leadership award – an association he was instrumental in developing and transforming into a full-fledged personal membership group within the American Hospital Association. For his efforts and contributions, the American Society of Hospital Purchasing Management elected Gossett its first president in 1962 during a conference in New York.

Tragically, a fatal car accident cut his life short just three years later at the age of 38. Kim Gossett was 14 at the time.



“I’ve missed him for 45 years,” Kim Gossett choked while tearing up, “but hey, I’ll see him again [with a smile, pointing upward]. I long for that.”

Shortly after Gossett’s death, ASHPM created an award in his honor. Today, the George R. Gossett Leadership Award represents the highest honor AHRMM bestows. To date, 28 men and women and one company have earned the award.

George Gossett certainly left an indelible impression on son Kim who jettisoned corporate America in 1984 after a trip to Africa.

“When I saw the plight and the need of the refugee camps in Kenya on the borders of Sudan I came home and quit my job with National Semiconductor,” Kim Gossett said. “I’ve dedicated my life to the Lord and now travel to Third World nations.” As a pastor and missionary, he launched the non-profit New Covenant World Outreach (www.newcovenantchristiancenter.net) to do missionary work and bring much-needed medical supplies to the people in such places as Kenya and Uganda, Africa, among others.

After his organization supplied a small hospital in Africa he reflected on his father.

“All I could think about was my dad and how he did that here as a standard in America. Now we’re doing it in remote parts of the world,” he said.

In heartfelt e-mails sons Jim and Kim Gossett reflected fondly on their father.

“He was a good man, and all I have is good memories when he was alive,” Jim wrote.

“Not one day has passed since May 27, 1965, when our hearts were deeply broken, do I not remember my Dad,” Kim wrote. “He is with me daily. I am honored to have been his son.” ¹

◀ Kim C. Gossett talking about his father, George Gossett at Bellwether League 2010.

CLARK PIONEERED PURCHASING PROWESS AS 'APOSTLE OF COOPERATION'

By Rick Dana Barlow

Guy J. Clark was the consummate purchasing executive whose commitment and dedication to the industry and profession clearly was evident in his long-standing and consistent career path that spanned nearly four decades.



Bellwether League

Inc., the Hall of Fame for Healthcare Supply Chain Leadership, recognized Clark's pioneering accomplishments, influence and leadership, and inducted him into the Bellwether Class of 2009.

Clark's career began in Cleveland's City Hall in the early 19-teens where he served as a purchasing agent for five years for the city of Cleveland. Clark left for a brief stint in the real estate business before he was invited to join the two-year-old Cleveland Hospital Council (CHC) as its first purchasing agent in 1918. Clark developed CHC's Cooperative Purchasing Service (CPS), which nurtured relationships between the hospitals and vendors, as well as the central organization to which the hospitals belonged. Clark served as the first executive director of CHC's CPS, which also was one of the first in the nation.

From its inception, CHC's Cooperative Purchasing Service for hospitals was regarded as one of the major service activities of the Cleveland City Council, and it became one of the largest and most successful local programs of its kind. CHC's CPS affiliated with the older Hospital Bureau of Standards and Supplies of New York, which was founded in 1910 and recorded as the first group purchasing program in the nation.

The challenge Clark and his new operation faced was that each hospital

operated its own purchasing department, which made its own buying decisions for supplies and equipment. Clark had to foster relationships with the hospitals' administrators and purchasing agents alike to participate.

Clark developed policies on specifications and simplifications that involved the "least possible expenses." He provided members with a bulletin service that advised them of new contracts, agreements, price changes and market conditions. During the first decade of its operation (1918-1928), the CHC CPS saw its purchasing volume soar to more than \$1 million from nearly \$23,000, including nearly \$183,000 from non-hospital organizations.

CPS continued to grow until the stock market crash in 1929 and the Great Depression hit in the 1930s. Hospitals placed severe restrictions on their buying policies with the lowest point recorded in 1933, but resumed growing to a membership of 42 facilities.

In the autumn of 1926, Clark became CHC's third executive director (technically executive secretary), a post he held for 29 years until his retirement in 1955. His career also included serving as a member of the house of delegates of the American Hospital Association, and a president of the Ohio Hospital Association, and for 14 years a member of OHA's legislative committee. He also served as the executive secretary of the Hospital Finance Corp. for more than 35 years, concurrent with his similar post at CHC.

During his 37-year career at CHC, Clark never forgot his purchasing history and roots, and "never ceased to be a purchasing agent," consistently pursuing cost-cutting initiatives and economic efficiency for the central organization

and its members, even during his 29 years at the chief executive's desk. He had a penchant for economy and cost cutting to the extent that "staff members would affectionately kid him about his barren office furnished only with an old desk and chair."

“He affectionately was referred to as Cleveland’s “Mr. Hospital,” and a champion of health and welfare in the city.”

Clark was credited for organizing CHC's purchasing service, developing and implementing uniform cost accounting and common employment and collections procedures to help hospitals operate more efficiently. Through Clark, CHC achieved state and national recognition. During one tribute, the president of the Cleveland Welfare Federation referred to him as "a seemingly brusque but sensitive, retiring man, who was the champion of health and welfare in Cleveland," according to an April 13, 1944, report in the Cleveland Plain Dealer.

In the same report, another feted Clark as "a pioneer in the hospital council movement, an apostle of co-operation. In the Cleveland Hospital Council he has perfected a model and held it up to the world for the inspiration and imitation of all."

CHC, which later became known as the Greater Cleveland Hospital Association

Continued on next page...

MATISKA BROKE BARRIERS, NEW GROUND

She helped found community hospital, led supply chain

By Rick Dana Barlow

Lillian Matiska demonstrated that she was all about consistency and dedication. After all, she began and ended her healthcare career at one hospital that she actually helped found for the community.

Jeannette (PA) District Memorial Hospital, which was located in a suburb of Pittsburgh, had approximately 149 beds and became part of Excelsa Health System until it was closed in 2011 and the building demolished for facility/structural issues after more than five decades in operation. Not only did Matiska help found the hospital with several other community members, including the Sisters of Mercy, but she officially served as its first employee.

Bellwether League Inc., the Hall of Fame for Healthcare Supply Chain Leadership, inducted Matiska into the Bellwether Class of 2009.

As an active volunteer in community affairs, she became committed to the concept of the small town (population approximately 9,900) having its own hospital and worked to make that happen by helping to raise the funds for its construction in 1959. She dually served as the director of purchasing – and head of personnel – at the hospital when it opened.

Matiska rose to national stature in the field of materials management, becoming


“She dually served as the director of purchasing – and head of personnel – at the hospital when it opened.”

president of the American Society for Healthcare Materials Management (now known as the Association for Healthcare Resource & Materials Management) in 1973. In fact, she was the second woman to become president of the organization. She was very active in the field and spoke in 28 states on various subjects in materials management. She pioneered many supply chain concepts during a time when the profession was just emerging in healthcare. Matiska was dedicated to her profession and her hospital. She believed in hard work and the small town work ethic. She believed in people and helped others realize their potential. She helped organize and was a president of the Pittsburgh Materials Management Society.

Matiska was recognized for her leadership and contributions to the field by receiving the George R. Gossett Award from the American Hospital Association (ASHMM) in 1980, the eighth recipient. She also received the Ellis Karp Award for leadership from the Hospital Council of Western Pennsylvania.

Matiska never stopped working hard in the healthcare field. After retirement,


she organized the Association of Retired Employees of the hospital and had twice served as president of the Jeannette District Memorial Hospital Auxiliary and donated thousands of hours to that organization. She even conceived of the idea of having the Auxiliary create a scholarship for medical students to enable them to establish a practice in Jeannette following their studies, thus providing the community with qualified doctors for many years. She worked tirelessly for the hospital and the health-care field for more than 40 years.

Matiska was married to her husband John for 58 years at the time of her death on Nov. 10, 2001, at the age of 83. Nearly a year after Lillian’s death, John passed away in 2002 at the age of 90. After serving in the U.S. Army, reaching the rank of a decorated sergeant, he spent much of his civilian career employed by Westinghouse Electric. However, during the founding of Jeannette District Memorial Hospital he joined Lillian at the facility in 1959 to be chief maintenance engineer where he instituted several well-regarded programs. He then returned to Westinghouse until his retirement. 

Clark continued...

and currently The Center for Health Affairs, called Clark “innovative” to the point that it retains many of his innovative procedures. One of his more famous procedures includes the “simple, but effective” “can cutting” technique for purchasing canned food in that “labels are disguised so that they may be rated on quality so that the best adjustment of price may be made.”

He affectionately was referred to as Cleveland’s “Mr. Hospital,” and a champion of health and welfare in the city. “Described as didactic, dedicated and indefatigable, Clark had the capacity of keeping personally involved with the many committees he had established as executive director. During the 1930s and 1940s there was a committee for ‘almost everything.’”

On July 2, 1957, however, CHC lost Mr. Hospital. Clark, 68, walked into Cleveland’s Lutheran Hospital at about 11 a.m. that morning for emergency treatment, according to his obituary in the *Cleveland Plain Dealer*. By 1:30 p.m., Clark had died of a heart ailment. 



HEALTHCARE'S INTEROPERABLE WORLD

Transparency has its privileges, pitfalls

By Ed Hisscock

This is getting personal.

One of the things that I find most valuable about serving in a Catholic healthcare organization is our culture of reflection. Upon receiving an email message the other day about a benefit that covers identity theft protection, here's how I reacted.

Having just returned from a conference, I reflected on a presentation where I watched a professional hacker call someone up on stage, ask her name and the city where she lived, and then within 20 seconds had enough information on her to take out a loan in her name. The scary personal information privacy aspects of that demonstration came to mind first, but I had just received my morning dose of talk radio and needed some positivity. I went somewhere different. I thought about the potential value in all of these personal "big data" talks within healthcare and the work that we do in supply chain.

That took me back to a general session presentation that I delivered at the national conference of the Association for Healthcare Resource & Materials Management (AHRMM) in 2007. The talk focused on technology – specifically, the use of technologies prevalent in industrial and commercial supply chain operations that I believed could be brought into healthcare to help us better communicate with our clinical stakeholders. After I demonstrated the use of an optimization algorithm to conduct real-time "what if" analysis on implant data for a fictitious group of surgeons, I ran an audio clip under the heading, "Caution: Securing Data and PHI Confidentiality."

The audio clip, a humorous dramatization produced by the ACLU, featured a gentle-

man attempting to place an order for a double meat pizza, only to have the pizza shop attendant talk him into a sprout sub and tofu sticks. As the fellow tried to order the attendant kept interrupting to alert him to data in "the system" that suggested the double meat was a bad idea. She shared information on his high blood pressure and cholesterol from his medical record and a recent purchase of size 42 waist pants. The attendant went on to add a delivery surcharge because the fellow lived in an area that was seeing an uptick in recent criminal activity (unbeknownst to him) but added that she knew he could afford it since he had just booked an expensive vacation to Hawaii.

While that audio clip may have achieved the mid-presentation levity that I desired, it also may be prescient. Looking back, it appears that the tenets of that clip seem to be gaining more traction than the specific technology that I was demonstrating. Granted, tech is everywhere, but the ability to leverage what is now known about us is staggering.

Just then I checked my calendar to remember precisely when the "lean training" workshop I was scheduled to attend would be held. Undoubtedly influenced by the upcoming workshop, I thought about variation and people as variables.

In healthcare operations we are confronted with the need to "lean out" our processes, reduce variation and drive standard work. These are noble aims and worthy pursuits. However, the fact remains that we operate in a people business. And people are the ultimate variable in any process.

The people variable adds tremendous complexity. Take comparative effectiveness as an example, another

noble pursuit, but beyond most provider organizations today. When we finally get the data cleansed to a point that it has integrity, and we begin interrogating the information, it seems as though every question that we answer just begs more questions.

Take any two competing products or devices and attempt to compare their clinical effectiveness. Derive a correlation between a product and length of stay, and patient demographic questions (age, gender, ethnicity, etc.) arise. Answer those and then acuity or comorbidity questions arise, answer those and then clinical technique is questioned, answer that and... on and on it goes.

I'm reminded of the old adage; how do you eat an elephant? One bite at a time. True enough, but this elephant is in the midst of a stampeding herd. We need help. The people variables are piling up at an alarming rate. In the last few months I've sent five new companies offering some sort of patient app over to our digital health team for evaluation. Each of those companies heralding their app would track patient compliance and gather data on the patient experience. Add to that the increasing amount of data that we are gathering on clinical practice from our electronic medical record (EMR) systems and you have big data.

So what happens when some of the other recent entrants into the healthcare space (i.e., Walmart, Google, Amazon, Chase, Berkshire Hathaway, etc.) apply their consumer (a k a covered lives, patients) information into the mix. Are a patient's eating habits or exercise regimen not also valuable health variables? What about all that is known about us from our online purchases or even our on-site purchases,



such as when you check out at the grocery and use your frequent shopper card and/or a credit card that links the purchases to you and your bank account?

Another slide in the AHRMM general session deck that I presented back in 2007 illustrated the “DIKW” hierarchy. This systems thinking and behavioral science model shows the relationship or transformation from Data to Information to Knowledge to Wisdom. It articulates how we take individual symbols (Data), link them together to form sentences or structures that convey meaning (Information), apply the structures to a context to codify learning (Knowledge) and finally utilize the learnings to evaluate the unknown and develop understanding (Wisdom). Fortunately, people are not only passive variables adding complexity to processes. We also are problem solvers and have learned to adapt our various capabilities, approaches and perspectives into creative pursuits and the ability to innovate.



We are developing technologies to assist with assimilating these big data and moving them up the hierarchy. Technologies, such as IBM’s Watson and other advanced analytics and machine learning tools help us gather all that is known and apply

“ I’m reminded of the old adage; *How do you eat an elephant? One bite at a time.* ”

True enough, but this elephant is in the *midst of a stampeding herd.*

We need help. The people variables are piling up at an alarming rate. In the last few months I’ve sent five new companies offering some sort of patient app over to our digital health team for evaluation. Each of those companies heralding their app would track patient compliance and gather data on the patient experience. Add to that the increasing amount of data that we are gathering on clinical practice from our electronic medical record (EMR) systems and you have big data. ”

it to questions about health. With this information and knowledge our clinical experts can develop new wisdom about our health and well-being.

So how does supply chain fit into this mix? Certainly, we’ll face challenges in helping our stakeholders discern which technologies to acquire and negotiating those deals. Yet the same fundamentals we apply to the physical logistics of supply chain also apply to data. We are accountable to physically provide the products and services to the clinicians and support staff. Why would it not also be true for the data associated with the utilization of these products and services? We are in possession, or should be, of the data about the what, where, when and who received the products and services.

With comparative effectiveness, provider supply chain professionals clearly are in the best position to gather and assimilate data about the utilization of the products and services. With my involvement in the recent Meaningful Use Phase III

requirement to ensure that all implanted items are captured in the EMR, I know that we will be called upon to fulfill an ever-increasing role in the clinical documentation of care. Leveraging that information is a start, but answering questions about the implanted items will only beg more questions requiring additional data and information. Some of that data and information will involve the additional supplies and purchased services used by a clinician to care for the patient.

I also thought about our role to ensure that the purchased services firms that we engage will be required to provide the data. And for that matter, what will the purchased services look like in the future? Will we be negotiating with Amazon and Google to provide data about our patient population? Seems a bit farfetched but thinking about a consumer getting more engaged in their care and valuable data about their health and well-being hosted by a third party, there is plausibility in the thought. **1**

This is getting personal.

Ed Hisscock is a supply chain executive with Trinity Health and a Board Member of Bellwether League Inc.

“ When we finally get the data cleansed to a point that it has integrity, and we begin interrogating the information, it seems as though every question that we answer just begs more questions. ”



FAR SURPASSING SURVIVAL OF THE FITTEST

We meet at the intersection of change and choice

By Nick Gaich

When asked to write a column in Bellwether League's inaugural edition of *Leaders & Luminaries* I was both honored and anxious. After all, the leadership and contributions exhibited by all of the wonderful professionals dedicating their time and expertise as advisory board members and contributors to this publication is unparalleled.

Upon deeper reflection, I realized that there was a centering theme for their success: A message of "Change and Choice."

Change: The very essence of the word itself insights such a wide range of emotions within us all. In some it stirs up fear, anxiety and pressure to perform. In many it evokes a sudden and immediate pullback from recognizing a simple truth that a situation or environment we have grown to know will soon transition into a new or different way of life. In others it stirs emotions of excitement, opportunity and a personal drive to challenge oneself to not only accept a new environment but to lead others in the transformation. Both sets of emotions are natural conditions of change we have all experienced with various outcomes of success or failure.

So why do some falter when change occurs, and some others succeed? Some may say certain individuals are just geared to navigate stormy waters while others are just inclined to resist at all cost. I believe there is an intersection where success or failure resides. That intersection represents "choice."

Through a few hard-knocks experiences in my personal journey I began to realize the important benefits of adopting the teachings of Heraclitus (noted for the quote "the only thing that is constant is change"). A concerned educator once shared it with me. A humbling experience at the time, his guidance proved to be an awakening. I realized that I would continually be called upon to make a choice either to embrace or to resist various levels of change if I aspired to be an empowering leader.

Choice to change

Recognizing the importance of change acceptance is key. In its purest form the nature of change follows three distinct paths (*with varying degrees of overlap throughout the change process*).

- **Path 1:** That which is done to us
- **Path 2:** That which we do to ourselves
- **Path 3:** That which we do to others

Recognizing the levels of complexity and importance of accepting and embedding change principles as a leadership attribute in your arsenal of skills is an essential step forward as a chosen leader.

The choice to change goes beyond survival of the fittest. In fact, Darwin is usually misquoted as to what he said about change. His entire quote says, "It is not the strongest of the species that survives, nor the most intelligent that survives. It is the one that is the most adaptable to change."

Defining the path forward

Where does that leave us knowing that change remains our only constant and opting out not a sound choice? How do we raise the probability of success with all the time and effort required? I have learned along the journey that to successfully lead a change/transition strategy focusing on not only the **What** but also the **How** and the **Why** is imperative! The following questions will help lead the way:

- What is at stake if we do not change?
- What is our current state and where is our desired future state?
- What needs to change?
- Where are we going?
- How do we get there?

< DETOUR AHEAD

On a strategic level, champions of change in our first edition of *Leaders & Luminaries* stacked the odds in their favor by:

- Providing relevance and meaning by overtly linking the change effort to business strategy.
- Paying attention to change governance providing clear change leadership roles.
- Generating a strategic discipline on how to lead change.
- Providing leadership in initiative alignment and integration unifying and integrating strategy and operations in detail and with measures.
- Honoring organizational culture as the cradle of the values driving behaviors and not underestimating it as a driving factor in the change.
- Providing leadership modeling and identifying internal champions willing to change their mindset and behaviors to model the change.
- Nurturing the human dynamics component, proactively addressing the emotional side of the equation striking a balance between content and process.
- Incorporating engagement and communication as a strategic element in gaining stakeholders' as agents of change.

The exploration of new beginnings fueled by a constant force of change positions us all as supply chain leaders to meet at the intersection of "Change and Choice," accept our responsibilities to engage, and most importantly, fear not but leverage our strengths as Healthcare Champions of Change. **1**

Nick Gaich (Bellwether Class of 2013) serves as Chairman, Bellwether League Inc.

What if...



WHAT IF... Stretches Possibilities in the Healthcare Supply Chain Mindscape

Fred Crans spins a scintillating yarn. If his prose doesn't tug at your heart strings it rekindles fond memories of yore or stretches your imagination about events and people gone by.

That's why it made some rational sense to tap into Crans' mental vein to develop what we hope will be one of *Leaders & Luminaries'* more entertaining, popular and thought-provoking features – a look back at what might have been had something gone differently.

Alternate timelines and parallel dimensions may push the limits of sci-fi credibility, but they also can help us learn from the past to guide current and future decisions.

Imagine, for example, if President Herbert Hoover, our nation's first business-minded "millionaire" Chief Executive, were not "blamed" for the stock market crash in 1929 and were re-elected to a second term in 1932 as the nation sank into what would become known as the Great Depression. Where would we be now with government spending, public works and Social Security, not to mention healthcare?

With that premise, we launch this feature as an observational essay by or Q&A with some veteran industry observer or pundit with a historical point of view that can reflect on and project healthcare industry momentum. The lead-off man? *Leaders & Luminaries* turned to one of the healthcare supply chain industry's unofficial historians, Fred Crans. His healthcare supply chain background includes tours of duty in the military, hospitals, integrated delivery networks (IDNs), group purchasing organizations (GPOs) and consulting firms, including his current position with Sedlak Supply Chain Consultants.

The inaugural fuse? What if managed care never took root within the healthcare industry?

L&L: What if Congress ultimately voted down the 1982 Tax Equity and Fiscal Responsibility Act, killing TEFRA's prospective payment system for remittance of healthcare costs?

CRANS: In a very brief time, something would have had to be done. The burden placed on the states' and federal budgets by the ever-increasing number of Medicare and Medicaid recipients was fast-creating a fiscal crisis. In the initial year of enactment, healthcare costs comprised roughly 6 percent of the GDP, there were 18.9 million Medicare enrollees and 4 million Medicaid enrollees. That number continued to grow rapidly to the point where, today, healthcare costs accounted for 19 percent of GDP, there were 44 million Medicare enrollees and over 70 million Medicaid enrollees. From the start, legislators knew that the options were (1) change participation criteria to limit growth,

(2) significantly limit benefits and reimbursement or (3) find a methodology to mitigate exposure. The DRG/TEFRA linkage provided that avenue. In the "good old days" of cost-based reimbursement, focus was on revenue. Under TEFRA, the focus transferred to cost management. If Congress had voted down TEFRA, it would have been forced to take measures in the very near future that may have been much more drastic. TEFRA got the industry thinking about cost management, which was a good thing.

How would Congressional rejection of PPS and DRGs have changed management thinking about the need for cost containment and the formation and growth of such payer-centric entities as Kaiser Permanente and others?

Given the predictable fiscal impact of future demands on the healthcare system (the Aging of America), the cutting-edge thinkers, such as Kaiser Permanente and others, would probably have forged forward just as they did. Given the impending burden of the cost of healthcare, and its inverse – the impending opportunity for those who could craft a successful strategy to address those demands – it is not unreasonable to think that heretofore "out-of-the-box" approaches would have come forward on their own. Even in an industry such as healthcare where "no change" is always the first and best option for senior leadership, there will be visionary organizations that can see and will act on the future before it comes into the purview of the "ordinary" organizations. Organizations that live in a "future context" are always going to be trailblazers. The companies that manufactured vacuum tubes for radios in the 1940s and 1950s produced products so fine they are still working 75 years later, yet someone was always looking beyond the immediate "now." Hence, the introduction of transistors and the drive toward the technologies that are present today. The same thing would doubtless have happened in healthcare. Someone would have seen the future and implemented it, and others would have followed. Video killed the radio star. Advances in information processing and logistics would eventually kill the standalone community hospital.

What if, in his bid for federal controls (via GAO) over hospital purchasing, Sen. Herman Talmadge (D-GA) failed to motivate hospital purchasing executives to improve their operations and thinking on their own without government intervention?

As someone who was an active practitioner during this period, I would say that this was perhaps one of the most active periods of thought in the healthcare supply chain. It was the time when many of today's recognized leaders and mentors were learning their craft. It was also the period of time that saw the growth of AHRMM and many of the professional journals and magazine.

I went to work every day focusing on how I could reduce costs – governmental pressure or no. As a result of (1) the core of eager newcomers such as myself and others, (2) the growth of the professional organizations and (3) the concurrent growth of the professional journals, the disciplines that would ultimately compose what is now known as Supply Chain shot up rapidly in their competence in addressing cost management. Certainly, regulatory pushes may have sped the process up somewhat, but the truth is, these were prime learning years for the industry and its practitioners. Much of the innovations during that time can be attributed to the richness of the collaborative environment as opposed to the pressures from governmental sources.

Under the Prospective Payment System, the government essentially created a model that transferred cost/expense management among healthcare providers to federal and private payers (e.g., HCFA-turned-CMS and insurance companies) via reimbursement. If the government failed to transfer control over hospital and doctor costs to ayers and the market would have been left as is, how might hospitals and doctors controlled what was viewed back then as their runaway expenses? Who would focus on cost controls going forward?

As long as expenses were reimbursed on a cost-plus basis, most healthcare organizations saw no real need to address “runaway expenses.” We upped charges annually with little or no attention given to lowering costs. Most hospitals also augmented their operating revenues through foundations and other groups whose only *raison d’être* was to raise money for the organizations. Couple with that the investment strategies and proficiencies of the finance staff, and pooled investments often became a far bigger contributor to the bottom line than revenues from operations. There were so many revenue streams and so little time. The focus before TEFRA was bumping up income, not controlling costs. Unfortunately, the incredible weight of the expected future costs that hovered over the heads of the federal and state governments would not have allowed the situation to exist much longer without some kind of clamp down, and, as the industry learned later when the markets collapsed, making up the shortfall from operations via managing investments was not a sound strategy either.

How would the presidential healthcare reform efforts under the Clinton, Bush and Obama Administrations each have fared if hospitals and physicians didn’t have payers influencing charges via reimbursement?

I look at this as an outlier question in the sense that the healthcare reform efforts of every president were impacted more by the larger and more politically-charged battles that took place in Congress than anything done by payers influencing charges via reimbursement. Clinton’s efforts were doomed from the start when he put Hillary Clinton in charge of the initiative. Not yet known as a proven commodity, it was thought of as nepotism to have her leading such an initiative. The Clintons became an easy target for the Republicans, who were able to squelch his efforts to bring sweeping reform. He retreated

and never picked up the initiative again. George W. Bush, surprisingly, made some pretty impressive forays into healthcare reform. He was able to gain American support for the worldwide fight against AIDS, expand Medicare coverage to prescription drugs and, surprisingly, he also granted Massachusetts a Medicaid waiver, which allowed it to implement the universal health coverage program known as “Romney Care.” Surprisingly, when Barack Obama attempted to implement key aspects of that selfsame “Republican” program a few years later, he was met with bitter opposition.

Healthcare reform was, and is, a game played in the political forum – one that is fraught with big-time egos, big-time lobbyists and with big-time revenue at stake. The question goes far beyond what is best for the people. Among those with the most opportunity at stake are Big Pharma, Big Device Manufacturers and Big Payers. The payers alone are not the only influence. Another factor is the Republican vs. Democrat confrontation wherein winning is more important than doing the correct thing. This is not a simple issue and until, in Mr. Spock’s words, “the needs of the many outweigh the needs of the few (or the one),” it will be difficult for meaningful healthcare reform to be enacted.

Would hospitals have formed integrated delivery networks, acquired physician practices, merged with other hospitals, developed clinical/critical pathways and comparative effectiveness and evidence-based performance improvement initiatives?

Yes. Healthcare does not exist in a vacuum. It is a part of the same environment that, since the 1970s, has witnessed, first a vast reduction in local enterprise in favor of fewer and larger regional and national firms and second, a rapid change in the way business is done via e-fulfillment and in the cloud. In 1970, there were over 7,000 hospitals in the U.S. Today, there are fewer than 5,000. The span of influence for the traditional stand-alone community hospital was up to 50 miles. Improvements and gains in information gathering and processing and in logistics, coupled with the high cost of doing business as an individual entity have made it necessary for healthcare organizations to explore opportunities to expand their geographic influence, aggregate demand and optimize operating costs. Just as there are an infinitesimally small number of mom-and-pop grocery stores and pharmacies, so too are there fast becoming an infinitesimally small number of standalone community hospitals. The growth of IDNs was reflective of the evolution of business practices across many industries during that same period.

Value analysis represented an integral part of doing business in other industries, such as manufacturing and retail, since the 1950s. Without managed care would value analysis concepts have migrated to healthcare in the 1970s and 1980s?

Once again, healthcare is not simply a “slow adopter,” but often a resentfully slow adopter of change. As for Value Analysis, the term hit the workplace before the discipline itself. Just as “Supply Chain” replaced “Purchasing” and “Materials Management,” “Value Analysis” replaced “Product Standardization Committee,” and was a “discipline” in name only. Information-

based decision support tools were not utilized, and opinion-based outcomes were still the rule of the day. Fortunately, the skilled clinicians and supply chain leaders in the industry, hungry for process and protocols that would lead to the best and informationally best supported outcomes, rushed to add the rigors that gave credibility to the name. At glacial speed, and lagging over a half century behind “real business,” healthcare began to understand that sound business practices were more important than placating petulant physicians. Value Analysis is an integral component of the evidence-based decision making model, and thankfully, it is now present in most healthcare organizations (although opinion-based decisions still happen).

How would a managed care-free industry have affected the adoption and implementation of a variety of automation and computerization, such as bar coding, real-time location systems, electronic health/medical records and the need for supply data standards? How might those have evolved?

Sooner or later, healthcare gets to the places other industries have already been. Just as “video killed the radio star,” the changes associated with automation and computerization represent opportunities for moving disciplines and entire industries factors of speed faster than normal incremental change. Think of the affect that same computerization/automation has had on the life of the average individual. Our ancestors would

not recognize the world we live in; they would be overwhelmed by our technology. But leave them alone with all our tools associated with the Activities of Daily Living, and a five-year old to technology, and within a few months, they would be able to use most of them in at least a beginner’s level of expertise.

Alternative history is a fun game to play, but the more closely you look at things, the more clear it becomes that the environment (milieu) is the primary predictor of what will happen now as well as what is most likely to happen next. Even events such as the giant asteroid that struck the Earth millions of years ago and wiped out the dinosaurs and the rise and fall of the Third Reich were products of their milieu – the first, the milieu of the Universe, the second the milieu of a country devastated by an abusive and revengeful peace settlement. One might say these were disruptive events (both caused a tremendous amount of destruction and left their respective “worlds” in disarray), but the truth is, after each of these events, normal, evolutionary change returned. ¹



Editor’s Note: In a remote link to the Hooverian connection, Bellwether League was conceived and launched just prior to the start of the Great Recession, holding its inaugural event just inside of one month after the stock market crash of 2008.

if.

I’m Smarter than a Neurosurgeon, Right?

By John B. Gaida

Well, at least that’s what I told a neurosurgeon friend of mine! While he didn’t readily agree, he did say he “used to be smarter than me, and now he’d go with being equal.”

When I asked him what that meant, he said when he just practiced neurosurgery, he felt he was probably smarter than most – certainly smarter than hospital administrators and definitely smarter than lowly materials manager types. But now that he has become a hospital administrator himself, he understood more of what it takes to run a hospital and what is involved in managing a sophisticated supply chain operation. We had a good laugh, but I still made him buy me lunch!

Being advanced in years (i.e., a seasoned supply chain executive), I’ve pondered how our “lowly” profession has advanced over my more than 40 years in the business. We’ve gone from a surgeon saying, “hey you, go get me this or that,” to “I need your help in understanding my costs and helping me run a better operation.” Now I’m certainly not saying all parties have changed in this equation, but more and more supply chain professionals are being recognized for the value and expertise they bring to almost any endeavor around cost savings, organization and efficiency.

As in most things, working together yields a better outcome than going it alone. I’ve always said negotiating contracts is much easier when you acknowledge there are subject matter

experts and negotiators who both can plan important roles in the contracting process. Materials Managers who are worth their salt over the years usually become pretty good negotiators but seldom can state they are subject matter experts over all facets of healthcare. Both sides bring their expertise to the party and will inevitably do better together than separately.

It’s much more rewarding now when an outcome is achieved and all parties feel engaged and successful on behalf of improved patient care. Any position in healthcare has always been a noble career, but in more recent times it has felt like the recognition is now there, and working collaboratively is more readily accepted by all parties. A healthcare career in Supply Chain Management is more important now than it has ever been!

So back to my neurosurgeon friend – I’ll always defer to him if I need brain surgery and he’ll readily defer to me when he needs some help in negotiating his next luxury car purchase! Such is how things are. Respect with age or more likely an understanding that a teamwork approach is better than arm wrestling over who’s smarter! ¹



John B. Gaida (Bellwether Class of 2018) retired in 2017 as Senior Vice President, Supply Chain Management, Texas Health Resources (THR) and is Chairman Emeritus, Bellwether League Inc. Gaida also served as Chairman (2014-2016), Secretary (2011-2012) and as a Founding Board Member. That neurosurgeon continues to practice at THR.

CLASS OF 2018



Amy Chieppa represents Supply Chain's link between Piedmont Healthcare's operations and clinical

leadership and business intelligence communities by coordinating and facilitating new and existing inter-departmental initiatives to achieve accuracy, efficiency and expense reduction overall. Some of her key projects involved bundled payments for care improvement and the alignment of quality care and cost management in orthopedics, the latter of which included product consumption and supplier contract compliance. She also led supply chain connectivity efforts within Piedmont's enterprise resource planning (ERP) implementation and electronic medical record (EMR) system, helped to capture more than \$1 million in reimbursement from a contact compliance issue, as well as manages a single item master for the entire multi-facility healthcare system.



Troy Compardo spearheaded the implementation of an automated guided vehicle (AGV) system

to manage the horizontal movement of inbound products within BJC's healthcare facilities even during construction and renovation projects, offsetting the need to augment staff levels for those duties. Compardo also oversees supply chain operations for BJC's vast network of more than 170 non-acute care locations from the integrated delivery network's four main distribution points on campus and throughout the organization. As BJC adds more physician group practices to its Medical Group, Compardo leads the training and development program for entry-level supply chain technicians and coordinators to service their needs.



Andy Leaders transformed selected distribution centers within Owens & Minor's network into revenue-

generating service centers by adding kit packing, printing and other relevant and useful provider-demanding services to the mix, and attracting provider customers to rely on those third-party

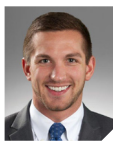
services to augment their own internal supply chain operations. Leaders convinced corporate management that creating, developing and managing third-party services demanded by providers could bring commercial value to the corporation as well as provide financial and operational relief to provider customers. With this model, Owens & Minor was able to offer traditional distribution service, third-party logistics service and even consolidated service center operations to provider customers on demand.



Ryan Rotar designed, developed and implemented a variety of process improvements

necessary for University of North Carolina Health Care's Supply Chain team to order, assemble, configure and fill every stocking location throughout the multi-facility organization. Among those process improvements was a comprehensive data analytics component that tracked every product and service from outside the organization to the point of use, as well as installing a storage equipment framework throughout the enterprise. Rotar also worked directly with clinical leadership at all levels – from floor staff to the CNO – to ensure product and service availability for clinicians to provide high-quality patient care. He was instrumental in streamlining the ordering, receiving, clinical documentation, replenishment and charge capture cycle down to 6 steps from 12, even reducing clinician participation only to two steps, a 90 percent reduction overall. His accomplishments helped the organization slash expenses by a cumulative \$2 million-plus initially and more than \$1 million annually.

CLASS OF 2017



After working as an undergraduate intern at Sanford Health, **Ben Cahoy**

led an organization-wide improvement project that implemented a location identification system of route numbers to improve the process of tracking and delivering products, employees and correspondence across 43 hospitals and 260 clinics in six states. The organizational structure of tracking employees by

work location for emergency situations, and distribution of information throughout the health system led to \$18.8 million in non-labor cost reduction. Sanford also used the system to implement product conversions in 10 facilities and bring them up on the organization's enterprise resource planning system.



Derek Havens used his global strategic sourcing expertise to help selected Premier

hospitals choose the "right fit" cochlear implant products for their physicians and clinicians by bringing them together with Supply Chain to explore options, designate a preferred supplier and negotiate the contract. Havens accomplished this through his quickly gained skill and ability to extract actionable information from collected data and bridge any gaps between clinical and operational players. He also ran a partially outsourced, for-profit supply chain department, incorporating best-practice, standardized conversion templates, value analysis tools and workflow patterns.



Mark Growcott, Ph.D., joined Ochsner Health without any experience in health-

care but quickly established himself as an expert on supply chain metrics and financial analytics for member facilities. His own analytical work has propelled strategic planning and the successful launch of several business ventures by the health system, including a molecular imaging service with a disciplined supply chain process, an orthopedic initiative designed to transform the surgical process and a new business model for the system's regional purchasing coalition. Growcott actively works with physicians, nurses and technicians to strive for organizational and patient outcome success.



Karen Kresnik, R.N., demonstrates an ability to draw even the highest-level hospital executive into value

analysis meetings and motivate him or her to actively participate in relevant discussions and decisions about clinical products and services. With a clinical and consulting background that reinforces her business acumen, judgment

and negotiations, Kresnik tackles historically difficult projects in such areas as orthopedics, laboratory distribution and blood management, working with clinicians to cut costs by more than \$2 million for their organization and bolstering its self-distribution model.



Christine Crestin effectively serves as a bridge between Supply Chain's sustainability culture-

engrained efforts and the clinicians and end users who work with appropriate alternative products and services. Naughton works to match Supply Chain's cost management and reduction duties with the department's identification, evaluation and implementation of sustainable products for system-wide use. By uniting the aims and operations of Dignity Health's Supply Chain and Sustainability teams, Naughton is carving out a new and developing discipline within an organization that already has earned considerable renown and a minted reputation in the healthcare sustainability movement.

CLASS OF 2016



Jimmy Henderson joined Outpatient Surgery Center of Jonesboro during a

challenging time that involved a clinical manager change and an operating room expansion within a relatively tight time frame. Henderson had to start from scratch and fill two empty surgical suites with products and technology under budget so that these two rooms were fully operational within four months. Meeting intense deadlines for this project was tough, but Henderson successfully negotiated pricing, freight and delivery terms that netted thousands of dollars in savings and continually generates savings for the expanded facility.



Nisha Lulla leads clinical resource management initiatives that hinge on supply cost reduction strate-

gies and process improvement efforts across multiple service lines at Chicago's Rush University Medical Center. She recruited a team of multi-functional departmental leaders within

the hospital to participate in ongoing initiatives, generating more than \$3 million in annual savings for the last three years. Her polished and professional approach to complex projects and cross-functional leaders internally and with external partners continues to generate success for her organization.

Amid a backdrop of continually declining reimbursements,



Catherine Polczynski

embraced and enforced a new methodology

at Geisinger Health System that involves an evidence-based value analysis approach to supply selection, standardization and utilization management. She worked with senior leaders and external consultants, data analysts and suppliers to implement a series of initiatives with key measures and timelines that tackled physician preference items in a balanced and dignified manner that solidified clinical, financial and operational participation.



Through the efforts of **Rob Proctor**, Owens & Minor Inc. infuses its field sales organization with

new talent each year, tapping into the collegiate ranks to promote the healthcare industry. Proctor developed a junior sales associate program that targets college interns and new college graduates, recruiting them for customer-facing roles that support existing field teammates. Over time these junior associates will be trained to fill open field positions, reducing the typical learning curve and speed-to-value by up to a year when compared to the process for sales professional candidates hired from outside the company.

To unify the San Francisco Department of Public Health's historically decentralized purchasing structure,



Baljeet S. Sangha, FACHE, founded the DPH Supply Chain Council to establish some

control over a city department with more than a \$2-billion operating budget. Through value analysis and standardization, Sangha brought clinician leaders – both physician

and nursing – into the process of integrating supply chain operations across the flagship hospital and other facilities that are part of the IDN, and overturning practices that had been in place for decades, and generating at least \$2 million in savings during the last two years alone.



On the job for a year, **Erik Walerius** faced a seemingly daunting task:

Re-organize, manage

and eventually consolidate supply chain operations for four medical centers within the University of Washington Medicine. While all four facilities are different legal entities and compete against one another, that didn't faze Walerius. Instead, he launched a value analysis initiative with the goal of centralizing contracting and purchasing activities, merging the contracting and purchasing staff of the two largest facilities into one office. So far, Walerius' early value analysis efforts to navigate around a large integrated delivery network have generated at least \$10 million in savings.

CLASS OF 2015



At Ochsner for four years, **William Barrette** played a key leadership role in several strategic

supply chain initiatives, including a physician-led value program that has realized more than \$13 million in savings since its inception in 2012, an initiative that will change how orthopedic joint replacement surgery is performed and the launch of a radiopharmaceutical production and distribution facility. Barrette worked with physicians and led the formation of the Ochsner Center for Molecular Imaging LLC last July to meet patient demand for positron emission tomography (PET), cardiac PET and other diagnostic imaging isotopes in Ochsner's market area that stretches from southern Louisiana through southern Mississippi and southern Alabama on the Gulf Coast. The initiative is expected to reduce Ochsner's drug expense by \$500,000 per year and to generate more than \$2.5 million in revenue annually.

During his five years at Loma Linda, **Justin Freed** spearheaded an



initiative to standardize orthopedic vendors for hips and knees and replace orthopedic sales representatives

in the operating room with surgical technologists trained in-house to support physicians during surgical procedures. Through Lean principles, Loma Linda was able to save more than \$1 million with a 60 percent-62 percent reduction in hips and knees and a return on investment for instruments in only a few months. The initiative generated an additional benefit, too. The hospital was able to make cost-saving changes to the design and construction of a new sterile processing department to accommodate the new procedures.

At Mercy Health's St. Rita's

Jason Hays implemented a



project that coordinated nursing, information technology and a vendor's efforts to use IT to document

and link supply consumption to the electronic medical record. The project involved point-of-use supply technology in the OR that integrated information directly into the OR record, regardless of a patient's language. In fact, Hays used his technical skills to initiate programming changes for the new process that converted initial nursing resistance because of perceived workflow issues into overwhelming support once the benefits were realized. Those benefits included reduced OR record documentation time by seven minutes per case, reduced OR supply costs by nearly 12 percent and reduced nursing trips away from patients by 89 percent.



During his two years at Texas Health Resources, **Nathaniel Mickish** made

it his mission to improve the practices and professional lives of the physicians who worked there in a physician office service that was struggling. Within 13 weeks, Mickish converted all 250 physician offices to a common distributor and installed a new computer system for them geared specifically to the non-acute market. He also recruited and trained a team of dedicated staff members to oversee and support the system. Through these efforts, Texas

Health Resources has generated more than \$2 million in savings and more than \$1 million in revenue. Mickish's team now offers this specialty program to other types of healthcare services in the surrounding area.

Three years into his strategic sourcing leadership role in Chicago,



Eric Tritch has challenged healthcare suppliers to continuously improve service to

his organization in a new way. Tritch's strategic sourcing team manages their suppliers with an internally developed "Scorecard Business Review" process recognized by several organizations as a best practice to drive improvements in quality, cost, delivery, technology and service. The review process encompasses clinical, non-clinical and pharmacy products with customer expectations of zero defects and 100 percent fill rates as well as expectations of shared cost savings ideas between customer and vendor. Their goal was to track factors impacting the supply chain department's ability to provide high-quality customer service in an effort to contribute to the delivery of high-quality patient care.

After one year on the job,

Donna Van Vlerah already



has made waves on Parkview's top and bottom lines. She and her team revamped its orthopedic contracting

strategy to the tune of reaping more than \$6.25 million in savings over a three-year period. They optimized their patient chargeable program to capture \$11.4 million in charges, orchestrated the receipt of more than \$1.5 million from a variety of contractual rebates, conducted a Six Sigma Black Belt project to re-engineer the courier and transportation system, eliminating more than 207 hours of service and a three-year contract savings exceeding \$860,000 and converted more than 900 line items that eliminated \$408,000 in wasteful spending. Parkview's new automated purchase order program transmits more than 40 percent of all orders electronically. Further, "total expense per adjusted discharge" has remained flat for the last five years even as orthopedic supply expense Oper adjusted discharge dropped by six percent.

BELLWETHER CLASS OF 2018

Patrick E. Carroll Jr., 1948-2018,



relished providing supply chain guidance to those provider facilities typically overlooked or forgotten – smaller or rural hospitals that may have needed consulting experience and financial and operational expertise as much as their larger or urban colleagues. Without hesitation, Carroll was their advocate, their champion. He gave them the supply chain advice and attention they needed to operate effectively and efficiently in the provision of quality care to those communities they served. After starting in the hospital supply chain trenches himself, Carroll steered his consulting firm on the road less traveled, paving the way to success for hundreds of hospitals throughout the country.

Marvin J. Feldman, R.Ph.,



applied the concept of process redesign to the practice of hospital pharmacy long before it gained widespread acceptance as a management strategy. Through his initial groundbreaking pharmacy logistics work at two prominent Boston-area hospitals, Feldman expanded his program into a third-party service that could be implemented at other hospitals via consulting and group purchasing initiatives. Feldman's program attracted executive-level interest into this high-cost specialized area, and by linking clinical, financial and operational elements he helped to transform it into a high-performing segment of the supply chain within healthcare provider organizations.



John B. Gaida

tapped his retail experience not merely to push the envelope in healthcare supply chain operations in the early 1980s but to punch a hole clearly through it. Gaida used Apple II, III and Macintosh computers and bar coding to track functions and

supplies. He also converted a vacant 52,000-square-foot warehouse to serve as an off-site warehouse for multiple hospitals within his health-care system, all operational novelties among provider organizations more than three decades ago. From California to the Northeast to Texas, Gaida left an indelible mark on supply chain operations, improving departmental performance and mentoring teammates and colleagues along the way. He also co-founded what would become Strategic Marketplace Initiative that would design and develop educational and training programs for supply chain performance improvement.



Winifred S. Hayes, Ph.D.,

made the concept of evidence-based clinical value analysis an acceptable household term among healthcare organizations striving to access equipment and technology needs as well as link clinical decisions to strategic cost management discussions. Leading a qualified team of clinicians, researchers and technology experts, Hayes helped to apply and refine value analysis to evaluate the efficacy, safety and comparative effectiveness of drugs, biologics, immunizations, laboratory studies, radiology, genetic tests, devices, implants, medical equipment, procedures, therapies and complementary and alternative medicine. She provided a wealth of data and information to shape clinical operations going forward.

As an epidemiologist and clinical research professor specializing in sharps injury prevention and control to reduce healthcare workers' risks from occupational exposures to blood-borne pathogens



Janine C. Jagger, Ph.D.

campaigned for safer practices for hundreds of thousands of clinicians and administrators. She also moved market share, purchasing power and industry thinking, influencing the clinical, supply chain, group purchasing and supplier communities from the early-to-mid-1980s forward. Jagger's groundbreaking research in

process- and product-related needle-stick injuries and needlestick injury prevention procedures, which included the innovative EPINet tracking system, launched a nationwide sharps safety movement during the 1990s, leading to the creation and development of a new category of safety-designed medical devices and federal legislation and occupational regulations for usage.



Mary A. Starr

represents one of the earliest supply chain advocates for embedding inventory control coordinators, materials managers and/or materials management information systems coordinators in the operating room and for extending supply chain expertise to non-acute care facilities. Back in the late 1980s Starr also co-developed an industry-wide initiative for supply chain performance indicators that would serve as a measurement tool on which supply chain departments could benchmark their operations and progress. Top-flight surgical services teams today employ business managers and value analysis leaders as bridges between clinical, financial, operational and quality analytics and benchmarking, while supply chain teams routinely gauge their service levels using benchmarks they provide to C-suite executives, reinforcing her early efforts.

Nicholas C. Toscano



catapulted from a hospital supply chain management directorship and successfully steering the New Jersey Hospital Association's group purchasing program as a regional leader to a groundbreaking role as a prominent integrated delivery network's Chief Supply Chain Officer. At Virtua Health, Toscano designed and developed a "Clinically Integrated Supply Chain Model" that featured one of the nation's pioneering Consolidated Distribution Centers, which he modeled after several large retailer and manufacturer examples. Toscano extended that model to include a "Shared Service" hub that handled a variety of services for multiple facilities – an archetype for the contemporary Consolidated Service Center model in operation at more than a dozen health systems

around the nation. Through his unique partnership with General Electric, Toscano worked with GE to develop and train the first Six Sigma Black Belts among healthcare provider organizations.

For more than five decades,



Robert T. Yokl

has served as a foundational value analysis evangelist in healthcare, having adapted the value engineering philosophy of General Electric's legendary value analyst Larry Miles for the healthcare provider market. After more than 20 years in hospital supply chain leadership where he put industrial value analysis intelligence into practice, Yokl decided to share his influential insights via consulting and software development, launching a software product and value analysis curriculum that has been used by leading GPOs and more than 500 hospitals over the years. Yokl also shares his strategic value analysis education and training content via magazines, newsletters, podcasts and webinars.

Trivial Pursuits

Carroll was the first consultant/non-provider elected to the leadership of AHRMM (*what was the presidency of ASHMM back then*).

Since retirement, **Feldman** has been training to help people with their Medicare selections through a federally funded volunteer program called SHINE (Serving the Health Insurance Needs of Everyone).

Gaida collects "all kinds of stuff – cars, guns, magazines, swords, old newspaper headlines, hats, T-shirts, and a whole lot more – but it's neatly organized!"

Hayes possesses an uncanny ability to find four-leaf clovers – hundreds in her lifetime, so far.

Jagger once directed an orchestra even though she does not play a musical instrument.

Starr started her healthcare supply chain career in Food Service on the dinner tray line, where she learned how to make a mean "clear liquid" meal.

Toscano paid for college tuition his freshman year by playing keyboard and singing in a rock band called Medusa that toured as a warm-up band for some famous rockers – like Bob Dylan and Levon and the Hawks.

Yokl is so "terrible with directions" that he often gets lost while using GPS.

2017

BELLWETHER CLASS OF 2017



Sara Bird brought commercial logistics business practices, industrial motivation and private-sector supply chain processes into the federal government's realm. Through her efforts, the Department of Defense inserted performance improvement and process efficiencies into its massive supply chain operation that spans the globe for American military personnel and first responders in peacetime and wartime.

James R. Francis



effectively consolidated three distinct supply chain operations when three different faith-based organizations merged to form BJC HealthCare in the mid-1990s, paving the way for new business relationships with a prominent supplier and group purchasing organization at the time. At Mayo Clinic, Francis serves as one of the pioneering forerunners that model successful supply chain relationships with physicians.

For the last four decades,

Jamie C. Kowalski



has created, developed, evaluated and implemented custom supply chain solutions to everyday supply chain problems for hundreds of providers, suppliers and service

companies – even while he worked within their ranks. Kowalski's high-level expertise filled gaps when administrative, clinical, financial and operational clients, colleagues and customers needed it most.



Hiram Lake, 1925-2016,

parlayed his World War II military and post-war missionary background, and electronics and inventory management training into helping non-healthcare companies and hospitals succeed in the burgeoning field of materials management in the mid-to-late 20th century. Lake was instrumental in providing real-world materials management challenges and solutions, motivating teamwork and mentoring next-generation professionals.



As a management engineering expert, James W. Oliver

could identify organizational problems and distill effective supply chain management solutions that relied on the right people and necessary tools to make it happen. Through his executive leadership, northeast regional GPO Yankee Alliance moved supply chain management into the non-acute sector and expanded the definition of value-based contracting decades ahead of today's trend.



Kristine R. Russell

entered the healthcare publishing world in the early 1980s

through the automation and information technology topical arena, and foresaw connections to the clinical and supply chain realms. Russell worked to integrate the administrative, clinical, financial and operational minds leading providers and suppliers with a noteworthy group of media properties, such as Healthcare Purchasing News, that industry professionals recognize as providing necessary intelligence to succeed in a reforming environment.



Dudley Sisak

classifies himself as a "fixer" of processes, particularly in the supply chain management operations of providers and suppliers. Sisak specialized in conversion efforts and cross-functional processes, implementing advanced distribution and inventory programs and technology. One of his noteworthy traits involves facing a provider or supplier operational challenge full-on and working with clinicians and supply chain professionals to develop and implement successful processes.



Craig Smith

may have been instrumental in building Owens & Minor into the nation's largest medical/surgical supply distributor and a global healthcare logistics service company, but his philosophy of corporate cross-functionality and view of supply chain as a big-picture technology-enabled enterprise to improve efficiency, productivity and patient welfare foreshadows industry direction. From sales and operations to executive and

education, Smith strives to shape supply chain's next generation.



Without William V.S. Thorne, 1865-1920,

contemporary group purchasing and supply chain management in healthcare might not have evolved to where it is today – or even emerged as an industry. As the creator and founder of New York-based Hospital Bureau of Standards and Supplies Inc. in 1910, Thorne translated his turn-of-the-century railroad industry business and purchasing expertise for the healthcare world, crafting a blueprint for hospital-based "cooperative buying" that influenced and shaped industries and market segments to follow for more than a century.

Dwight Winstead



contributed a number of noteworthy concepts to supply chain management that defined and shaped industry thinking in the 1980s and set financial and operational bars going forward. With a career that spanned the provider, GPO, supplier and service industry segments, Winstead developed the separation of product costs from distribution costs in "cost-plus" contracting, private-label group contracting and GPOs establishing authorized distribution agents, and he was instrumental in bringing selected outsourced management services to integrated delivery networks.

Trivial Pursuits

Since retirement, **Bird** has filled her schedule with practices, rehearsals and gigs by playing saxophone and clarinet in two community concert bands and two jazz bands, which perform music from the "big band era."

When the President and CEO of BJC HealthCare offered him the job of running supply chain for the system, **Francis** thought he faced the end of his career in healthcare administration because his office would be located next to the morgue for all eternity.

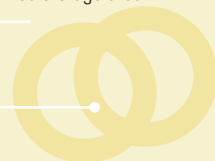
In New Guinea, **Lake** and his wife Mary Beth served as missionaries with the Christian and Missionary Alliance where they learned the Dani language, translated portions of the Bible, gave medical help and taught people to read and write; he also helped build two airstrips, assembled and repaired radios,

gasoline engines and generators, dug wells, developed rainwater storage systems, built five houses including a grass hut for the family, surveyed new areas, and, with a mission surgeon, provided medical attention to the Dani people, but also was known for keeping a neatly organized storage area.

Oliver and his wife Deb eloped and were married in Bermuda without their parents' knowledge.

Thorne conceived his idea for healthcare cooperative buying – the root of group purchasing – from the railroad industry.

Winstead humorously blames his speech impediment for keeping him from getting a better job!



BELLWETHER CLASS OF 2016



As a medical intern and clinician during the 1930s and 1940s, **Edwin Crosby, M.D.**, recognized the inherent value of supply chain to healthcare, a philosophy he carried with him throughout his storied career that included being one of the youngest directors at Johns Hopkins Hospital, the founding director of what now is The Joint Commission and president and CEO of the American Hospital Association in the 1960s where he helped found what now is the Association for Healthcare Resource and Materials Management (AHRMM).



From the 1920s through the 1950s, **Irving Mills** transformed his father's garment factory into a leading medical supply distribution company that pioneered the use of consignment shipping for hospital customers. Following a brief retirement in the 1960s, Mills returned to healthcare distribution, helping his sons found one of the largest healthcare distribution companies in the nation.

During the late 1970s, **William Pauley** was one of the pioneers who developed and actively operated one of the earliest consolidated service center models for hospitals. The centralized purchasing and distribution operation supported three hospitals and other healthcare facilities in Southern California. Furthermore, as far back as the 1960s, Pauley was publishing articles in industry publications about quality buying and value analysis in purchasing.



During the 1980s, **Carol Stone** served as one of the earliest advocates for the adoption and implementation of data standards for product and organization identification and greater use of bar codes in the healthcare supply chain, long before it became fiscally and operationally fashionable. At a time when direct customer-to-supplier electronic data interchange (EDI) was considered "high-tech," Stone was one of the first proponents of open EDI transactional capabilities whereby customers electronically could transmit data to any participating supplier via standard codes.



During the late 1970s and early 1980s, **Peggy Styer** promoted the idea that supply chain should be connected electronically to revenue cycle transactions, working with a trailblazing software company at the time to incorporate that functionality into its systems. As a materials management leader, Styer also demonstrated keen proficiency in engaging physicians in supply chain issues by understanding their practices and preferences, recruiting them to participate in the process and maintaining professional connections between them and the C-suite.



As a hospital supply chain leader during the 1970s, **Gary Wagner** understood the effectiveness and efficiencies of hospital supply chain departments working with suppliers. At one healthcare organization Wagner automated ordering processes and worked with a major supplier at the time to implement it and then roll it out to the market. In the early 1980s, he launched a novel automated "desktop delivery" service for forms and office supplies with two other suppliers. During the early 1990s, he integrated inpatient and outpatient surgical services operations, worked with surgeons to launch specialty orthopedic ORs and with a third-party distributor to handle OR case-picking processes.

Trivial Pursuits

As the first physician to be inducted into Bellwether League, **Crosby** demonstrated the importance of the healthcare supply chain through a set of bald ambulance tires, leading to his executive promotion at the hospital from intern in 1934.

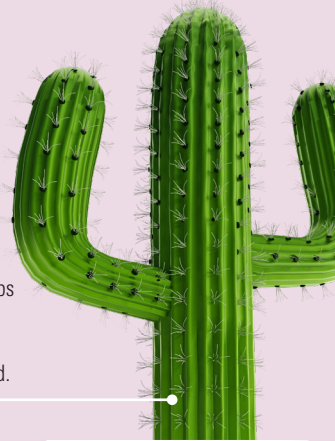
A contemporary of Foster McGaw (Bellwether Class of 2010), **Mills** turned a tiny garment factory in the 1920s into a prominent healthcare product supplier where he pioneered the use of different-colored scrubs and consignment purchasing.

Pauley planted a cactus garden wherever he moved.

Stone is a certified "broiler chef" and worked the grill for a number of years cooking all kinds of steaks at a popular steakhouse.

Styer has a passion for adventure travel, and Africa is her favorite destination.

Wagner loved auto racing so much he figured out a way to get into NASCAR events free and hang out with all of the drivers in the infield, but also worked with NASCAR to establish the infield medical care criteria it uses today.



What were Healthcare Supply Chain Executives saying at Bellwether League's 2018 Healthcare Supply Chain Leadership Forum?

"Patient-centeredness drives and differentiates the healthcare supply chain."

"Supply chain will get closer to the consumer as consumers become more engaged in their care."

"Embracing technology and data need to be a priority for the future success and expansion of Supply Chain activities."

"I saw a deep appreciation for those who have and still are forging the way for the next generation. At the same time, I saw the previous generation understanding that there is an opportunity to do better."



What might you hear next year?

7th Annual Healthcare Supply Chain Leadership Forum
September 30, 2019 | The Westin-O'Hare

2015

BELLWETHER CLASS OF 2015



Ed Becker brought computerization to sterile processing, electronically linking supply chain operations to surgical services as a means to improve patient care delivery, a groundbreaking achievement several decades ago.



Pete DeBusk built his now-global company, DeRoyal Industries Inc., around bar-coded, custom-crafted products to help surgeons, physicians and nurses provide better care more efficiently.



Dee Donatelli applied her experience as a registered nurse into a career in supply chain management deeply rooted in value analysis principles and further honed by an evidence-based philosophy that she promotes industry-wide.



Nancy LeMaster used her extensive background in performance improvement and strategic planning to reinvigorate supply chain operations at several prominent healthcare organizations, specializing in data standards and utilization management.



Mike McCurry rechanneled his industrial supply chain acumen to create and develop one of the market-leading multi-hospital shared service operations models in healthcare, even serving as a hospital CEO and IT executive along the way.



Jim Olsen brought fundamental product and purchased services contracting and sourcing improvements and information technology expertise to several high-profile healthcare organizations in both the investor-owned and not-for-profit sectors.



Jane Pleasants was an early pioneer of self-contracting, stockless distribution and supply chain automation in hospital settings as well as a federally recognized expert in integrating finance, IT and supply chain with clinical effectiveness.



Mike Switzer leveraged technology and biomedical engineering ingenuity to design and develop innovative logistical products and services that redefined healthcare warehousing and consolidated service center operations.

Trivial Pursuits

Becker is a Life Master duplicate bridge player, thanks to the cooperation of his son Drew who is a world-class bridge player.

DeBusk enjoys building buildings, raising cattle, and sports.

Donatelli has a favorite getaway – being on a lake; floating on a raft, being on a boat or swimming.

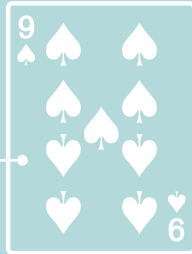
LeMaster was a member of one of the first student group exchanges with communist Russia in 1975.

McCurry married his childhood sweetheart, now has six grandchildren and loves to go fast.

Olsen and his twin brother were almost cast as Little Ricky Riccardo on the “I Love Lucy” show.

Pleasants claims to be the loudest whistler in her family of all men at basketball games.

Although **Switzer** loves music and maintains an extensive music library; his musical ability is jinxed in that he played trumpet until his front teeth were knocked out, played guitar until he snapped off a knuckle while playing volleyball and then lost the ability to sing (thanks to dry throat and coughing) after open heart surgery.



IT'S TIME TO LEVEL UP. What Ammer level are you?

You won't know unless you apply.

The “Dean S. Ammer Award for Supply Chain Excellence” represents a self-assessment and validation of documented and observed best practices that meet or exceed Bellwether League’s organizational criteria for supply chain performance excellence. Bellwether League named the award after its first honoree, the iconic Dean S. Ammer, Ph.D., with permission of the Ammer family to honor his memory and extensive contributions to the industry.

Bellwether League’s Ammer process works like this: A provider organization completes and submits the Ammer self-assessment questionnaire that requires extensive financial and operational data, as well as anecdotal observations, about policies, practices and procedures of the departmental/organizational candidates. A select committee of Bellwether League’s Board of Directors verifies and validates the submitted assessment forms to determine whether the candidates demonstrate Ammer Level 1, 2, 3, 4 or 5 performance achievements.

Those departmental/organizational candidates considered as Ammer Level 4 or 5 operations then undergo a thorough onsite consultation of their self-assessment by selected members of Bellwether League’s Ammer Award committee to determine at which level of performance they have achieved success. A department/organization earning Ammer Level 5 status represents the highest honor bestowed by Bellwether League on a healthcare supply chain management team.

For more information, visit Bellwether League online at BellwetherLeague.org/nominations.html.

BELLWETHER CLASS OF 2014

Henry A. Berling



through his Southern home-spun affability, helped to forge and expand a number of prominent distributors, including Owens & Minor Inc. and Stuart Medical, as well as craft solid contracts with some of the larger healthcare systems and industry-leading integrated delivery networks searching for supplier partners to assist in cost reduction and process standardization.

Robert P. "Bud" Bowen



demonstrated his customer service and group purchasing acumen by helping to form, develop and grow Amerinet Inc. into one of the largest and leading group purchasing organizations in the nation, translating his prior administrative and supply chain experience from long-term care provider New England Management Corp. and distributor American Hospital Supply Co.

Brent T. Johnson



relied on decades of supply chain experience in other industries to develop Intermountain Healthcare's highly regarded consolidated service center, which has served as a model for other healthcare organizations to emulate, as well as to implement a self-distribution strategy generating noteworthy benefits for his organization and the patients served, and extending potential boundaries for others.

Norman A. Krumrey



applied the supply chain skills he honed in the aircraft industry to hospitals starting in the early 1970s, implementing centralized process and coding controls and automated cart systems in supply processing and distribution, as well as working with clinicians and physicians, which elevated him to the C-suite as a supply chain leader, and later propelled him to GPO leadership ranks.



Keith Kuchta

may be synonymous with Kimberly-Clark Health Care after spending nearly four decades with the company, but it's his industry contributions through Kimberly-Clark Health Care that elevates his stature, including helping to establish the annual Georgetown Healthcare Leadership Institute for hospital supply chain and other departmental leaders and developing a number of Strategic Marketplace Initiative projects.

Randall A. Lipps



an industrial engineer from the airline industry, was inspired and motivated by personal healthcare experience to develop and manufacture automated technology for hospitals and other healthcare facilities in an effort to reduce – if not eliminate – process inefficiencies, redundancies and risks in the administration and delivery of patient care.

Dale A. Montgomery



represents a bonafide healthcare supply chain veteran, having completed his career as a C-suite-based supply chain executive after working up the ladder from orderly four decades earlier for the same organization. His dedication to his employer was matched by his dedication to the supply chain profession, having spearheaded clinical quality value analysis and dedicated physician relationships to solidify his organization's clinical, fiscal and operational foundation.



Richard A. Perrin

has been a tireless advocate for and ambassador of healthcare supply chain information technology use and a pioneering voice for supply data standards since migrating from the hospital supply chain leadership ranks where he, too, started his healthcare career as an orderly. Perrin also helped bridge the clinical and corporate gaps between government and private sector supply chain operations.

Joseph M. Pleasant



so faithfully and steadfastly believed in healthcare information systems interoperability and supply data standards that he helped found and chair separate organizations to justify and promote either cause. Through his CIO chair in Premier's C-suite, Pleasant worked with other GPOs to drive data standards adoption and implementation as well as helped the federal Department of Defense pilot data standards use for its facilities.

Earl G. Reubel, 1937-2011,



broke new corporate cultural ground with the introduction of what he called "supplier diversity" mentoring to nurture diverse, small and local suppliers into growing incrementally via financial and operational planning into national players even as he led his own distribution company. Through the late Reubel's efforts, suppliers learned how to reach across the provider aisles, linking the C-suite and other administrators to physicians and clinicians serving patients.

Trivial Pursuits

Berling is a cigar aficionado.

Bowen is a "Judge Judy" fanatic who tries not to miss any of her shows, and he also believes she would make a great U.S. president.

As of 2015, **Johnson** had never spent a day in a hospital (as a patient), never broke a bone and didn't take a sick day in 20 years.

Krumrey actually negotiated the starting salary for the best buyer in his Purchasing department to work for another firm, a supplier.

Kuchta has played golf with Arnold Palmer and Ben Crenshaw, two Masters Champions.

Lipps loves learning and playing the latest board games.

Montgomery only will join an organization that he is willing to lead.

Perrin did three cross-country trips by motorcycle in the U.S. and completed two cross-Europe journeys by motorcycle as well.

Pleasant earned his private pilot's license and water skied bare-foot in college.

In his early teen years, **Reubel** started his first business, a car wash service where he recruited and hired people who were five to seven years older than he was.

Bellwethers Future Famers Ammer-level Honorees

Bellwether League. Honoring Healthcare Supply Chain Leadership.



Past Performance
Present Practice
Future Success
Achievement
Tradition
Legacy
History

2013

BELLWETHER CLASS OF 2013

Christopher J. Bale, 1971-1996, pioneered modern-day healthcare supply chain journalism by bringing journalistic standards to reporting on the industry,



through knowledgeable, insightful and thought-provoking reporting back in the late 1970s. Through such publications as Purchasing Administration (later Hospital Purchasing News and then Healthcare Purchasing News) and Medical Product Salesman (later Medical Products Sales) magazines, Bale helped educate, inform and mentor a generation of healthcare supply chain journalists and association and trade group executives through his leadership and industry example.



Lynn Britton translated his early retail industry and initial hospital supply chain experience

into the creation, founding and development of a comprehensive, consolidated and provider-based corporate supply chain operation that services a variety of healthcare facilities in multiple states for St. Louis-based Mercy Health System. Britton parlayed his leadership and expertise and leadership to the position of CEO at one of the largest regional integrated delivery networks in the nation. A weather-related disaster tested, shaped and refined his executive leadership resolve and resilience.



James F. Dickow used his corporate engineering background, which included simulating astronaut

link-ups with the space station, and his executive posts with several national, regional and local hospital medical/surgical product distributors and management consultancies to help hospitals with their operations improvement and facility planning initiatives. With an emphasis on quality outcomes while reducing costs, Dickow routinely challenged the status quo and backed it up with solid analysis. He shared his knowledge and skills with Supply Chain leaders and staff in hundreds of hospitals across the United States and Canada.

William A. Donato Jr.



demonstrates a keen knack for bridging clinical and supply chain operations, linking physicians

and surgeons with those who fortify them in the surgical suites. Whether he's leading supply chain operations at a nationally renowned hospital system, a national GPO, or product marketing and development efforts for a prominent medical products supplier, Donato expanded the art and science of authentic clinical supply chain operations to optimize the support to the caregiver and patient alike.



Nick Gaich was as pioneering and instrumental in giving physicians and surgeons authority

and a voice in supply chain operations,

as he was in implementing "stockless" supply systems for high-end clinical products and strategic point-of-use service center models in a prominent university medical center setting. Gaich then expanded his clinical service line management best practices program globally, promoting integrated supply chain excellence in the Middle East, Germany and China.

Donald E. Greenslade, 1934-2013, pioneered regional



purchasing, storage and centralized distribution operations in the United Kingdom's National Health Service for the first four decades of the NHS' existence, before bringing his logistics and procurement expertise across the Atlantic. Greenslade guided supply chain leaders and their organizations in the United States and Canada, helping them to redefine and reshape their supply chain thinking and apply that to the redesign and reconfiguration of their practices and procedures, to achieve greater effectiveness and efficiency.

Michael T. Rosser is regarded



as "the father of the modern healthcare supply chain in Canada," and is credited with spearheading both the initial design and operations of the original, consolidated "shared services organization model" for Canadian healthcare provider organizations. Since his retirement in 2010, after a 35-year healthcare supply chain career, Rosser has been consulting as well as volunteering in Haiti

to rebuild a hospital and recreate their supply chain operations in the aftermath of a major earthquake.

Alan D. Weinstein spent more than three decades launching and leading businesses that provide shared programs and services



to hospitals and other healthcare facilities, including the predecessor to Premier Health Alliance and its clinical- and data-driven successor organization Premier Inc. Since his retirement from Premier in 2000, Weinstein has shared his clinical and healthcare operational acumen with dozens of manufacturers, distributors, service companies and hospitals as board member and consultant. He also has mentored many supply chain leaders throughout his career.

Paul E. Widman, 1918-1983, was one of



the "founding five" executives that "formed the nucleus of non-physician, professional operations" at the modern-day Cleveland Clinic. Widman didn't have to promote supply chain management as a C-suite operation because he actually accomplished it back in the 1960s and 1970s. Widman was recognized internationally as a hospital purchasing authority, regarded for his love of people and known for his keen wit. He frequently published articles and served on the Editorial Board of the industry newsletter Hospital Materials Management.

Trivial Pursuits



Jamie C. Kowalski

Which BOD members have been to all 11 BIDEs from 2008-2018?

Jamie Kowalski and Rick Barlow



Rick Barlow

Outside of those two Board Members listed earlier, who is the one professional with perfect attendance in that he/she attended all 11 BIDEs from 2008-2018?

Kristine Russell | Bellwether Class of 2017, from Silver Sustaining Sponsor HPN.



Kristine Russell

MARK YOUR CALENDARS BIDE 12

12th Annual Bellwether Induction Dinner Event
September 30, 2019
The Westin-O'Hare
 6100 N. River Rd., Rosemont, IL



BELLWETHER CLASS OF 2012



John H. Clarke was instrumental in helping the U.S. Department of Defense and Veterans

Administration convert to a global supply chain system similar to the framework used by the private sector, including serving as the chief proponent and architect of integrating the government's variety of clinical and operational databases and promoting data standardization.

Paul V. Farrell, C.P.M., 1915-1997,



is considered one of the foremost purchasing experts in the nation since

the 1940s. He dedicated nearly five decades of editorial and management service to purchasing activities, including writing and editing news articles and prominent educational textbooks, as well as teaching, consulting and participating in various professional development programs, to promote purchasing excellence and performance.

Max Goodloe Sr., 1921-1997,



founded General Medical Corp., the second-largest distributor of health-

care products at the time (behind American Hospital Supply Corp.), but the largest supplier directly targeting physicians. Goodloe pioneered the concept of a national distribution company with a local sales and warehousing presence so customers anywhere in the nation could rely on either same-day emergency or next-day delivery service.

Roberta Graham, R.N.,



retires at year's end as executive vice president of UHC after nearly two decades of

service there. During Graham's nursing and supply chain career, which spans more than 40 years,

she was instrumental in launching and developing extensive benchmarking, operational improvement and value analysis programs as well as linking clinical and operational data and human resources.

As the lead systems design consultant for American Sterilizer Co. (AMSCO),

George O. Hansen introduced



and incorporated the principles of throughput and workflow analysis – planning the size,

layout and equipment for processing services based on volume and cycle-time requirements – into centralized supply processing and distribution departments in hospitals around the globe.

Among his varied healthcare supply chain career, **James L. Hersma**



served as the founding president of Novation, merging the disparate supply management operations of VHA

and UHC, and led CIS Technologies to a financial and operational turnaround and eventual sale. But many know him as a supply chain mentor and motivator, producing and presenting training materials for C-suite and supply chain executives, physicians and clinicians on a national, regional and local level. Hersma also was a key advocate for using technology in supply chain operations, helping to create one of the earliest automatic order entry systems for providers and suppliers.

Thomas W. Hughes may have



launched his stellar career in hospital supply chain operations but he cemented his industry stature and

status after founding his prominent and market-leading supply chain management consultancy that helped thousands of healthcare facilities improve clinical, financial and operational performance. Hughes also helped form, develop and lead the Strategic Marketplace Initiative (SMI), which brings providers and suppliers together to develop actionable solutions to healthcare supply chain issues.

Carl L. Manley has spent more than three decades in supply chain operations where he was one of the earliest



developers and implementers of integrated delivery network supply chain strategies and regional purchasing collaboratives, IDN-directed consolidated service centers, performance improvement initiatives and physician/primary care integration with supply chain activities. He also was instrumental in the founding of SMI and its predecessor organization that brought together IDNs to cover supply chain strategic initiatives.

Raymond Seigfried serves



as a prominent and stalwart advocate for integrated system thinking and management engineering in supply chain operations. He created interdepartmental and inter-specialty groups of clinicians and administrators to improve quality performance, product and technology acceptance and acquisition, as well as supply chain oversight of system-wide clinical purchasing activities.

Since the late 1970s,

Robert A. Simpson has excelled in just about every facet of the healthcare supply chain industry, from provider



to government agency to group purchasing organization to supplier to association leadership to clinical charity activities, and has developed university curricula on healthcare operations. He currently applies his vast experience and skills to leading a growing IDN, a regional collective of healthcare systems in Florida and a successful consolidated service center that works with organizations inside and outside of healthcare as well as a collegiate internship program to mentor healthcare industry-bound students.

Trivial Pursuits

Who are the only Bellwether League Board members to have held two different officer positions?



John Gaida

John Gaida
Secretary (2011-2012)
and Chairman (2014-2016)



Pat Carroll

Pat Carroll
Treasurer (2007-2011)
and Secretary (2013-2018)

Bellwethers Lost Since Inception in 2007:

Year Lost	Bellwether Class
2018	Patrick Carroll2018
2018	Laurence Dickson2011
2016	Alex Vallas2008
2016	Gene Burton2008
2016	Samuel Raudenbush ...2009
2015	Brien Laing2009
2015	Carter Blake2010
2014	Sara Mobley2009
2013	Donald Greenslade2013
2012	William McKnight2009
2011	Mark McKenna2010
2011	Earl Reubel2014
2011	William Pauley2016

Bellwethers Inducted Posthumously:

Bellwether Class
Dean S. Ammer, Ph.D.2008
George Ainsworth2009
Charles Auslander2009
Guy Clark2009
Gordon Friesen2009
Lillian Matiska2009
George Gossett2010
Donald Soth2010
Robert Majors2010
Foster McGaw2010
Paul Farrell2012
Max Goodloe, Sr.2012
Christopher Bale2013
Paul Widman2013
Edwin Crosby, M.D.2016
Irving Mills2016
Hiram Lake2017
William Thorne2017

BELLWETHER CLASS OF 2011

Laurence A. Dickson, 1945-2018



Larry Dickson knows a thing or two about buying and selling products in healthcare.

After a decade of selling products for McGaw Laboratories in the 1970s to hospitals and other healthcare facilities and working with group purchasing organizations (GPOs) from the sales side, Dickson joined Providence Health System where he worked to unify the procurement and logistics operations for 15 hospitals on the West Coast by establishing clinical resource groups that linked doctors and nurses with purchasing and distribution decision makers, establish internal regional warehousing and distribution capabilities as well as committed contracting and a forward-thinking recycling/waste program.

Daniel J. Dryan



Dan Dryan never used retirement as an excuse not to contribute to and participate in supply chain operations development and progress.

During his 46-year career he developed shared-service warehousing and multi-hospital materials management information systems, set up supply chain operations for off-site nonacute care facilities; he was an early adopter of bar coding and hand-held devices and an early advocate of supply chain becoming involved in the construction process. Dryan also holds the notable claim of being the first hospital in the nation to implement completely the Friesen

concepts for hospital management. Gordon A. Friesen was inducted into the Bellwether Class of 2009.

Derwood B. Dunbar Jr.



From his childhood working in his father's pharmacy to his high school summers as a teenager in hospital

purchasing to his leadership of one of the nation's largest GPOs, Derwood Dunbar has radiated supply chain management throughout his professional life. Dunbar spent roughly the first half of his supply chain career in materials management for seven hospitals in the Chicago area. During the second half he developed shared services operations for a regional group in Western Pennsylvania and then established a group of GPOs, Mid-Atlantic Group Network of Shared Services (MAGNET). Dunbar also was instrumental in launching a professional association for GPOs and the Health Industry Group Purchasing Association (HIGPA), where he served as the first president.

Steven P. Gray



Steve Gray specialized in applying business and clinical process redesign in hospitals to improve quality,

reduce costs and implement new technology, using industrial engineering methods for hospital-based material re-processing and movement processes for operational efficiency and facility planning. He developed the first engineered formulas for determining space and staffing requirements to replace experiential and "rules of thumb" decision-making. As a senior leader of Chi Systems, Gray was a pioneering consultant with hundreds of hospitals and succeeded Dean Ammer, Ph.D., (Bellwether Class of 2008) in managing the industry publication Hospital

Materials Management. Gray has been a prolific author of educational articles and textbooks, as well as a college lecturer on industrial engineering and supply chain topics.

Betty Hanna



Since 1958 Betty Hanna has been – and continues to be – the professional development engine

behind "central services," widely known as the sterile processing and inventory management components of supply chain management. In her executive director role she helped promote CS/SPD as an integral hospital department critical to clinical care. Starting with chapters in New York and Chicago totaling 64 total members, Hanna helped grow the International Association of Healthcare Central Service Materiel Management to more than 14,000 professional members with chapters in 32 states. During the last five decades, IAHCSSMM helped establish and implement professional guidelines, rules and standards where there were none.

Larry Malcolmson



Until Larry Malcolmson came along, capital equipment acquisition in

healthcare organizations was unprofessionally organized and executed, grossly inefficient and altogether needlessly costly. Malcolmson recognized that healthcare professionals needed an objective third-party information source when making equipment and device purchases to counter the "buy-whatever-you-want"

philosophy prevalent in healthcare prior to managed care-based reimbursement. He founded MD Buyline to provide healthcare organizations with pricing assessments and acquisition process consulting and services for clinicians and administrators alike. To this day, his company continues to be regarded as the "gold standard," a must-have source for the industry for equipment selection and acquisition decision support.

John W. Strong



John Strong is a seasoned healthcare operations innovator who has been actively involved in virtually

every aspect of supply chain management as a hospital director, consultant, GPO executive, educator and supplier advocate. Through his diverse career Strong has helped raise the level and visibility of the supply chain as a clinical and C-Suite concern. He spent more than a decade with three hospitals and launched a shared-services supply chain company. Strong then joined GPO Premier as vice president of materials management, culminating as COO of its Purchasing Partners unit. He then spent a year in consulting before serving for the next decade as founding president and CEO of Consorta, the leading Catholic-sponsored GPO. He also served as president and CEO of World Product Centre Marketing, a proposed 60-story building in Manhattan for healthcare training, testing, education and supplier showcasing. Strong recently retired as a senior executive from Greater New York Hospital Association, one of the WPCMs' founders.

SAVE THE DATE

7th Annual Healthcare Supply Chain Leadership Forum

Sept. 30, 2019 | The Westin-O'Hare

6100 N. River Rd. | Rosemont, IL

Trivial Pursuits

Which Sustaining Sponsors have supported Bellwether League consistently since Year 1?

7 (Four Founding/Platinum, Two Gold and One Silver): Halyard Health (started as Kimberly-Clark Health Care), Owens & Minor, Premier, Vizient (started from MedAssets), Cardinal Health, Wingfoot Media, *Healthcare Purchasing News*

How many different hotels has Bellwether League held its 11 BIDES?

Five (Four years at the first hotel, three at the second hotel, two at the third, one at the fourth and one at the fifth in 2018.)



BELLWETHER CLASS OF 2010



Ted Almon

As president and CEO of the Clafin Co., one of the industry's leading regional independent healthcare product distributors, Ted Almon embraced and implemented advanced logistics programs, such as stockless, for hospitals and directed his company to become the industry's first ISO 9002 Certified distribution firm. As chairman of HIDA and NDC, Almon also remains a passionate, public and tireless advocate for supply chain management principles, distribution performance and fundamental healthcare reform in the areas of cost, quality and access.



Carter F. Blake, 1937-2015

Equipped with Army training and a military medical career in sterile processing, Carter Blake entered into the purchasing arena by detailing pharmaceuticals to doctors, clinics and hospitals and then transferred into an entry-level junior buyer position for a regional faith-based group purchasing organization. After mastering supply chain fundamentals with the group, he ventured more than 1,000 miles away to develop a group purchasing program from the ground up for another regional faith-based organization that spanned five states. Before retiring in late 1997, Blake finished his nearly four-decade career as an executive for Vector Healthsystems, a founding shareholder of Amerinet Inc.



Br. Ned Gerber

Br. Ned Gerber, CPA, was a diehard evangelist and developer of industry benchmarks, having spearheaded the national Performance Indicators program for AHRMM, one of the earliest national sources of metrics for healthcare supply chain management. During the 1980s and early 1990s, he was a prolific author and speaker on healthcare materials management topics. After leading supply chain activities at Chicago's

Northwestern Memorial Hospital, Gerber transitioned into a consulting career where his devotion to clients was legendary, including making 11 p.m. Friday visits to hospitals to see how the 3rd shift in distribution was doing. Gerber continually pushed the envelope for new ideas. He proceeded to devote himself to ministry work, serving as a Benedictine Brother, while consulting on broader healthcare topics in Sydney, Australia.

George R. Gossett, 1927-1965



The late George R. Gossett believed in the fundamental importance of

healthcare materials management, envisioning its long-term prominence, and promoting educational and professional development of the discipline. While serving at Baltimore's Johns Hopkins Hospital, Gossett was instrumental in transforming the group that would become known as the Association for Healthcare Resource & Materials Management (AHRMM) today into a full-fledged personal membership organization that emphasized professional education, and was elected its first president in 1962. AHRMM aptly named its highest honor, an award that recognizes industry-advancing leadership and professionalism, after Gossett.



Frank Kilzer

Frank Kilzer is recognized as being the first to implement an internally developed

bar-code scanning and electronic commerce technology in a healthcare materials management operation in 1985, located in North Dakota. For the past four decades he has focused on educating all sectors of the healthcare industry about the benefits of using these technologies to streamline the supply chain. Kilzer continues to assist hospitals, distributors, manufacturers and the transportation sector with re-engineering their material handling processes and remains an active driver for developing industry standards for bar coding healthcare products.



Michael Louviere

Michael Louviere actively linked supply chain with pharmacy

operations more than two decades before it became a more mainstream model in management efficiency circles. Louviere parlayed his pharmacy background and training into progressively higher supply chain management executive positions for a number of hospitals and health systems. During the turbulent healthcare reform-focused 1990s, Louviere assumed a leading supply chain and strategic product development executive role at investor-owned Columbia/HCA Healthcare Corp., which also developed a consolidated service center model under his watch. Louviere also pioneered supply chain operations for a market-leading group of cancer-treatment facilities.

Robert Bross Majors, 1943-2007



The late Robert Majors was an early and avid supporter of electronic commerce with expertise in healthcare systems automation,

but he was renowned for his stalwart dedication to group purchasing and its inherent value to hospital supply chain management, and best known for his tireless efforts to promote supply chain as a strategic component of hospital operations that belonged in the C-suite. With a keen understanding of the buyer-seller relationship culled from nearly three decades in hospital materials management and 10 years in sales, Majors strove for seamless partnerships with every department in the hospital setting to generate high-quality patient outcomes.

Franklin J. Marshall



Credit Frank Marshall for bringing centralized purchasing and distribution center programs to a small faith-based

healthcare system in North Dakota in the late 1960s to mid-1970s, and later for establishing and implementing successful group purchasing programs in Delaware, Washington, DC, and Denver. During his term as executive director of Denver-based COPAC Inc., Marshall nearly tripled the regional GPO's membership base and more than tripled its contracting commit-

ment. He was best known in GPO circles as a tireless and eloquent advocate for committed-volume contracting practices, and for the advancement of GPO excellence. He also served as AHRMM president from 1974 to 1975.

Daniel E. Mayworm



As an active participant in healthcare supply chain management development, Dan

Mayworm successfully published several influential magazines dedicated to the industry and served as a frequent speaker at various trade association meetings after he spent a market-leading career in medical product packaging. A prolific author, educator, speaker and advocate of materials management, sterile processing, surgical services and infection control issues, principles and standards, Mayworm consistently sought to foster clinical and process innovation and quality, as much as report and write about it. His publications and seminars encouraged and influenced many in the industry to explore the scope and depth of the healthcare supply chain as something more than just purchasing.

Foster G. McGaw, 1897-1986



If there were a list of most frequently mentioned leaders and titans in the healthcare

supply chain industry, Foster McGaw certainly would be on it, if not perched near or at the top. His name remains a marketed brand and his quotations and business philosophies are used by many companies as benchmarks. McGaw founded American Hospital Supply, one of the leading and most influential medical/surgical product manufacturers/distributors in the nation that promoted ethical supply chain management principles and advocated high-quality customer service. McGaw and his company, which now is part of Cardinal Health Inc., shaped the hospital supply industry and helped to create and develop the standards under which it continues to operate. He also was a renowned philanthropist who donated millions of dollars to hospitals and educational institutions.

**Mark M. McKenna,
1948-2011**



As the second and longest-serving president to date of one of the nation's largest group purchasing organizations in terms of annual purchasing volume, Mark McKenna brought growth, with order and stability to Novation during a turbulent period in GPO history. McKenna deftly guided Novation during his tenure, overseeing membership and program expansion and diversification, as well as advocating and defending group purchasing on Capitol Hill and within the healthcare industry.

G. Gilmer Minor III



Gil Minor III has been intimately involved with the healthcare supply chain industry since the 1960s, well before he took his family-owned company, Owens & Minor Inc., public, and within the last decade, set out on the path through acquisitions and organic growth to become the nation's largest distributor of medical/surgical supplies. Under Minor's leadership, the company pioneered the Activity-Based Costing method for pricing distribution services, just-in-time/stockless distribution and a series of software products for enhancing supply chain management efficiency. He continued the company founders' principles of providing services to customers and dealing with colleagues ethically, solidifying the company's reputation in the industry. Minor also spearheaded the founding of O&M University, originally to provide supply chain training and career advancing education to O&M staffers, but, in recent years, has expanded access to the hospital community that may not have other resources for formally training its supply chain staff.

Curt M. Selquist



As company group chairman of Johnson & Johnson Medical and Johnson & Johnson Healthcare Systems, Curt Selquist wasn't interested in watching Internet-based electronic commerce develop from the sidelines, nor was he content or satisfied with available options at the turn of the millennium. So

he marshaled support within Johnson & Johnson's top corporate hierarchy, as well as rallied and recruited his chief executive counterparts at such leading firms as Abbott Laboratories, Baxter International, GE Healthcare and Medtronic, to found, fund and launch an independent, open and vendor-neutral online trading exchange. Today, GHX remains the nation's largest online healthcare e-commerce hub and one of the largest in the world.

**Donald G. Soth,
1920-1997**



In healthcare circles, the late Don Soth successfully managed the delicate balance between the art and science of supply chain efficiency, and could be described as both a pragmatist and a visionary with his sterile processing and logistics concepts and implementations. As the face in front of AMSCO's Systems Division, which now is part of STERIS Corp., Soth worked with the late Gordon Friesen (Bellwether Class of 2009 Inductee) to develop a variety of material handling and processing models and technologies, such as automated loading and unloading washer-sterilizer units, pneumatic tube systems, cart lifts and guided vehicle systems. AMSCO's industry-leading education programs served as the forum for these models and concepts and for Soth's skills in presenting them.



Louis Vietti
Lou Vietti was one of the more prominent advocates for implementing state-of-the-art industrial applications to hospital support services and linking supply chain operations to information technology. Vietti demonstrated a mastery of JIT/stockless distribution in a university hospital setting and developed a first-class, off-site warehouse for the University of Minnesota Hospitals and Clinics. He showed how the use of computers and exchange carts in inventory and logistics management could improve accuracy and productivity, as well as process flexibility for clinicians.

BELLWETHER CLASS OF 2009

George Ainsworth

The late George Ainsworth was instrumental in the success of group purchasing operations at 10 state, regional and municipal hospital associations. As a leading executive during the 1960s and 1970s within Hospital Bureau Inc. (HBI), regarded as the nation's first commercial group purchasing organization by its founding in 1911, Ainsworth helped coordinate buying power by ushering in such concepts as committed-volume contracting, one member-one vote philosophy and vendor administrative fee collection by GPOs.

Charles Auslander

As a Midwestern hospital purchasing director in the late 1930s and early 1940s (Chicago's Michael Reese Hospital), the late Charles Auslander was an early advocate of product standardization, due in large part to material conservation efforts during World War II. Auslander joined Joint Purchasing Corp. (JPC) as executive director in the mid-1940s and helped to build JPC as one of the forerunners of contemporary GPOs. During his three decades of service at JPC, Auslander developed one of the earliest group purchasing programs for laboratory products, and he was particularly skilled in dealing with CEOs, COOs and hospital department managers to consolidate purchasing volumes.

Guy J. Clark, 1889-1957



As a purchasing agent for the city of Cleveland in the early 1900s, the late Guy Clark was invited to join the two-year-old Cleveland Hospital Council as CHC's first purchasing agent in 1918. Clark developed CHC's cooperative purchasing service, which bridged relationships between the hospitals, vendors and central organization, serving as its first director. In 1926, Clark became CHC's third executive director, a post he held for 29 years until his retirement in 1955. During his 37-year career at CHC, Clark never wavered from his purchasing

roots, consistently pursuing cost-cutting initiatives and economic efficiency for the organization and its members, even during his 29 years of top leadership service. Uniform cost accounting, common employment and collections procedures were three of the efficiencies he helped implement, earning him the accolade of "champion of health and welfare in Cleveland." Clark also was a former president of the Ohio Hospital Association and a director of the American Hospital Association.

**Gordon A. Friesen,
1909-1992**



Few have reached the late Gordon Friesen's impact on hospital design and healthcare supply chain operations. An influential thought leader who recognized as far back as the mid-1930s that the rapidly expanding patchwork hospital incubated deeper operational confusion within its walls. Consequently, Friesen rallied for systematic planning and personalized patient care over an apparently unwieldy mass production approach and a growth of "little kingdoms." In a career that spanned more than 50 years, Friesen envisioned, designed and implemented dozens of hospital projects that redefined and reorganized hospital operations, borrowing ideas from the airlines, hotels and manufacturing industries. Friesen promoted such concepts as each private patient room functioning as a well-equipped nursing station; nursing teams and zoned nursing strategies; the overhead monorail-driven Automatic Cart Transportation System (ACTS); exchange carts; automated washer-sterilizers; dedicated clean and soiled product traffic paths; management engineering and space planning standards; and centralized or regional shared services for food services, laundry and receiving and warehousing.

**Brien Laing,
1926-2015**



A distributor executive who helped initiate electronic data interchange and bar coding between providers and suppliers in the 1960s and 1970s, Brien Laing spent his entire 37-year career at American Hospital Supply

Corp. and Baxter Healthcare Corp., interrupting his two-year retirement to return as a director and non-executive chairman of the board of Span-America Medical Systems for another 11 years. Laing helped to promote stockless purchasing and inventory management, as well as the exchange cart system, and marketed the popular exchange cart cover. Laing was one of the first to recognize vendors needed to educate the purchasing professional and would host numerous materials management seminars. He also was an early advocate of group purchasing and the distributor's integral role. Laing was responsible for training dozens of young managers who would go on to become company CEOs. His mentoring and emphasis on effective management were legendary, contributing to the theatrical career launch of salesman-turned-actor McLean Stevenson, best known for playing Col. Henry Blake during the first three seasons of CBS-TV's M*A*S*H in the early 1970s.

Lillian R. Matiska, 1918-2001

The late Lillian Matiska may have spent her entire supply chain career at the small community hospital she helped to found in 1959, but she left an indelible mark on the profession. Committed to the idea of Jeannette, PA, having its own hospital, Matiska worked to raise the initial funds to build Jeannette Memorial Hospital and became the first employee as director of purchasing and head of personnel. Matiska also rose to industry prominence and national stature as the second woman to serve as president of AHRMM in 1973, earning the association's George Gossett Leadership Award, as well as the Ellis Karp Award from the Hospital Council of Western Pennsylvania. She routinely spoke about materials management topics in 28 states, and after her retirement Matiska organized the Association of Retired Employees at the hospital and created a hospital auxiliary to provide scholarships to medical students as an incentive to launch their practices locally.

William M. McKnight, 1929-2012



After working in hospitals for several years, enrolling in a pre-med college program and serving as a regional sales representative at American Hospital Supply Corp. until the late 1960s, Bill McKnight can be credited with inaugurating media coverage of supply chain management within the healthcare industry. Among his publishing accomplishments in the late 1960s and 1970s, McKnight launched a trade magazine for distributors (Medical Products Sales) and one for hospital materials managers (Hospital Purchasing News), the latter of which continues to publish as Healthcare Purchasing News. McKnight also created a trade show for providers and suppliers and an association of manufacturing and sales executives in the 1980s.

Sara I. Mobley, 1929-2014



Sara Mobley's 41-year career in healthcare began in 1949 as a clerk-typist at one prominent Florida hospital and culminated in 1992 as vice president of materials management at another. During those five decades, Mobley rose through the ranks of materials management, successfully developing patient-focused cost savings programs even prior to prospective payment, honing her solid contract negotiation skills, becoming one of the first healthcare supply chain leaders to achieve membership in the American College of Healthcare Executives and serving as AHRMM president in 1983. As a leader in AHRMM, Mobley helped develop certification criteria and helped expand a number of state and local chapters, as well as elevate the profession in executive circles. As a leader in hospitals, she mentored a number of professionals still active in supply chain management today.

Paul B. Powell



With more than a decade of purchasing and operations experience in the airline industry in the 1960s and 1970s, Paul Powell became one of the first major proponents of implementing

industrial procurement practices in healthcare organizations. As director of purchasing at United Air Lines and then vice president of operations for InFlight Services Inc., the firm responsible for broadcasting major films during flights, Powell oversaw the procurement, management and distribution of supplies, food, equipment and services, facilitated by computerization and keen negotiating skills. Joining American Medical Inc., which quickly was acquired by Humana Inc., in 1974 as senior vice president of material management, Powell helped make Humana a leader in contract terms and pricing, significantly pushing for product standardization throughout the entire Humana system and emphasizing collaboration between providers and suppliers. Powell also helped to pioneer electronic catalogs and computerized purchasing data management. His philosophies on supply data management and supplier relationships are common practice today.

Samuel G. Raudenbush, 1931-2016



Sam Raudenbush dedicated himself professionally to supply chain management, steadily rising through the ranks in purchasing to a senior-level support services position three decades later. Raudenbush was an early adopter of vendor partnerships between providers and suppliers and a pioneering leader in expanding materials management to a support services role responsible for such areas as biomedical engineering, maintenance, power plant, central service, patient transportation and operating room. He was one of the first hospital executives to plant a supply chain professional in the operating room in the 1980s to manage inventory and relationships with surgeons and nurses, as well as a proponent and implementer of exchange carts, OR replenishment systems and low-unit-of-measure distribution. Raudenbush also was a staunch supporter of electronic data interchange (EDI), serving as an early advocate of Johnson & Johnson Health Care System's COACT program. Raudenbush was known for mentoring scores of supply chain professionals

who went on to advance their careers, something he considers one of his proudest achievements. He served as AHRMM president in 1988, where he helped to fortify regional educational seminars, improve chapter recognition and institute Board-Elect positions for more effective policy continuity, earning the association's George Gossett Leadership Award in 1990.

Warren D. Rhodes



Warren Rhodes may have started his supply chain career as a purchasing agent at Evanston (IL) Hospital in 1960, but within four years he began his meteoric rise in group purchasing ranks by heading up shared services operations at another local hospital. By 1968, Rhodes was tapped by two Catholic health systems to head up their collective group purchasing effort, forming the multi-system GPO Mercy National Purchasing Inc. where he served as president for 34 years until his retirement. Rhodes expanded Mercy National in 1987 to manage the purchasing of non-Mercy-owned for-profit affiliates, a concept that the leading investor-owned hospital companies at the time had yet to explore. In addition, Rhodes helped to establish the first Catholic member group purchasing collaborative known as C+R+O+S+S in the 1990s, a national GPO that lasted for five years and inspired the creation of future GPOs Ascension and Consorta.

James E. Stover



Jim Stover can best be characterized as the "Johnny Appleseed" of distribution innovation in that he helped to spread the process efficiencies and improvements he amassed during his more than 40-year career throughout the industry. In relentless pursuit of knowledge and innovation, Stover eagerly adopted leading-edge trends at his distribution company and cultivated such seeds within the industry as bar coding, computerization and product numbering systems. Stover contributed to the distribution industry through extensive association work as well, serving as executive director of HIDA in the 1980s and executive director of ABCO in the 1990s, now known as NDC.

BELLWETHER CLASS OF 2008

Dean S. Ammer, Ph.D., 1926-1999



Ammer, an acclaimed Northeastern University

professor of industrial engineering and economics, was a prolific author and speaker, regarded by many as the father of healthcare materials management – even in contemporary circles. As far back as the early 1960s, he advocated the effectiveness of purchasing, predicted that materials management would be viewed as a corporate position and a profit center and promoted a supply chain function that integrated a variety of operational components to service customers throughout the hospital. Although Ammer died in late 1999, his publications and influence remain popular and are still quoted and sourced today.

Lee C. Boergadine



Boergadine was known for his accomplishments and leadership as a supply chain

management director for not-for-profit and investor-owned hospitals almost as much as his popular continuing education and training seminars. Through those seminars, hosted by Health Service Corporation of America's Academy for Professional Development, Boergadine helped train more than 600 materials management professionals in the areas of finance and supply chain operations.

Gene D. Burton, 1927-2016



After a decade in hospital purchasing, Burton launched a full-service shared

services organization for not-for-profit hospitals in western Kentucky in 1968 before overseeing and expanding centralized corporate purchasing operations at two of the nation's largest investor-owned hospital chains. He retired from the healthcare purchasing world to found a successful equipment planning and

procurement consulting firm in the late 1980s that still operates today.

Charles E. Housley



Housley was one of the few hospital supply chain management

directors to become president and CEO of a facility. He pioneered the concepts of just-in-time and stockless distribution in hospitals, product evaluation and standardization committees and emphasized the value of forecasting and product formularies back in the 1970s and 1980s. Most of his authoritative published works, and consulting and speaking engagements reflected his advocacy that materials managers should be elevated to executive level positions for the business side of hospital operations.

Thomas W. Kelly



Kelly spent a decade of his supply chain management career at one of the oldest and most venerable

institutions in the nation – Massachusetts General Hospital – where he restructured the facility's purchasing organization to be more responsive to the needs of hospital employees and vendors, as well as control costs through standardization, value analysis and workflow improvements. With his 35 years as an adjunct professor of management information systems/information technology at Northeastern University, Kelly established and maintained a micro distributed computerized system for finance, purchasing and materials flow for a large healthcare network in the Northeast.

William J. McFaul



Despite his early career in not-for-profit hospital purchasing and shared services operations, McFaul

may be best known for launching a prominent consulting firm that helped hospitals control non-salary expenses and streamline operations. McFaul was an influential proponent of shared services ventures between related and unrelated healthcare facilities and was instrumental in the creation and development of one of the 10

largest group purchasing organizations in the industry. He pioneered the concept of contract management services for materials management, as well as developed concepts for data sharing, statistical analysis of product and service consumption and standardization, clinical value analysis and strategic resource management. Today he leads The Center for Modeling Optimal Outcomes, a firm he created to cultivate critical thinking, leadership, management and visionary process development and has earned patents on a number of learning and leadership training programs.

Tom Pirelli



Pirelli is best known for founding Enterprise Systems Inc., a healthcare software firm that was one of

the first companies to offer personal computer-based business systems for use in hospitals. In fact, ESI was the first software company to install a local area network in a hospital and the first to integrate bar code scanners and touch screens for tracking hospital supplies. ESI's supply chain application software was considered the industry standard during the 1980s and 1990s because it brought discipline and efficiency in a user-friendly package to the business of managing the supply chain. Through his Arial Foundation Pirelli is dedicated to working with children, handicapped individuals and poor families, helping to construct new homes and apply

automation, robotics and voice-controlled technology to improve daily living and local economies.

Donald J. Siegle



Siegle parlayed his buying skills acquired in the steel industry in western Pennsylvania to help create and

develop one of the five largest group purchasing organizations in the nation. As a passionate and vocal advocate of collaboration and cooperation between hospital buyers, a strategy that could help them collectively negotiate with the multi-million dollar companies supplying the healthcare industry, Siegle stressed procurement education as the seed of professional success and reduced healthcare costs.

Alex J. Vallas, 1932-2016

Vallas, whose hospital materials management career spanned more than three decades, helped introduce



the concept of value analysis into healthcare from industry and was one of the first to push for materials

management certification. He strongly advocated that materials management play a major role in a hospital's financial stability, urging the need to elevate the status of purchasing, materials or supply chain management to an executive level and arguing for a clear separation between providers and suppliers in favor of professional leadership development.



Invest in Healthcare Supply Chain Excellence

Become a sustaining sponsor of Bellwether League, the Hall of Fame for Healthcare Supply Chain Leadership. For details on the various

sustaining sponsorship program opportunities, visit Bellwether League Inc.'s web site (www.bellwetherleague.org) and/or contact Executive Director Rick Dana Barlow at rickdanabarlow@bellwetherleague.org.

Bellwether League also invites you to nominate innovators, leaders, pioneers and visionaries in healthcare supply chain management for the Bellwether Class of 2019, as well as the Future Famers Class of 2019 and the Dean S. Ammer Award for Supply Chain Excellence. Find the official nomination forms online.



LEADERS & Luminaries



BELLWETHER LEAGUE SALUTES...

more than 80 companies that historically have sponsored and sustained the organization and its selfless pursuit of shining a light on healthcare supply chain excellence for more than a decade. This includes nearly 40 that continue with us currently and the dozen that have been with us since the very beginning.

The Board of Directors and Bellwether and Future Famer classes recognize current and past sustaining sponsors by level and term.

CURRENT

Founding/Platinum



Halyard Health (2008-present)



HEALTHTRUST

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Owens & Minor (2008-present)



Premier (2008-present)



VIE Healthcare (2017-present)



Vizient Inc. (2008-present)

Gold

AmerisourceBergen (2012-present)

Cardinal Health Inc. (2008-present)

GHX (2009-present)

M.D. Buyline (2012-present)

Medline Industries Inc. (2015-2017)

Valify (2017-present)

Wingfoot Media Inc. (2008-present)

Silver

ASP Global (2017-present)

BD (2009-2017)

C.R. Bard Inc. (2009-present)

Clafin Co./ National Distribution and Contracting, Inc. (NDC) (2012-present)

Crown Health Care Laundry LLC (2017-present)

DeRoyal Industries Inc. (2011-present)

Healthcare Purchasing News (2008-present)

Healthcare Supply Chain Association (HSCA) (2011-present)

Henry Schein (2017-present)

Medline (2018-present)

Omniceil Inc. (2010-present)

Resource Optimization & Innovation (ROI) (2009-present)

STERIS Instrument Management Services (IMS) (2011-present)

Bronze

Advocate Health Care (2017-present)

Beaumont Health (2017)

Geisinger Health System (2017-present)

Mayo Clinic (2017-present)

Northwestern Memorial Hospital (2017-present)

Ochsner Health System (2017-present)

Texas Health Resources (2017-present)

Corporate & Professional

Bellwether League Inc. Board of Directors

Champion Healthcare (2015, 2017-present)

HealthCare Links (2013-present)

Jamie C. Kowalski Consulting LLC (2008-present)

John Strong LLC (2013-present)

Johnson & Johnson Health Care Systems (2012-2015, 2017-present)

MedSpeed (2012-2015, 2018)

NCI Consulting Group LLC (2018-present)

Patrick E. Carroll & Associates (2008-2018)

Strategic Marketplace Initiative (SMI) (2008-present)

SVAH Solutions (2008-present)

TECSYS (2012-present)

The Wetrich Group (2014-present)

PAST

Founding/Platinum

Hospira (2008-2013)

Kimberly-Clark Health Care (2008-2014)

McKesson (2012-2015)

MedAssets (2008-2015)

Gold (originally Charter)

Amerinet (2008-2015)

Broadlane (2009-2011)

Novation (2010-2015)

Stryker (2011-2013)

Silver (originally Corporate)

AdvanTech (2008-2015)

Ascent Healthcare Solutions (2009-2011)

Baxter (2009-2012)

Covidien (2011-2016)

GS1 Healthcare US (2010-2016)

Gene Burton & Associates (2009)

Corporate & Professional (originally Contributing)

Amerinet Central (2010)

Blue.Point Supply Chain Services (2017)

CareFusion (2012)

DataPros for Healthcare (2012)

Health Care Solutions Bureau (2010-2012)

Healthmark (2011-2012, 2017)

Hill-Rom (2015-2016)

Innovative Health (2017)

IntelliCentrics (2014-2015)

Jump Technologies (2016)

LeeSar (2012, 2014)

LINET Americas (2017)

Logi-D (2011)

Management Health Solutions (2010)

MDR (2016)

OpenMarkets (2012, 2016-2017)

The Optimé Group (2011-2014)

PAR Excellence (2010)

Pensiamo (2017)

Prodigio Solutions (2017)

Vendormate (2013)

Xanitos (2017)