



“Like Turning a Ship in a Channel”: Reframing Complexities and Solutions for Supplier Diversity and Local Purchasing in Healthcare

Citation

Doan-Soares, Stephanie Deborah. 2022. “Like Turning a Ship in a Channel”: Reframing Complexities and Solutions for Supplier Diversity and Local Purchasing in Healthcare. Doctoral dissertation, Harvard T.H. Chan School of Public Health.

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This Doctoral Project, “‘Like Turning a Ship in a Channel’: Reframing Complexities and Solutions for Supplier Diversity and Local Purchasing in Healthcare” presented by Stephanie Deborah Doan-Soares, and Submitted to the Faculty of The Harvard T.H. Chan School of Public Health in Partial Fulfillment of the Requirements for the Degree of Doctor of Public Health, has been read and approved by:

Laurie S. Pascal

Laurie Pascal

William Bean

William Bean

Martin Lucenti

Martin Lucenti

Date: July 28, 2022

“Like Turning a Ship in a Channel”:
Reframing Complexities and Solutions for Supplier Diversity
and Local Purchasing in Healthcare

Stephanie Deborah Doan-Soares

A Doctoral Thesis Submitted to the Faculty of The Harvard T.H. Chan School of
Public Health in Partial Fulfillment of the Requirements for the Degree of Doctor of
Public Health

Harvard University

Boston, Massachusetts.

November 2022

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and Local Purchasing in Healthcare

Abstract

Background: US healthcare systems have begun establishing and expanding supplier diversity and local purchasing programs, in response to an increasing focus on equity and the role of hospitals as anchor institutions. The literature contains multiple lists of best practices and recommendations but does not contain an analysis of the complexities that stymie successful implementation.

Aims: This thesis provides a framework to understand the complexities of impact purchasing and offers some recommendations based on that framework.

Methods: The analysis relies on three primary sources of qualitative data: semi-structured interviews with 20 healthcare purchasing experts; insights from five reports highlighting healthcare impact purchasing case studies; and the author’s observations and conversations with colleagues while working at UMass Memorial Health. Structuring the analysis around Bolman and Deal Reframing Organization’s Four Frames, these data sources were coded to identify key themes.

Results: Through decades of pressure to reduce costs and respond to increasing quality standards, contracts with vendors in the healthcare sector have grown in scale, complexity, and specificity, limiting the ability of small businesses to respond competitively to bids. The reduced capacity to compete has also been driven by unequal access to capital and rising local labor costs. Common approaches to supplier diversity in healthcare rarely acknowledge or address

the historical origins that have created the current purchasing system in healthcare, limiting the health system's ability to create the desired economic growth impacts.

Recommendations: Healthcare leaders should update purchasing processes, ensure adequate staffing to handle the relationship-intensive work of connecting with local and diverse businesses, and build data systems that enable decision-making. Leaders should empower and incentivize staff at multiple levels (within supply chain and the departments making purchasing decisions) to make changes. Senior leaders must link supplier diversity to business strategy, and leaders at all levels should negotiate with vendors and others to create innovative solutions and multiply impact. Finally, by continuously telling stories, leaders can position local and diverse supplier efforts as an important symbol of the organization's commitment to diversity, equity, and inclusion, likely increasing the interest of local and diverse vendors in doing business with system.

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Acronym List

AHA	American Hospital Association
B2B	Business-to-business (type of corporation)
B2C	Business-to-consumer (type of corporation)
B2G	Business-to-government (type of corporation)
CSR	Corporate Social Responsibility
GPO	Group Purchasing Organization
HAN	Healthcare Anchor Network
HRET	Health Research and Educational Trust, a center within AHA
IPC	Impact Purchasing Commitment
MHA	Massachusetts Hospital Association
MBDA	Minority Business Development Agency
MBE	Minority-owned Business Enterprise
MWBE	Minority- or Women-owned Business Enterprise
NMSDC	National Minority Supplier Development Council
OMBE	Office of Minority Business Enterprise (renamed MBDA)
UMMH	UMass Memorial Health
WBENC	Women Business Enterprise National Council
WBE	Women-owned Business Enterprise
UMMH	UMass Memorial Health

Glossary of Terms

Anchor institution: Institution that support the economy of a city or region, most public or quasi-public institutions with deep place-based roots (e.g., hospitals, colleges and universities, and utility companies)

Anchor mission: A commitment by an anchor institution to consciously apply the place-based economic power of the institution, in combination with its human and intellectual resources, to better the long-term welfare of the community in which the institution is anchored

Healthcare Anchor Network: A non-profit organization that convenes healthcare systems to share best practices, address common challenges, and create solutions and tools to support anchor mission strategies

Category owner: Individuals who oversee the budget and purchasing decisions of a particular department or functional area

Causal loop diagram: A systems dynamics tool for understanding how the pieces of a complex system relate to one another (see section 2.3.3 for more information)

Tier I: An institution's direct vendors, sometimes called prime vendors

Tier II: Suppliers or subcontractors of the institution's direct or prime vendors

Impact purchasing commitment: A leadership pledge organized by the Healthcare Anchor Network focused on increasing local, diverse, and environmentally sustainable purchasing

Value analysis process: A framework for making purchasing decisions about clinical products—from gloves to implants to equipment—that acknowledges needs of multiple stakeholders

Acknowledgements

While I might have been the captain, this doctoral project had a full crew of incredibly gifted humans that made crossing the finish line possible!

To my amazing committee: Laurie—for helping me get my engines going when I needed it, for teaching me to ask questions differently, and for your presence on the journey; Bill—your clear and gentle and humorous guidance made this process better (and more fun); Marty—I don’t think I would have gotten here without your willingness to talk about all this complexity for hours. I’m so grateful!

To the incredible team at UMass Memorial: Especially Doug for the mentorship and noodling and opportunity; to Sergio for all the lessons and metaphors; Kate B and Kate M for being my partners in crime; Ed, Kathleen, Steve, Denise and all the members of anchor mission purchasing committee, and Diane and Patti for taking such good care of me. Thank you!

To “the Nine”: I’m grateful for the things you’ve taught me in this program!

To the DrPH program team: To Susan who helped make this thesis readable, to Rick for the connection to UMMH, to Jocelyn for sponsoring my IRB, Fawn, Gary, and others--Thank you!

To HAN, its members, and others who shared their insights with me: Your work is inspiring and incredible—thank you for what you’ve shared so willingly as you journey toward equity.

To my incredible friends and family: You know who you are—and there are too many to name. I’m a product of all of your love and support—both in the years before this program and while you cared for me in the midst of it. I’m forever grateful.

Finally, to my co-captain, Max: Thanks for the space and encouragement to get this done.

Looking forward to being out on the open ocean with you!

1. Introduction

“Changing the way a hospital buys things is a little like turning a big ship in a narrow channel.” This was the image that the Chief Financial Officer at UMass Memorial Health (UMMH) shared with me in one of our first monthly check-ins about my doctoral project. I had been hired to support the healthcare system’s Anchor Mission—a commitment to leverage the system’s business practices to support a more equitable and healthy local economy. One of my key tasks was serving as a project manager for implementing the system’s recent pledge to increase its purchasing from diverse and local businesses.

In the CFO’s analogy, the sides of the channel are firm and unmovable—like the complex system of regulations and requirements that determine what a hospital can and can’t buy. Getting the big ship moving in a different direction takes a series of small and coordinated movements—not a simple one or two turns that might be required out in the open ocean. And doing those small, coordinated movements is even more challenging if the weather is stormy (perhaps from budget austerity measures) and there is a strong current in the channel (perhaps momentum toward bigger contracts to build cost savings by achieving economies of scale).

This thesis project was originally envisioned as a chance to document the lessons learned from UMass Memorial Health’s entry into world of supplier diversity and local purchasing. Since most of the leaders in healthcare supplier diversity are large hospital systems anchored in a large metropolitan area or spanning multiple states and cities, I anticipated that the lessons learned from UMass Memorial Health (UMMH)¹ might pave the way for other mid-

¹ Based in the mid-sized city of Worcester, Massachusetts, UMass Memorial Health (UMMH) includes a flagship medical center with 4 community hospitals, a behavioral health provider, and 70 clinical

sized health systems who are beginning a similar journey. However, getting UMMH's anchor mission purchasing initiative off the ground took more time and effort than originally anticipated, and my doctoral project quickly became an inquiry into why it is so difficult to make directional changes to a \$1 billion-a-year purchasing machine (rather than the planned documentation of successful action steps).

While the available literature contains several lists of recommended actions for getting started and maintaining progress on supplier diversity programs, none of these sources document the resistance that stymie successful implementation—or how to coordinate among actions given the numerous complexities present in the healthcare purchasing ecosystem.

Building off the available literature around supplier diversity efforts and the unique challenges of healthcare purchasing, I conducted a series of interviews with experts engaged in supplier diversity and local purchasing efforts within the healthcare sector. I also analyzed the purchasing and anchor mission ecosystem at UMass Memorial Health, relying on my observations and a series of informal interview conversations with staff and leaders across the system. Utilizing these information sources, I examined the complexities of local and diverse purchasing through the lens of Bolman and Deal Reframing Organizations, an organizational behavior framework that encourages leaders to examine problems and potential solutions from four different perspectives or 'frames': structural, human resources, political, and symbolic.

The primary outcomes of this project are a list of key complexities and considerations for local and diverse purchasing in healthcare, a new model for understanding both the internal

practices. The \$3 billion system manages 1,117 beds and serves both as a safety net for central Massachusetts residents as well as the clinical partner of the state's only public medical school.

and external drivers of why it's so hard to increase purchasing from diverse and local vendors, an exploration of promising practices, and a set of recommendations for both UMass Memorial Health and other healthcare systems interested in making progress on their supplier diversity and impact purchasing initiatives.

Note on Terminology

While conducting this project, I encountered a range of different terms to describe the concept of leveraging purchasing power to create positive social and economic change. One key component of the effort—most often called “supplier diversity”—focuses on purchasing from businesses owned by minorities, women, and other individuals (including veterans, member of the LGBTQ community, etc.) who have historically encountered barriers to growing their businesses. Sometimes people call this “diverse purchasing,” and others have used the terminology “minority and women-owned Business enterprise (MWBE) purchasing,” particularly when wanting to point to a specific definition or type of businesses.

Another component is the idea of keeping an organization's resources and purchasing power in the local economy—often called “local purchasing” or “buying local.” There's not a clear standard for what local means, often depending on the sector or size of the buyer. For example, a state or local government often uses its jurisdiction boundary; others might use a particular distance from their factory or headquarters; and others might focus on the places where their employees or customers live. Finally, many organizations track “local” at multiple levels—from a target zip code to a multi-state region.

The third component is “environmentally sustainable” spending, focusing on the environmental impacts of different spending decisions (e.g., carbon emissions from energy

purchases or a fleet of vehicles, chemicals in products, or waste disposal). Sometimes this is called “sustainable” or “green” spending.

Often, diverse, local, and green spending are grouped together. Some organizations call these three combined efforts “impact” purchasing while others call them “sustainable” purchasing and still others “social procurement.” At UMass Memorial Health—and several other healthcare organizations with a dedicated anchor mission—stakeholders use the term “anchor mission” purchasing.

Since anchor mission purchasing at UMMH has largely focused on purchasing from local and diverse businesses, and since the environmentally sustainable purchasing implementation efforts largely require different types of strategies, I have focused this paper on supplier diversity and local purchasing. I utilize several different terms during this paper: “local and diverse purchasing,” “supplier diversity and local purchasing,” “impact purchasing,” and “anchor mission purchasing” since there’s not one term that I believe best conveys the issue with clarity or simplicity.

People often use the terms “sourcing,” “procurement,” or “supply chain” to replace “purchasing.” One differentiator among terms is whether the action is relevant only to the purchase of items, goods, and commodities, as is often the case with the word “supply chain.” Since the purchase of services—in addition to goods—offers a significant opportunity for local and diverse vendors, I’ve used the word “purchasing” throughout most of this paper. However, some interviewees use these other terms depending on the language used by their employer.

2. Background and Context

In this section, I begin with a summary of the literature around supplier diversity and hospital purchasing practices and trends. I next explore some high-level background on UMass Memorial Health (UMMH), its anchor mission, and my position as an administrative fellow while completing this project. I finish the section with an overview of the frameworks and tools that ground the analysis and findings for this paper: Bolman and Deal's reframing organizations framework, the Lean Six Sigma process improvement approach, and the causal loop diagram.

2.1 Literature Review

Below, I explore the peer-reviewed literature (and, where not available, the grey literature) describing the history of supplier diversity efforts in the US, related business strategy trends, the supplier diversity business case, and best practices for implementing supplier diversity efforts across business sectors. I then shift to exploring trends and business practices within healthcare organizations, including the rise of the concept of the anchor institution. I end with an overview of the unique attributes of the hospital supply chain and an overview of the limited literature specific to healthcare supplier diversity and local purchasing initiatives.

2.1.1 History of supplier diversity

Eventually growing into a core businesses strategy of thousands of firms across the US and the world, the concept of supplier diversity began in the US with the civil rights movement of the 1960s. Signed into law by President Johnson, the Civil Rights Act of 1964 legislated the equal inclusion of black and brown citizens in the nation's economy and society, particularly as employees and customers.

However, during this same time, affluent—mostly white—residents had moved out of cities and into the suburbs, taking with them the wealth and capital that had once held together city neighborhoods (O'Connor, 2007; Shah & Ram, 2006). The Nixon campaign's civil rights agenda and plan for improving the conditions in the nation's cities focused on strengthening "black capitalism"—the idea that creating additional economic opportunity for black residents might quell urban unrest (NMSDC, 2018; Shah & Ram, 2006).

To fulfil these campaign promises, Nixon created several executive orders that launched the concept of supplier diversity. These executive orders created both the Office of Minority Business Enterprise (OMBE, renamed the Minority Business Development Agency) and the Small Business Administration (SBA) and directed federal agencies to develop a plan for a minority business enterprise (MBE) federal contracting program (MBDA, 2021). In the 1970s and early 1980s, Congress legislated multiple set-asides for businesses owned by women, veterans, minorities, and other disadvantaged populations; these were replicated as similar requirements in state and local governments.

Throughout the 1970s, large manufacturers—like General Motors, IBM, and AT&T—began establishing formal supplier diversity programs, motivated largely by a desire to comply with federal government contracting requirements. By the early 1980s, the federal government's policymaking around supplier diversity slowed considerably and legal scrutiny reduced the use of government set-asides. But even with less government support, supplier diversity efforts continued to grow and expand as business leaders identified other benefits of working with a more diverse set of suppliers, like access to customers (NMSDC, 2018). Organizations like the National Minority Supplier Development Council (NMSDC) and the

Women Business Enterprise National Council (WBENC) played a critical role in the growth of supplier diversity efforts by serving as an intermediary platform for connecting corporations to minority- and women-owned businesses (MWBs), and vice versa.

By 2019, 85% of US Fortune 100 companies had some sort of supplier diversity program, with 10% of supplies and services within these companies procured from diverse suppliers (Swette & Boyo, 2021); more than 1,900 corporations were members of either a local or national chapter of the NMSDC (NMSDC, 2019); and 28 companies had been added to the Billion Dollar Roundtable (BDR, 2021), an organization that brings together businesses who spend more than a billion dollars with MWBs.

While the concept of supplier diversity got its start in the US, companies across the globe, particularly the western world, are now paying more attention to the way they purchase goods and services from disadvantaged businesses. These efforts are often called by other names including “social procurement” (in Canada and Australia), “responsible procurement management” (in the UK and EU), and “ethical sourcing” (in the UK) (Barraket et al., 2020; Brown, 2005; Worthington, 2009). See Appendix A for a more in-depth exploration of this history.

2.1.2 Related movements and trends impacting supplier diversity

The idea of supplier diversity didn’t develop in a vacuum. The expanding concept and acceptance of Corporate Social Responsibility (CSR) has provided significant impetus for supplier diversity to be integrated into corporate business strategy. Similarly, new ways of conceptualizing supply chain management have provided language, tools, and best practices (and sometimes competition) for supplier diversity integration into procurement practices. This

section will look briefly at some of these trends and their associated impact on supplier diversity.

- **Corporate social responsibility (CSR):** The roots of modern Corporate Social Responsibility (CSR) are often traced to Bowen’s book, *Social responsibilities of the businessman*, which defined a set of specific principles that allow the “businessman” to fulfil his social responsibilities (1953). Others who followed Bowen over the next seven decades refined both the strategy behind and the definition of CSR, adding concepts related to sustainability, globalization, strategic management, shared value, and performance. While definitions abound, most include some concept of CSR as a self-regulated (going beyond legal requirements) business strategy that includes contributing to the improvement of society through voluntary action, philanthropy, and ethical practices (Carroll, 2015; Latapí Agudelo et al., 2019).² One of these CSR strategies has been the development and expansion of supplier diversity in a company’s purchasing decisions.
- **The value chain and shared value:** While supply chain management has traditionally been viewed as a process for moving and acquiring goods and services, the growing concept of “value chains” or “best value chains” encompasses the idea that value might arise from more than just cost—and examines that value across the full operational lifecycle (production, procurement, distribution, logistics) (Barraket et al., 2020).

² Both Carroll (2015) and Latapí Agudelo et al. (2019) provide a deep and thoughtful look at changes in CSR frameworks and thinking through history. While both discuss the challenges of the diffuse and disparate definitions of the concept, neither offers a clear definition for the term nor suggest the use of someone else’s definition.

Additionally, managing a “value chain” includes examining agility, alignment, adaptability and other considerations as key components of “value” to the company (Ketchen & Hult, 2007).

As it has evolved, CSR has encompassed the concept of creating “shared value,” defined as the “the policies and operating practices that enhance the competitiveness of a company while simultaneously advancing the economic and social conditions in the communities in which it operates” (Porter & Kramer, 2011). One of Porter and Kramer’s recommendations for creating shared value was to redefine productivity in procurement decisions beyond cost, further strengthening the alignment between CSR and supplier diversity.

- **Strategic and relational supply chain management:** Building off the field of strategic management, strategic supply chain management views the supply chain not just as a way to procure and move items but as a key component of a company’s business performance (Ketchen & Hult, 2007). A leading component of strategic supply chain management is the development and maintenance of ongoing relationships with suppliers with a goal of working jointly to get the best value for the company (Barraket et al., 2020). As noted in the next section, integration of supplier diversity into the overarching business strategy and the development of clear and forward-leaning relationships with diverse suppliers are consistently identified as best practices for effective supplier diversity implementation.
- **Sustainable supply chain management:** Whether called sustainable supply chain management (SSCM), green procurement, sustainable procurement, or some other

combination of terms, SSCM has evolved in a parallel track to supplier diversity. SSCM focuses on incorporating social, economic, and environmental considerations into supply chain management decisions (Tay et al., 2015). Historically the focus has been on environmental issues, with the addition of social components related to labor and ethical practices of supply chain vendors. However, there appears to be a growing connection between sustainable supply chain management and supplier diversity, particularly in Europe and Australia where both terms are brought together under the concept of “social procurement” (Barraket et al., 2020).

2.1.3 Business case for supplier diversity

Demographic shifts in America are seen by many as the primary foundation for a business case for supplier diversity beyond government regulation compliance (Adobor & McMullen, 2007; Shah & Ram, 2006; Worthington et al., 2008). For the first time in the history of the census, the absolute number of people who identified themselves as non-Hispanic white decreased in 2020 from 2010, with non-Hispanic Whites representing 57.8% of the total US population (U.S. Census Bureau, 2021); the non-Hispanic white population is anticipated to fall below 50% of the total US population by 2045 (U.S. Census Bureau, 2020). Many businesses, or at least those which are forward-looking ones, have been paying close attention to these changing demographics in the US population: with a shift in population comes a change in how the populations spends its money.

A 2021 report by the Selig Center estimates that the buying power of African Americans, Asian Americans and Indigenous populations has grown to \$3 trillion in 2020 from \$458 billion in 1990, now representing 17.2% of the total US buying power (Melancon, 2021). Similar

increases can be seen in the Hispanic population, which in 2020 wielded \$1.9 trillion in buying power or 11.1% of the US total buying power (Melancon, 2021). Many corporations have leveraged their supplier diversity programs to develop linkages, relationships, and insights into those sections of the populations where they saw a potential for new business and customers (NMSDC, 2018; Worthington et al., 2008).

But a change in customer base alone is not a sufficient for justifying investment in a supplier diversity program, particularly when one of the primary mechanisms used in supply chain management for controlling costs has been reducing the overall number of suppliers

(Worthington et al., 2008). Worthington (Worthington, 2009) examined perceptions of the strength of the business case for supplier diversity programs in the literature and through interviews, identifying several areas where a corporation's performance could be improved by supplier diversity efforts. Commonly cited improvements included new market access, cost-control, risk spreading, and strategic fit (see Box 1 for more detail).

Box 1: Key opportunities for building a supplier diversity business case

Key opportunities for improved organizational performance through supplier diversity efforts:

- Revenue earning activities (primarily through access to new markets and growth in demand)
- Cost control and reduction (local suppliers can reduce shipping, inventory, and other costs; competitive pricing when including more vendors; and opportunities for innovation)
- Risk spreading (reducing over-reliance on existing suppliers; alternative supply sources during crises; reduction to reputational threats by demonstrating commitment to diversity)
- Strategic fit (demonstrating commitments to Corporate Social Responsibility and sustainability; achieving best value and better fit with government grants; brand-building)

Adapted from Worthington, 2009.

These same concepts—sometimes with different terminology—form the basis of most justifications for linking supplier diversity to business strategy. Some business case descriptions more clearly spell out the advantage of improving conditions locally (e.g., increasing revenue

from the local community through increased wealth and jobs, and improved brand recognition from being known as a company that does right by the local community) (Bateman et al., 2020; Members of the BDR, 2012). Others highlight the value of supplier diversity—along with broader diversity, equity, and inclusion efforts—in creating an attractive employment opportunity for hiring talent, particularly when recruiting from the millennial and Gen Z population (Bateman et al., 2020). Others focus on the importance of diverse suppliers in ensuring a high-quality final product that leverages innovative approaches that might not have been explored using existing suppliers (Members of the BDR, 2012).

Most agree that the business case for supplier diversity initiatives—to be effective as a tool—must be tailored to the specific considerations of the corporation’s sector and focus. For example, a business-to-business (B2B) corporation will have a very different business case from a distributor, manufacturer, or direct-to-consumer service provider (Crump, 2020; Members of the BDR, 2012; Worthington et al., 2008).

Despite theoretical support and a multitude of case studies demonstrating the value of supplier diversity programs, very few quantitative studies have examined the impact of supplier diversity on corporate performance. A study by Richard et al. examined the 2002 performance of a sample of US Fortune 1000 companies (a 14% response rate). They found that the relationship between short-term performance (productivity) and supplier diversity was moderated by whether the corporation was operating in a munificent (or resource-rich and growing) environment or sector, with munificent corporations having a negative relationship between the two while non-munificent organizations (resource poor and declining) had a

positive relationship. The opposite was true when looking at the relationship between supplier diversity and long-term performance (profitability).

2.1.4 Best Practices and Themes for Action

The peer reviewed literature contains a few lists of best practices for supplier diversity, gleaned largely from case studies. For example, based on a case analysis of three different corporation's initiatives, Shah et al identified the following as key: organizational commitment at a senior level, emphasis on outreach activities, and close monitoring of the success of initiatives (Shah & Ram, 2006). Adobor and McMullen laid out six key guidelines: incorporating supplier diversity into business goals, top management support, key role of supplier diversity champions, supportive organization culture, relationship building with vendors, and strategies for recruiting MBEs (Adobor & McMullen, 2007). Additionally, a review of Caterpillar, Inc's supplier diversity program found similar concepts—but added that an organizational culture of inclusion was needed to shift to a diverse supplier pool and away from a “good old-boy's network” (Min, 2009).

Best practices in trade publications, consultant and association reports, and other stakeholder websites abound. In 2010, the NMSDC corporate members came together to identify eight best practices for supplier diversity, with a set of measures for success accompanying each practice. In 2012, the members of the BDR published a book highlighting more examples in each of these best practices, and added additional details on tools, techniques, technologies, and tips, along with highlighting an example from one of their members. Table 1 highlights each of these best practices (Members of the BDR, 2012).

Table 1: Eight best practices for supplier diversity from NMSDC and the BDR

Best Practice	Key Components
1. Establish Corporate Policy and Top Corporate Management Support	- Clearly articulated business case linking supplier diversity to corporate strategy - Data systems for measuring progress and review by senior leadership - Support and accountability from senior leadership, at the CEO or C-Suite level - Cross-functional advisory council linking all lines of business in the corporation
2. Establish a Corporate Diverse-Supplier Development Plan	- Corporate policy that includes clear goals and mission/commitment statements - Training and clear communication on the business case and plan - Internal HR incentives that are aligned with policy/plan implementation - Supplier-focused identification, development, and readiness support programs
3. Establish Comprehensive Internal and External Communications	- Incorporation of supplier diversity into standard communications infrastructure, leveraging technology and social media/networking - Predesigned templates—business case discussions, supplier meetings, factsheets on supplier diversity performance, advertisements etc. - Database of diverse suppliers (active and growing), create a community for connection and collaboration and mentorship - Creative and non-traditional communication mechanisms to find diverse suppliers in “challenged communities”
4. Identify Opportunities for Diverse Suppliers in Strategic Sourcing and Enhancement	- Business case aligned with strategic sourcing principles and new revenue opportunities (competitive advantage, customer satisfaction, brand positioning) - Review of full corporate value chain for opportunities to partner with diverse vendors (don’t exempt specific spend categories from consideration) - Training and accountability for strategic sourcing - Diverse supplier registration system
5. Establish Comprehensive Diverse-Supplier Development Process	- Training and capacity building to help suppliers understand needs of the corporation and expand business capabilities, including a mentorship program - Focus on relationship building, leveraging concepts of supplier relationship management - Dedicated personnel for supplier development - Leveraging of alliances, partners, associations, etc. for development activities - Recognition and reward programs
6. Establish Tracking, Reporting, and Goal-Setting Mechanisms	- System for tracking supplier diversity data (by business unit/commodity, geography, certification type, etc.) - Estimation of MBE cost saving/cost reduction contribution (linking goal achievement to revenue generation, customer satisfaction, etc.) - Monthly review of performance goals and progress to drive accountability - Linkage between supplier diversity goals and personnel performance reviews
7. Establish a Continuous Improvement Plan	- Surveys of key stakeholders (internal and external) - Consistent meetings between supply chain, supplier diversity, and department purchasers to discuss plans, status, roadblocks, and solutions. - Benchmarking, leverage NMSDC and others to identify opportunities - Process for communication with MBEs on improvements to contracting process and other programs - Opportunities for identifying innovative and future directions
8. Establish a Second Tier Program	- Clear supplier diversity policy statement spelling out Tier-2 expectations - Goals set and reviewed with Tier 1 suppliers and with leadership - Formal system for suppliers to report Tier 2 performance quarterly - Remedial actions/sanctions if goals not met with accountability and buy in from sourcing manager

In addition to these eight best practices, the BDC added four additional emerging practices: 9) understand public sector supplier diversity; 10) integrate supplier diversity into sustainability Initiatives; 11) engage historically black colleges and universities (HBCUs); and 12) establish global supplier diversity strategy (Members of the BDR, 2012).

2.1.5 Healthcare organizations and looking outside the clinic

Healthcare organizations occupy a unique and ever-changing role in the US economy and society. Hospitals have moved from being institutions that provided charity care primarily to the poorest populations to institutions that made money by serving the rich to institutions that serve populations across the wealth continuum (Franz et al., 2019). By occupying this unique space, healthcare organizations were largely immune to the pressures to join the growing Corporate Social Responsibility (CSR) movement—and the related supplier diversity effort. However, as healthcare systems grew in economic power, they began to feel the pressure to find ways to be better neighbors to their surrounding communities (Koh et al., 2020; Longest, 2002).

Healthcare systems now make up one of the largest sectors in the US economy—employing 11% of the country’s workforce (Nunn et al., 2020), spending more than \$1 trillion annually (Centers for Medicare and Medicaid Services, 2020), and holding \$400 billion in investments (HAN, 2019). The size of the healthcare industry has grown significantly over the last few decades; healthcare comprised about 5% of the US economy in 1960 but accounted for 19.7 % of the GDP in 2020, a more than three-fold increase (Centers for Medicare and Medicaid Services, 2020; Nunn et al., 2020). In 2022, 19% of hospitals in the US were run by state or local

governments, 24% were investor-owned for-profit entities, and 57% had non-profit status (American Hospital Association, 2022).

Further encouraging hospitals to think about the community around them, government regulations require non-profit healthcare institutions to fund initiatives outside the clinic in order to retain their tax-free status (Franz et al., 2019; Koh et al., 2020). Beginning around the 1970s, healthcare systems spent significant effort arguing that they provide a community benefit through their clinical efforts and therefore shouldn't be subject to taxes. Challenging this assertion in 2007, policy makers and stakeholders required hospitals to document their "community benefit" activities to maintain their non-profit status; in essence, the requirement is that the hospitals provide at least the same level of community benefit that they would have paid in income taxes. Further expanding this requirement, the 2010 Affordable Care Act required hospital systems to conduct a triennial Community Health Needs Assessment and to generate corresponding implementation strategies for initiatives to address those needs (Evashwick & Jackson, 2020).

Simultaneously, the high and increasing cost of healthcare in America—despite falling life expectancy—has created huge initiatives across the healthcare system and policy landscape to find ways to reduce costs. Many of these strategies are focused on clinical operations—including significant supply chain initiatives to reduce the costs of commodities, services, and anything the hospital spends money buying (see more in Section 2.1.7). However, other efforts to reduce costs have been driven by research that what happens outside the clinic drives health much more than what happens inside of it. (U.S. Department of Health and Human Services, 2021). For example, evidence is mounting that hospital systems and insurers can spend less

money paying for housing programming for the chronically homeless than if they paid the emergency room bills for these “frequent fliers” (Garrett, 2012); similar gains have been seen by ensuring access to healthy foods for individuals with complex chronic health conditions like diabetes and renal disease (Gurvey et al., 2013). With reimbursement structures shifting to reward value by looking at the overall outcomes of a population’s health and away from paying directly for services obtained, there is increasing pressure for hospitals to think differently about the way they engage with their local communities (Fichtenberg et al., 2020; Franz et al., 2019).

2.1.6 History and emergence of the healthcare “anchor institution”

The concept of an “anchor institution” emerged in the 1960s as a response to the same issue of crumbling urban community economies that enlivened President Nixon’s investments in the “black economy” and supplier diversity described above. Universities—longstanding institutions with deep roots in a particular city or neighborhood—found themselves in need of a solution and several (like University of Chicago and Johns Hopkins University in Baltimore) took on a more prominent role in the effort to improve social conditions around them. In 1994, the Secretary of Housing and Urban Development, Henry Cisneros, created the Office of University Partnerships based on an acknowledgement that universities were a critical resource for improving America’s cities (and that the university would also benefit from serious engagement with the challenges of host communities) (Fulbright-Anderson et al., 2001). While there was certainly a theoretical benefit and a philosophical calling to be a good neighbor, this engagement in urban renewal issues was also a self-interest requirement for many universities,

since poor conditions in the surrounding area (crime and limited infrastructure) limited the ability to recruit faculty and tuition-paying students (H. L. Taylor & Luter, 2013).

In the late 1990s and early 2000s as federal government resources for development became scarcer, other organizations and institutions were sought out as partners to address inequity and community development challenges in urban places. This expansion to thinking about broader institutional partners—beyond universities—led to the Aspen Institute coining the term “anchor institutions” in 2001 as large, spatially immobile institutions with ties to the city and community, specifically colleges/universities, medical centers/hospitals, and public utility companies (Fulbright-Anderson et al., 2001). In 2017, the National Academies of Science, Engineering and Medicine further recommended—as part of a broad treatise on cross-sector partnerships for building health equity in communities—that healthcare institutions should adopt anchor institution approaches and find ways to mitigate any negative impacts their institutions have had in local communities (National Academies of Sciences et al., 2017).

Since 2001, this title of “anchor institution” has continued to grow in usage and popularity, and yet the term often lacks specificity and definitional clarity. Perhaps the most important distinguishing factor—with the most consensus—for an anchor institution is its spatial immobility, or the idea that the institution is so linked to a particular place that its relocation would be unimaginable. Meagan Ehlenz uses the concept of “sticky capital” as a key component of anchor institutions—because of the breadth of fixed assets like infrastructure, facilities, and land ownership held by these entities (Ehlenz, 2018). While there doesn’t appear to be any clear consensus for a threshold, most scholars and practitioners agree that anchor institutions should be relatively large in both size and influence, with significant ability to

impact both the economy and the culture of the host city or larger geography. Most organizations considered to be anchor institutions are one of the major employers and landowners in a geographical area and wield significant purchasing power (H. L. Taylor & Luter, 2013). While traditionally urban and non-profit in status, increasing numbers of for-profit and rural institutions—particularly in the healthcare space—are assuming the title of anchor institution (Cronin et al., 2021). However, some scholars and practitioners think the label of “anchor institution” shouldn’t be applied to businesses (L. A. Taylor et al., 2022), or should include an added requirement for ‘anchor institutions’ to be public or quasi-public (e.g., receivers of significant government funds or subsidies (Hannah, 2019).

Perhaps the most important factor in determining whether an organization can be considered an anchor institution is whether the leadership and vision of the organization are focused on actively being a change agent in the local community. One way to differentiate a powerful, place-based institution from an authentic anchor institution is examining whether or not the institution has adopted an “Anchor Mission” “a commitment to consciously apply the place-based economic power of the institution, in combination with its human and intellectual resources, to better the long-term welfare of the community in which the institution is anchored” (Serang et al., 2013). Supplier diversity and local purchasing has emerged as one fundamental strategy for leveraging an anchor institution’s economic power.

2.1.7 Unique aspects of healthcare supply chain complexities

While the purchasing power of hospitals is huge, the ways decisions are made and the structures surrounding purchasing differ significantly from purchasing systems in other sectors. Several scholars have suggested that the supply chains in the healthcare sector have been

underdeveloped and are only now beginning to fully leverage the tools and best practices around data analytics, strategic sourcing (developing relationships with vendors to meet needs), and other strategies that can improve efficiency and decrease costs (Knight et al., 2017; Nachtmann & Pohl, 2008). Elmuti and colleagues surveyed leaders from healthcare organizations and found overwhelming agreement that strategic supply chain management concepts are useful for meeting business goals like cost reduction, quality, and organizational performance(Elmuti et al., 2013).

While acknowledging opportunities to learn from other industries, Abdulsalam and colleagues describe the “exceptionalism” of healthcare supply chains; they suggest that this exceptionalism is driven by complexity related to several key factors: a reliance on intermediaries like group purchasing organizations; the range and criticality of products needed for diverse clinical departments; the complexity of products and services (e.g. specialized medical implants and devices that not only are expensive and highly complex but require special handling); and the need for physician involvement in supply chain selection (Abdulsalam et al., 2015). Betcheva and colleagues add some other healthcare supply chain challenges, including: uncertainty (lack of clear diagnoses, prognoses, and outcomes); the co-productive nature of healthcare (outcomes depend on the physician and patient and broader environment); complex economics including delegated decision-making, third-party financing, and information asymmetry; and the pervasiveness of fragmented care (Betcheva et al., 2021).³

³ While I highlight some of these topics below, I found the article by Lindia Becheva, Feryal Erhun, and Huoyuan Jiang to provide a particularly useful and accessible overview of the issues related to healthcare supply chains, specifically around their relation to the growing trends in healthcare toward population-based financing models (2021).

Emmett and colleagues describe how the challenges of providing quality care mean some standard supply chain practices—like just-in-time ordering where the next needed bag of saline solution arrives just as the last one is empty—might not be the best choice in an industry where human lives are at stake if there is a breakdown or delay in the supply chain (Emmett, 2019).

Below is a more detailed discussion of two key issues that make healthcare supply chains unique: the use of group purchasing organizations (GPOs), and clinician engagement in purchasing decisions.

- **Group Purchasing Organizations (GPOs):** The first US group purchasing organization (GPO) was formed by a group of hospitals in New York City in 1910 to jointly purchase laundry services (Saha et al., 2019). Over the last century, the concept of group purchasing organizations has evolved, spread to other industries, and become nearly ubiquitous in the healthcare sector, with nearly all 7,000+ hospitals in the US utilizing a GPO in some capacity (Healthcare Supply Chain Association, 2021). GPOs play a key role in the healthcare supply chain both by simplifying the purchasing and contracting requirements of hospitals and by aggregating volume across hospitals to negotiate lower prices (Ahmadi et al., 2019; Bruhn et al., 2018). The literature contains numerous studies on the value, benefit, and realized cost-savings of GPOs, with studies modeling both significant reductions in prices because of GPOs and studies finding that GPOs actually increase prices (Bruhn et al., 2018; Burns, 2014). Outside of academic literature, there have been several congressional and GAO inquiries into this issue—largely focused around the 1987 Safe Haven Law that allowed healthcare purchasing organizations to be exempt from the 1972 Anti-Kickback Law. Critics of GPOs suggest that this Safe Haven

exemption actually increases prices, stifles innovation, and makes it harder for small businesses to compete, since GPOs can require manufacturers to pay a fee to be listed in the GPO's list of products (Bruhn et al., 2018). Supporters of GPOs suggest that the GPOs have addressed these problems by reducing the use of sole source agreements and implementing other measures that increase competition (Ahmadi et al., 2019; Burns, 2014).⁴

Some studies have found that the usefulness of GPOs changes based on the size of the healthcare system and/or the way in which the healthcare system utilizes the services of the GPO, including, for example, whether the system leverages custom-contracting to purchase outside the GPO's established contracts (Saha et al., 2019). Nollet and Beaulier (2013) explored the changing structures of GPOs, finding that these organizations have and will continue to change to meet the needs of their hospital stakeholders (Nollet & Beaulieu, 2003). Many GPOs have already built out stronger programs in data analytics, supplier diversity, and strategic supply chain management.

- **Clinician Input and Standardization through the Value Analysis Process:** One of the key components of strategic supply chain management is standardization or the idea of ensuring consistency across units, products, and processes as a way to both meet

⁴ Burns et al. (2014) and Bruhn et al. (2018) both summarize the literature regarding the efficiency of GPOs but come to very different conclusions. Burns and colleagues argue in a white paper and detailed literature review that there is overwhelming evidence that GPOs save money for healthcare systems, citing a long history of investigation into the issue. Bruhn and colleagues argue the opposite in a JAMA article, calling for a reversal of the safe haven law and a reform of GPOs; they refute the idea of overwhelming evidence by pointing out that there have been no independent studies that have found significant cost savings. As a side note, there's an interesting back and forth in the letters to the editor following the Bruhn et al JAMA article –between the head of the GPO Trade Association and the original article authors that illustrates the continuing gap in opinions regarding the effectiveness of GPOs in reducing prices. (Bruhn et al., 2019)

quality goals and reduce costs through achieving economies of scale. Despite the complexities of healthcare delivery (or maybe because of them), many healthcare systems have been moving to standardize healthcare delivery, often with a notable focus on the products used to provide services (Betcheva et al., 2021). Still, any changes in the supply chain must also be motivated and guided by the needs and requirements of clinicians and patients and ensure the provision of safe and quality care.

One strategy employed in healthcare supply chains has been the use of the value analysis process—a framework for making decisions that takes into consideration the various needs of healthcare stakeholders: patients, clinicians, payers, and administrators. Usually this is accomplished through the establishment of internal committees (usually nurses, other relevant clinicians, and supply chain professionals, rarely including patients or community representatives) that evaluate and create processes around the introductions of new products and innovations to optimize patient outcomes, promote safety, and yield clinical efficiencies (Donatelli, 2019).

An entire profession has grown up around the value analysis process, with the Association of Healthcare Value Analysis Professions offering certifications and continuing education opportunities to a growing group of nurses, clinicians, and procurement staff engaged in the value analysis process (Association of Healthcare Value Analysis Professionals, 2022). The maturity of value analysis programs within healthcare institutions varies significantly, with less mature programs focused solely on cost reduction and more mature programs also addressing standardization, waste reduction, and population management (Donatelli, 2019).

2.1.8 Healthcare supplier diversity best practices and examples

Just as applying strategic supply chain management principles in the healthcare sector is an emerging and growing field, so too is applying supplier diversity to healthcare purchasing practice. Only a handful of supplier-diversity focused papers, reports, and case studies have been published, all within the last 10 years. In the peer reviewed literature, there were only two articles that included a discussion of supplier diversity efforts in the health sector. Koh and colleagues included a purchasing section in their description of healthcare anchor institutions that included highlights from Kaiser Permanent, ProMedica, University Hospitals, and Parkland Health System (Koh et al., 2020). J.R. Clapp described the overarching diversity leadership efforts at Rush University Medical Center in Chicago, including their work to partner with Minority- and Women-Owned Businesses (Clapp, 2010).

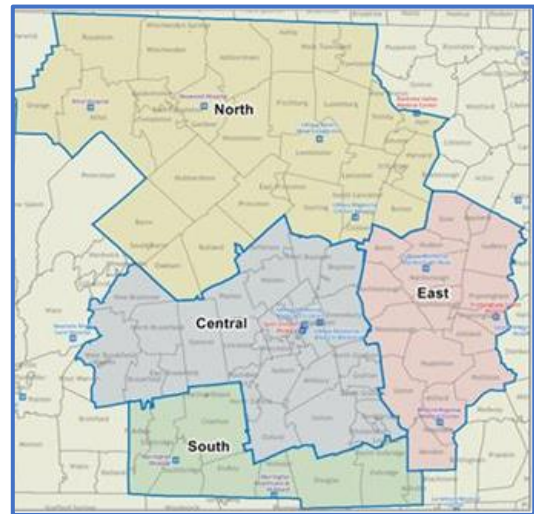
In the gray literature, three white papers/reports evaluated trends, provided case studies, and/or outlined best practices for supplier diversity among healthcare institutions. These include an American Hospital Association (AHA) published report with some case studies and action steps (Health Research & Educational Trust, 2015), a collaborative white paper organized by the GPO Premier that highlights a business and clinical case for supplier diversity with some case studies (Premier, 2020), and a toolkit from the Healthcare Anchor Network (HAN) that examines case studies, highlights strategies, and provides some tools for getting started (Zuckerman & Parker, 2016). These 2 peer reviewed articles and 3 reports have been incorporated as data sources into the qualitative analysis outlined in the methods section (see Table 2 for a more detailed summary of each article and report)

2.2 DrPH Project in Context

2.2.1 UMass Memorial Health

UMass Memorial Health (UMMH) is the largest health system in Central Massachusetts, with 4 hospitals on 9 campuses, a behavioral health provider, and more than 70 primary care clinics—staffed by more than 16,000 employees, all of whom are called “caregivers” no matter their role. The system sees itself as the “health and wellness partner of Central Massachusetts,” serving as the safety net provider for the region’s most vulnerable residents (See Figure 1 for a map of the UMMH service area).

Figure 1: UMMH Service Area



Additionally, the health system is the clinical partner for the state’s only public medical school, which gives the system access to leading health innovations, clinical trials, and research capacity and capability. The system holds a \$400 million dollar investment portfolio, purchases nearly \$1 billion in goods and services annually, and is the largest employer in central Massachusetts. UMMH leadership takes pride in utilizing the Lean Six Sigma process improvement methodology to drive change, along with a focus on making innovation and idea generation happen at all levels of the organization, from housekeeper to nurse to executive.

Building on a long history of impactful community benefits programming, the hospital system went through a rebranding process in 2020 to remove the word “care” from the system name (formerly UMass Memorial Health Care), reinforcing the commitment to address health both inside and outside of the clinic. In the fall of 2021, the board of trustees approved a long-term strategy to become a fully integrated health delivery system, which includes implementing a four-pronged strategy focused on “our patients, our peoples, our community, and our future” (see Figure 2). These four strategies include a key shift from previous years—the replacement of “our long-term financial health” with “our community.” See Appendix B for more detail on UMass Memorial Health’s Mission, Vision, and 2022 Strategic Priorities.

Figure 2: UMMH four long-term strategy goals



2.2.2 UMass Memorial Health’s Anchor Mission

In the fall of 2018, the UMass Memorial Health board of trustees approved the creation of an “Anchor Mission,” a conscious decision to apply the system’s economic and business assets to address upstream social determinants of health and structural inequalities in the diverse communities of Central Massachusetts.⁵ With this decision, UMMH joined the Healthcare Anchor Network (HAN), a learning community initially convened by the Democracy

⁵ The Harvard T.H. Chan School of Public Health Teaching Case Study entitled “Anchoring Health beyond Clinical Care: UMass Memorial Health Care’s Anchor Mission Project” (2019) describes the process undertaken to establish the Anchor Mission at UMMH. You can access the case here: https://alumni.sph.harvard.edu/s/1319/images/gid2/editor_documents/mhcm_alumni/ummhc_case_study.final_formatted.pdf?gid=2&pgid=61&sessionid=58c9bcc4-b2fc-4099-8b83-b02a6f712859&cc=1

Collaborative and composed now of more than 65 US health systems, each of which has made a commitment to serve as an engaged anchor institution in its local community.⁶

UMMH has earned a reputation as one of the systems that has moved the most quickly in institutionalizing an anchor mission. UMMH was one of the 13 initial signatories of the HAN place-based investing pledge,⁷ making a commitment to redirect 1% of the system's reserve pool of stocks and bonds to local investments designed to build community wealth and address social determinants of health. After three years of working toward this goal, the full \$4 million dollar commitment has been allocated to local projects, largely in support of affordable housing projects in neighborhoods with a history of underinvestment in the cities of Worcester, Fitchburg, and Southbridge.⁸ In 2020, UMMH acquired the Harrington Hospital, the first acquisition and merger in the nation that included specific anchor mission language and requirements; specifically, UMMH agreed to invest at least \$4 million dollars in the Harrington Hospital's service area over the next 10 years.

With participation open to any caregiver in the organization, the UMMH anchor mission steering committee sets the strategy for the system's overarching anchor mission. This committee, launched in 2018 with fewer than 20 individuals, now includes 100+ caregivers.

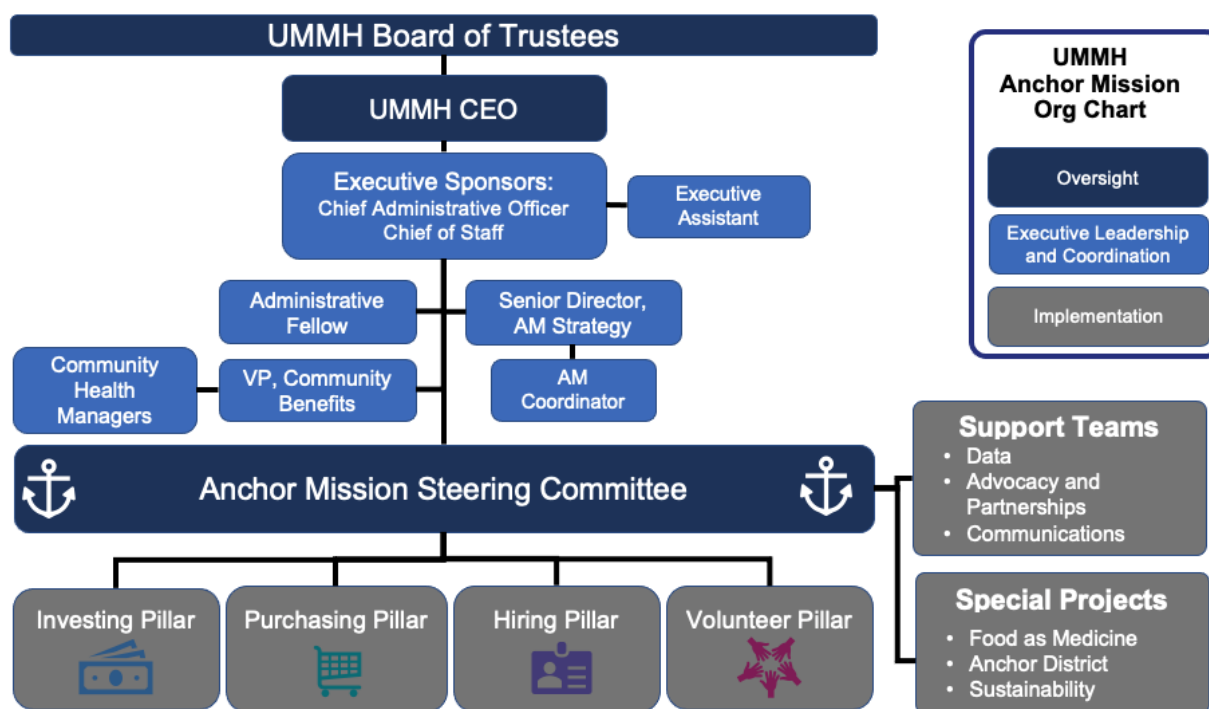
⁶ Now an independent 501(c)3, the Healthcare Anchor Network convenes healthcare systems to "share best practices for advancing an anchor mission approach within their health institutions, address common challenges, co-develop new tools, and identify areas where collaborative efforts may be possible." Read more here: <https://healthcareanchor.network/>.

⁷ The 17 signatories of the HAN Place-based Investing Pledge have committed to investing \$700 Million collectively to address racial, economic, and environmental disparities through place-based investments. Read more here: <https://healthcareanchor.network/2019/11/place-based-investment-commitment/>

⁸ UMass Memorial Health and the Healthcare Anchor Network collaborated to publish a case study of the UMMH community investment activities. Read more here: <https://healthcareanchor.network/2021/07/umass-memorial-health-care-community-investing-program/>.

Most of the implementation efforts happen in the four pillar sub-committees (investing, hiring, purchasing, and volunteering), along with other teams and workgroups formed for special projects and cross-cutting support. An implementation group composed of the pillar and committee chairs and coordination staff meets bimonthly (between the bimonthly steering committee meetings). See Figure 3 for the organizational structure of the UMMH anchor mission.

Figure 3: UMMH's Anchor Mission Organization Chart



In the last year, nearly all the pillars and committees have undergone some sort of re-launching to expand beyond the initial work that occurred in the early years of the anchor mission implementation. With the system's renewed focus on "our community," the anchor mission is slowly becoming more integrated into the language and culture at UMMH, although more work remains before UMMH's anchor mission becomes fully integrated into the way all caregivers approach their work, rather than a special project or initiative.

2.2.3 Healthcare Anchor Network's Impact Purchasing Commitment

Building on the success of the place-based investing pledge, UMMH became one of 12 signatories to join the HAN Impact Purchasing Commitment (IPC) announced in April of 2021. This commitment focused on increasing spending with minority and women-owned businesses, combating climate change by increasing sustainable spending, and building community wealth by creating pathways for doing business with more local vendors.⁹ In alignment with the HAN's guidance and definitions, UMMH made the following specific commitments (see Appendix C for the full HAN IPC):

- **Increase Diverse Spending:** UMMH will increase spending with minority and women-owned business enterprises (MWBs) from around \$4 million in FY2020 to more than \$14 million by FY2025. UMMH will also work with its vendors to include terms in future contracts that require vendors to increase their own spending with MWBs.
- **Promote Sustainable Spending:** By 2025, UMMH will ensure that 20% of food purchases are categorized as sustainable; that 50% of vehicle fleet purchases are alternative fuel vehicles; that the harmful chemicals PVC and DEHP will be eliminated from at least two types of medical products; and that at least 30% of annual furnishings and furniture purchases will eliminate the use of chemicals of concern (e.g., flame retardants).
- **Build Community Wealth:** UMMH will increase annual spending with businesses headquartered, owned, and operated within the system's service area by at least \$11

⁹ The HAN's Impact Purchasing Commitment was signed by the following initial signatories: Advocate Aurora Health, Baystate Health, Bon Secours Mercy Health, Cleveland Clinic, Common Spirit, Henry Ford Health System, Intermountain Healthcare, Kaiser Permanente, Providence, Rush, Spectrum, and UMass Memorial Health. More details about the HAN and their Impact Purchasing Commitment can be found here: <https://healthcareanchor.network/2021/06/impact-purchasing-commitment-ipc/>

million by FY2025, along with increasing spending with employee-owned, cooperatively owned, or non-profit business. UMMH will also work with vendors to provide dignified employment to community members through provision of a living wage and specific “impact hire” targets. In addition, UMMH will work to build capacity of diverse, local businesses through outreach and mentoring strategies.

- **Institutionalize and Incentivize:** UMMH will align these goals with policies, procedures, and data analytics. UMMH will enable a more resilient and equitable supply chain ecosystem by engaging with other key partners to advance these priorities within the diverse communities of Central Massachusetts.

2.2.4 Administrative fellow role

For my DrPH Summer Immersion in 2020, I spent two months as a doctoral fellow at UMMH under the mentorship of Doug Brown, Chief Administrative Officer and the President of Community Hospitals—and the executive sponsor of the UMass Memorial Anchor Mission. Reporting directly to the CEO, Brown oversees multiple system-level administrative departments including human resources, legal and compliance, philanthropy, and government/external relations, along with UMMH’s three community hospitals (Harrington, Marlborough, and Clinton Health Alliance) and Community Health Link, the system’s behavioral health provider.

Over the summer of 2020 and continuing part-time for the next year, I provided coordination and project management support to the UMMH Anchor Mission. In June 2021, I accepted a one-year appointment as an Administrative Fellow to continue to provide project

management, coordination, and communications support to the Anchor Mission as UMMH continues to build an Anchor Mission lens into the way that the health system does its work.

Much of this coordination has been in close partnership with Kate Behan, Senior Director for Clinical Affiliation and Anchor Mission Strategy, who committed 40% of her time to support Anchor Mission around the same time I started the Administrative Fellow position. With Kate leading the investment and volunteering pillars, my main responsibilities focus on making progress in the areas of purchasing, hiring, data/measurement, and the establishment of a “anchor district” to concentrate anchor mission and community benefit investments in a targeted set of neighborhoods, in addition to overall strategy and coordination of the Anchor Mission effort.

2.3 Grounding Frameworks

2.3.1 Bolman and Deal’s “Reframing organizations”

First published in 1984 and now in its 7th edition, Bolman and Deal’s book *Reframing Organizations: Artistry, Choice, and Leadership* provides an adaptable, simple, and useful approach to organizational behavior analyses (Bolman & Deal, 2021). Drawing on the large body of organization behavior, leadership, and behavioral economic scholarship, Bolman and Deal identify four frames—or perspectives for viewing a particular situation—that allow leaders to critically expand their thinking and approach to problems: the *structural frame*, the *human resource frame*, the *political frame*, and the *symbolic frame*. Figure 4 provides additional detail on each of the four frames.

Figure 4: Bolman and Deal's four frames for reframing organizations



Bolman and Deal suggest that these four frames can be applied to multiple different organizational processes—from strategic planning to reorganization to communication—and that the frames can be effectively applied to all types of organizations—from non-profits to government agencies to businesses. They posit that leaders benefit from “multi-frame thinking” when approaching a problem or strategy—the idea of not just using a single mental model or

perspective to understand a situation or challenge. Viewing an organization this way is needed because organizations are “complex, surprising, deceptive, and ambiguous.”¹⁰ Finally, their work focuses on the concept of “re-framing”, challenging the common approach to consider situations, problems, or decisions in the way they were originally framed.¹¹ However, the most effective solutions can often be found when intentionally approaching the problem from a different vantage point or frame.¹²

2.3.2 Lean Six Sigma

The Lean Six Sigma management approach combines the principles and tools of both Lean Management (a systematic approach to eliminate waste first developed by Toyota in Japan), and Six Sigma (a rigorous, data driven process to reduce variation and eradicate defects first developed by Motorola). This approach to process and outcome improvement has been readily adopted across the healthcare industry (Toussaint & Gerard, 2010), including at UMass Memorial Health. Lean Six Sigma focuses on five improvement steps (often collectively referred to as the acronym DMAIC): **define** the issue/problem, **measure** the process, **analyze** the data/find the root causes, **improve** the process, and **control** the processes (and sustain improvements). Many organizations, including UMass Memorial, utilize the A3 to help organize

¹⁰ Bolman and Deal draw from the writings of Peter Senge and others describing organizations as complex systems and setting up an organization as a “Learning Organization”. I recommend Senge’s book *The Fifth Discipline: The Art & Practice of The Learning Organization* for some additional tools on addressing and learning in complex organizations.

¹¹ Bolman and Deal rely heavily on the writings of the behavioral economists Daniel Kahneman and Amos Tversky as the basis for the concept of framing. I recommend Kahneman’s book *Thinking, Fast and Slow*, whose many (electronic) pages provided interesting content on many of my pandemic walks.

¹² This concept aligns well with the concepts from Ron Heifetz on *Adaptive Leadership*, a key text for the Harvard DrPH program. Heifetz uses a concept of “going to the balcony” to get a different viewpoint on the situation that might not be visible while “on the dance floor” in the midst of the situation.

the DMAIC process—an A3-sized piece of paper that holds all the critical information for the process improvement project. See Figure 5 for a template of UMMH’s problem solving A3.

While Lean Six Sigma, with its focus on process and structural improvements, largely falls within the strategic frame, the process of getting to these improvements requires looking at the organization through the

Figure 5: UMMH’s Lean Problem Solving A3 Template

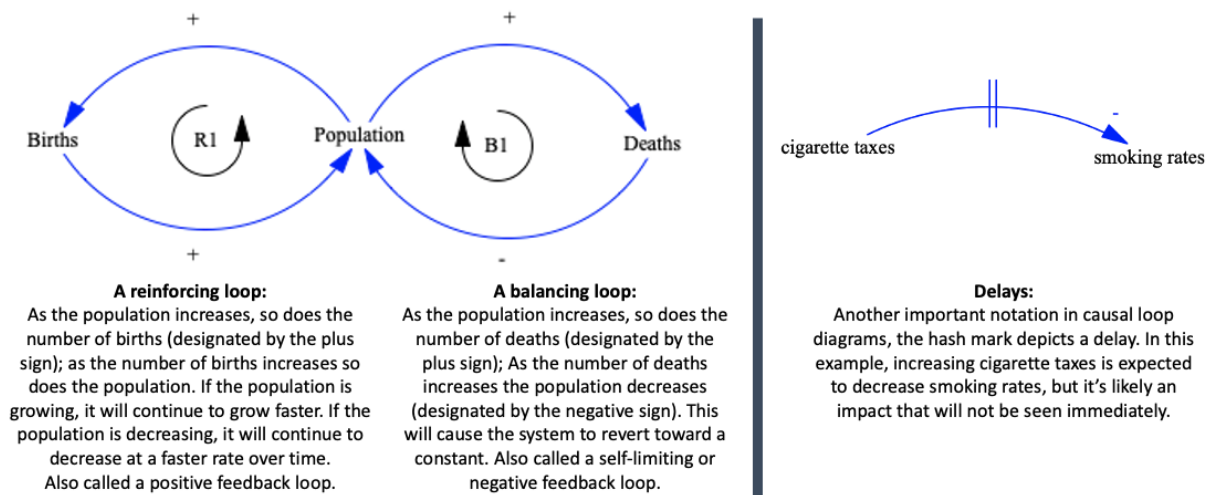
Problem Solving A3		Title:	Date:
Team Members:			
<u>Problem Statement (Define Opportunity):</u>		<u>Countermeasures:</u>	
<u>Scope (In/Out):</u>		<u>Improvement Implementation:</u>	
<u>Current Conditions (Map & Measure):</u>			
<u>SMART Goal:</u>		<u>Results/Conclusion:</u>	
<u>Root Cause Analysis:</u>		<u>Control / Sustain:</u>	

other three frames as well. One key first step for identifying and understanding the root cause of a problem is asking the ‘Five Whys’—consecutively asking the question “why is this happening?” to get to a deeper—and actionable—root cause. The Lean Six Sigma process encourages “going to the Gemba” or observing the process where it’s occurring and listening to people at the frontlines—a process that allows a leader to better understand the root cause (and “reframe” the problem”). Finally, Lean Six Sigma recommends having a “True North,” clear and simple measurements that allow everyone to see priorities and progress (Toussaint & Gerard, 2010). While this thesis will primarily rely on the Bolman and Deal “Reframing Organizations” framework, some of the final analyses and recommendations draw from the Lean Six Sigma management approach.

2.3.3 Systems dynamics and causal loop diagrams

Applied to issues from manufacturing to understanding the spread of pathogens to environmental challenges to manufacturing process improvements, systems dynamics represents a growing field of tools and approaches to understand constantly changing, complex systems. One tool for understanding how the pieces of a complex system relate to one another is the causal loop diagram. Causal loop diagrams uncover and represent feedback processes within a system, determining how things change over time (Sterman, 2009). Figure 6 highlights a simple causal loop diagram containing both a reinforcing or positive feedback loop, and a balancing, self-correcting loop.

Figure 6: Causal loop diagram and notation examples



Causal loop diagrams are helpful tools for both capturing and communicating hypotheses about the causes of change in a system and the feedback loops that making solving the problem challenging. They also can be used to form the basis of recommendation for ways to change the system in desirable ways: the trick is to interrupt those loops working against a goal and to strengthen those loops supporting the goal (Sterman, 2009). As above, while most

of this project's analysis relies on the four frames, the final conclusions draw from the creation of some causal loop diagrams for diverse and local purchasing in healthcare.

3. Approach and Methods

3.1 Purpose and Research Questions

Most guidance and tools for organizations building a supplier diversity program are simply lists of recommended actions or best practices. However, these do not provide a comprehensive or sufficient picture of the complexity of and resistance to establishing and expanding supplier diversity and local purchasing efforts within healthcare organizations. Particularly missing from these lists are challenges and organizational barriers that can slow progress in supplier diversity and local purchasing. With this context, this thesis attempts to answer the following questions:

- 1) What are the challenges and complexities of establishing and expanding local and diverse purchasing programs within the healthcare sector?
- 2) What best practices and strategies to mitigate those challenges have been adopted to build and sustain local and diverse purchasing programs in the healthcare sector?
- 3) How have organizational and leadership dynamics—and the broader community and economic context—at UMass Memorial Health affected the implementation of an anchor mission purchasing initiative?
- 4) Acknowledging the complexities, what are some “multi-frame” approaches that could be adopted to increase the impact and success of anchor mission purchasing endeavors at UMass Memorial Health and other healthcare systems?

3.2 Approach

Since the goal of this project is to understand the complexities of implementing impact purchasing in healthcare organizations, I selected a qualitative methodology for the project. Used often in applied research, qualitative methods focus on understanding and synthesizing meaning in the context of people's experience, rather than counting or describing the facts about something (Merriam & Tisdell, 2015).

To address the research questions, I utilized two related, but separate, study components. With a focus on understanding the broader considerations for impact purchasing (not specific to UMass Memorial Health), the first study component analyzed the insights from individuals engaged in local and diverse purchasing efforts in healthcare organizations. This analysis draws from semi-structured interviews with 22 experts and 5 published reports and articles. The second study component analyzed the ecosystem of UMass Memorial Health, synthesizing learnings from informal conversation with colleagues and my observations.

This project was conducted primarily in the 13-month period from July 2021 through July 2022 while I worked full-time at UMass Memorial Health, although some observations and learnings were acquired in the 12 months prior while I worked for a few hours a week coordinating the UMass Memorial Health anchor mission initiative. Study component 1 (qualitative analysis of expert interviews and published guidance) was approved as exempt human subjects research by both the Harvard Longwood Institutional Review Board (IRB) and the UMass Chan School of Medicine IRB (the IRB of record for UMass Memorial Health). IRB officials agreed that study component 2 did not need IRB approvals since it was not seeking to create generalizable information beyond UMass Memorial (see Appendix D).

3.2.1 Method 1: Qualitative analysis of expert interviews and published guidance

As the primary method for addressing research questions 1 and 2, I conducted a systematic analysis of the observations and insights of experts working on impact purchasing efforts in healthcare, utilizing insights published in best practice documents/case studies as well as semi-structured key informant interviews.

To consolidate the information and guidance for impact purchasing that exists in published literature (both academic and gray), I extracted the language from 5 publications that focused on impact purchasing endeavors in healthcare settings. These publications were identified using the ABI/ProQuest and Health Business FullText Elite Databases for peer-reviewed literature, and Google for gray literature. Table 2 summarizes the articles and reports included in the analysis.

Table 2: Published articles and reports examining supplier diversity initiatives in healthcare

Title and Citation	Summary	Publication Type
Anchor Institutions: Best Practices to Address Social Needs and Social Determinants of Health (Koh et al., 2020)	This article highlights the history of healthcare anchor institutions and examines common anchor strategies including impact purchasing. Specific to purchasing, the article highlights case studies from 4 health systems (Kaiser Permanente, ProMedica, University Hospitals, and Parkland Health and Hospital System)	Peer-reviewed article in <i>AJPH</i>
Diversity Leadership: The Rush University medical Center Experience (Clapp, 2010)	A case study examining the leadership for building a culture of equity and inclusion at Rush University Medical Center, focused on the Rush's diversity leadership group model. There are a few mentions of Rush's supplier diversity program in the article.	Peer-reviewed article in <i>Health Topics</i>
Increasing Supplier Diversity in Healthcare (Health Research & Educational Trust, 2015)	This report outlines 8 action steps for supplier diversity in healthcare and highlights case studies from 5 health systems (Christus Health, Grady Health System, Greenville Health System, St. Francis Care, and University of Chicago Medicine)	AHA publication, developed in partnership with HRET, Equity of Care, and the AHRMM.

Table 3 (Continued)

Innovative Strategies in Healthcare: Amplifying the Business Case for Supplier Diversity (Premier, 2020)	This report examines the how forces in healthcare are shaping the context for supplier diversity (e.g., COVID-19, emergency of telehealth, and new value-based purchasing strategies). The report includes case studies of specific vendor relationships between MWBE vendors and Premier member health systems.	Industry report authored by the group purchasing organization Premier.
Inclusive Local Sourcing Toolkit: Purchasing for People and Place (Zuckerman & Parker, 2016)	A 122-page report exploring the business case for supplier diversity in healthcare, case studies from 5 systems (University Hospitals, MD Anderson Cancer Center, Parkland Health and Hospital System, Charleston Medical Center, and The Chicago Anchors for a Strong Economy), critical strategies (highlighting several small examples from healthcare institutions), and some tools for data and planning.	Toolkit from the Healthcare Anchor Network/Democracy Collaborative, one of 4 in the hospitals Aligned for Healthy Communities series

To gain input directly from experts, I conducted interviews with 20 individuals from 16 institutions or organizations working on some aspect of impact purchasing in the healthcare sector, either directly for a hospital system or in a supporting role to hospital systems. Participants were identified as a purposive sample based on recommendations from the Healthcare Anchor Network (HAN) and the supply chain office at UMass Memorial Health; a few participants were identified through snowball sampling. Table 3 summarizes the roles and organizations represented in these interviews.

To guide the discussion in the semi-structured interviews, I developed an interview guide that covered the following topics: successes and effective initiatives, challenges and roadblocks, mitigations strategies, and the “why” at the institution for doing this work (See Appendix E for the full interview guide). All interviews were conducted via Zoom and lasted 45-60 minutes. At the start of each interview, I referenced the consent form that was shared via email prior to the interview and obtained verbal consent, both for participation in and recording of the interview (See Appendix F for the consent form).

Table 4: List of expert interviewees with organization and role

Name	Organization	Role	Type of Organization
Todd Bailey	Baystate Health	Purchasing and Contract Manager	Hospital System-IPC Signatory
Frank Robinson	Baystate Health	VP for Public Health	Hospital System-IPC Signatory
Berlon Hamilton	Cleveland Clinic	Director of Supplier Diversity	Hospital System-IPC Signatory
David Zuckerman	Healthcare Anchor Network	President and Founder	Supporting Organization
Claire Brawdy	Healthcare Anchor Network	Project Manager, Initiatives and Advisory Services	Supporting Organization
Shane Hughes	Intermountain Healthcare	Supplier and Community Relations Director	Hospital System-IPC Signatory
Elizabeth Eldridge	Kaiser Permanente	Director of Sustainable Sourcing	Hospital System-IPC Signatory
Andaye Hill-Espinosa	Kaiser Permanente	Lead Project Manager, Economic Impact and Impact Spending	Hospital System-IPC Signatory
Deborah Williams	Premier	Director, Supplier Diversity and Sustainability	Group Purchasing Organization
Sruthi Parech	Rush	Project Manager, Anchor Mission	Hospital System-IPC Signatory
John Andrews	Rush	Strategic Sourcing Manager/Business Diversity Manager	Hospital System-IPC Signatory
Diane Candeledo	RWJBarnabus Health	Director, Social Impact and Community Investment	Hospital System—HAN Member
Sarah Cartier	Spectrum Health	Senior Sustainability Project Manager	Hospital system—HAN Member
Ade Solaru	Supplier Gateway	Chief Executive Officer	Supporting Organization
Dameka Miller	Trinity Health	Vice President of Strategic Source and Value Analysis	Hospital system—HAN Member
Osvaldo Torres	UChicago Medicine	Director, Non-clinical Strategic Sourcing	Hospital System
James Williams	UChicago Medicine	Executive Director, Office of Diversity, Equity, and Inclusion	Hospital System
Ed Bonetti	UMass Memorial Health	Vice President for Supply Chain	Hospital System-IPC Signatory
Gary Tuggle	University of Maryland Medical System	Director of Diversity and Inclusion, Enterprise Supply Chain	Hospital system—HAN Member
Shaleta Dunn Vick	Vizient, Inc.	AVP, Member Diversity and Community Initiatives	Group Purchasing Organization
Carolyn Salsgiver	Yale New Haven Health System	VP for Community Health Equity	Hospital system—HAN Member

After transcription (conducted for half of the interviews with a third-party transcription service and for the other half by correcting the automated zoom transcript), I coded the interview transcripts and published guidance to align insights and comments to Bolman and Deal four frames, utilizing the Dovetail analytic online app.¹³ Within each frame, I then conducted an inductive analysis to identify themes related to my research questions.

3.2.2 Method 2: Ecosystem analysis at UMass Memorial Health

As the primary method for addressing research question 3 (How have organizational and leadership dynamics—and the broader community and economic context—at UMass Memorial Health affected the implementation of an anchor mission purchasing initiative?), I conducted an ecosystem analysis of the unique context at UMass Memorial Health. The multi-stakeholder ecosystem analysis has been increasingly used to understand the complex context for leadership change initiatives and innovation uptake (Pera et al., 2016; Schiavone et al., 2021). I relied primarily on two main sources of qualitative data for conducting this analysis: my observations from my immersive fellowship at UMass Memorial and confidential, informal interviews with 13 individuals in a range of roles at UMass Memorial Health.

Grounded in the field of ethnography, participant observation is one of the fundamental qualitative research methodologies. For this project, I occupied the role of “Participant as Observer,” since my research observations were subordinate to my participation as a project manager for UMass Memorial’s anchor mission purchasing effort (Merriam & Tisdell, 2015). My

¹³ Dovetail is a new analytic program (<https://dovetailapp.com/>) developed primarily for conducting qualitative customer research and translating that research into action. This online app is easy-to-use, particularly for coding and synthesizing individual interview data. I learned about it from a friend and colleague who had examined multiple qualitative analysis programs and recommended Dovetail for another project I worked on during the DrPH program.

observations covered multiple conversations, working group meetings, leadership meetings and updates, meetings among vendors, supply chain staff and purchasing managers, and conferences and webinars. My participation ranged from running the meeting to listening and learning. To document my observations, I took handwritten notes and journaled about my observations and experiences.

In addition to observations, I conducted confidential, unrecorded, one-on-one meetings with a range of individuals from across the UMass Memorial Health system specifically targeted to get their inputs and insights for this thesis. These colleagues included C-suite and VP-level leaders, supply chain team members, mid-level operations staff from both the medical center and community hospitals, and all three co-chairs of the anchor mission purchasing subcommittee. To frame these discussions, I asked the following open-ended questions:

- What do you think about UMass Memorial Health's progress on Impact Purchasing?
- What are some of the barriers/roadblocks that have stopped or slowed progress?
(Probe further on these: structures/policies/processes? Incentives and staff engagement? Power and interpersonal dynamics? Culture or inclusion?)
- What solutions or countermeasures are needed?

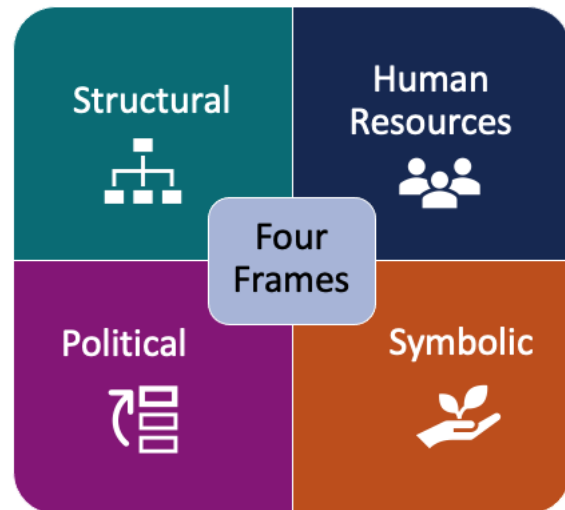
To conduct the analysis, I reviewed my notes and journal entries (both from my observation and the informal interviews) and entered key insights into the qualitative software Dovetail. I then coded these insights according to the Bolman and Deal "Reframing Organizations" framework to identify and analyze themes within each frame.

4. Analysis

This section provides an overview of the qualitative findings from this project, drawn primarily from expert interviews, but

augmented by published sources and informal interviews and a few examples from UMass Memorial Health. Within each section, the results are synthesized and structured around the Bolman and Deal four frames – structural, human resources, political, and symbolic (See Figure 7).

Figure 7: The Bolman and Deal four frames



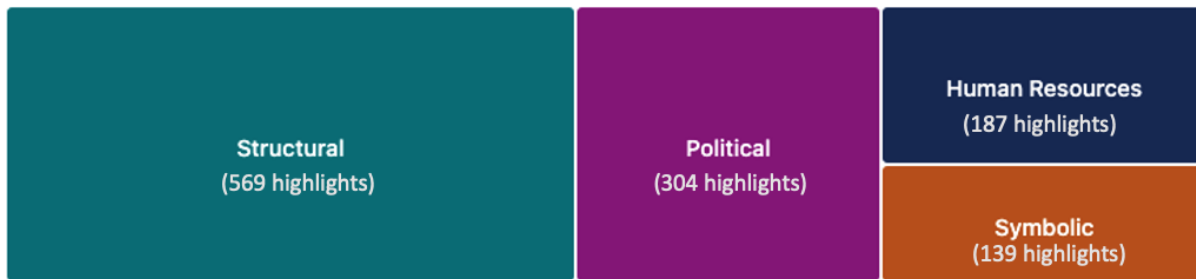
4.1 Complexities, Challenges, and Considerations

This section of results examines the range of complexities, considerations, challenges, tensions, and roadblocks related to the establishment and expansion of supplier diversity and local purchasing within healthcare institutions, drawing from expert interviews and published guidance. One participant summed up this complex system:

Supplier diversity, it's a complex—I don't want to call it an industry—it's a complex program. There's a lot of moving parts to it. There are a lot of challenges to it, there's a lot of opportunity for success. And supply chain is just one portion of it.

Of the nearly 1,200 coded text segments from across all participants and published guidance, a majority were related to the structural frame (see Figure 8 for a summary of the counts of each coded text segment by frame). These counts include summaries of challenges—which are presented in this section—as well as approaches and promising practices to overcome those challenges (presented in section 4.2).

Figure 8: Summary counts of highlighted text segments by frame



While most practitioners begin a reframing analysis from the structural frame, this analysis begins with the political frame since the topics covered under many of the issues raised in the other frames. Box 2 summarizes the key takeaways from this set of results.

Box 2: Summary of results on complexities, challenges, and considerations

Political Frame:  • Competing priorities (e.g., reducing costs, maintaining quality of care, decreasing vendor relationships to simplify the supply chain) can slow progress. • Other considerations—like a push for more resilient supply chains and the growing focus on diversity, equity, and inclusion—might help accelerate efforts. • The business case for local, diverse purchasing looks different in healthcare than other sectors, and the case is shifting with increase in value-based payment models. • Everyone agrees CEO and C-suite leadership buy-in is important—but buy-in must extend beyond words to include adequate resourcing and roadblock reduction. • Local, diverse purchasing is more of an exercise in negotiation and stakeholder organizing than anything else, with hundreds of potential relationships and partners. ○ Internally — purchasing decision makers extend beyond the supply chain office through all departments and entities. ○ Externally — stakeholders range from government agencies to coalitions to entrepreneurial support organizations to individual vendors. ○ Thoughtfully navigating all these relationships takes tenacity, effort, and political savvy.
Structural Frame  • Rapidly changing regulatory and clinical quality requirements can create barriers for new local/diverse vendors to enter the market.

Box 2 (Continued)

- Group Purchasing Organization (GPO) policies and practices tend to inhibit opportunities for small, diverse, and/or local vendors.
 - GPOs are increasing contracts with minority owned vendors—but usually only those with a national/regional scale. And some GPOs are better at this than others.
- Identifying MWBEs and local vendors requires significant staff time since available lists aren't comprehensive.
- Diverse/local businesses can often lack capital and scale to buy and sell at a competitive price, and may have limited experience with doing business with hospitals.
- Analyzing the hospital's baseline spend with diverse and local vendors is usually the first step, but it's fraught with challenges that can lead to fatigue.
- Setting goals for impact purchasing initiatives involves trade-offs. E.g., short vs. long timeframes; how to prioritize among local, green, and diverse purchasing; and what spend categories and types of projects to focus on.

Human Resources Frame



- People in healthcare are busy. Supply chain teams and purchasing decision makers don't have time to look for a small diverse or local vendor or provide that vendor with extra support if it's outside the normal scope of work.
- Whether or not something is written into a job description or compensation plan can determine whether it gets done—and this matters at both the staff and the leadership level.
- Intrinsic motivation often powers efforts on local and diverse purchasing but isn't always strong enough to stand against conflicting priorities and emergencies.
- Staff engaged—especially a designated resource—need a range of skills, from negotiation to communication to project management to cultural competency.
- Educating and orienting hospital staff requires constant attention.

Symbolic Frame



- Big cultural shifts in our society impact receptivity of local and diverse purchasing (e.g., antiracism, the workforce crisis, and the COVID-19 pandemic)
- Implicit racial bias and ungrounded perceptions about the quality of minority vendors creates roadblocks to doing more business with minority-owned businesses.
- Hardwiring supplier diversity and local purchasing takes intention because it's new and ambiguous

Skip ahead to the next summary:

[Box 3: Summary of results on common approaches and promising practices](#)

4.1.1 Complexities in the political frame



While participants very infrequently used the words “power” or “politics,” most participants identified at least a few complexities and tensions related to the political frame (e.g., influence and negotiations, driving change, and prioritization). The themes identified from participant interviews that related to political complexities and challenges fell into four overarching themes: a) the battle of priorities, b) a business case for impact purchasing, c) leadership buy-in and resourcing, and d) negotiations and alignment externally.

[The battle of priorities](#)

Nearly all participants talked about how competing priorities complicate the process of meeting impact purchasing goals. One participant summarized this theme succinctly: “I think the biggest roadblocks and challenges are conflicting priorities.” One participant noted:

I think we have leadership support for the initiative, I think we have a great level of enthusiasm and a great understanding. People are connected to it very quickly, and they want to do the right thing. But I think that we're all constrained with resources. And I think that's one of our big challenges right now.

Participants identified the following as some of the key competing priorities at play for leaders across the system when making purchasing decisions or setting policies and processes:

- **Cost:** Participants consistently noted that supply chain and purchasing decisions are most often driven by cost, particularly given thin profit margins and a general push to lower the cost of care. Supply chain and purchasing decisions are looked to as one of the primary ways of reducing the cost of care delivery. One participant noted: “And so supply chain is really focused on lowering the cost of care, that's their primary initiative and driver and value to the organization.”

- **Reducing variability and ensuring quality:** And while costs are the primary driver for purchasing decisions, participants also noted another key component of the “value delivered” by vendors—the ability to reduce variability and ensure quality in healthcare delivery. One supply chain leader explained:

And what I mean by that, the focus on supply chain, is to support standardization of equipment and products used in a clinical setting. We want to eliminate variability so that we can start to make a relationship or correlation between products used and purchased. Are they delivering the appropriate clinical care and operational efficiencies for the organization?

- **Aggregating purchasing volume and decreasing overall vendor counts:** One avenue to reducing variability is consolidating spend into a fewer number of vendors. The goal of reducing the number of vendors also helps contain costs—not just by getting cost savings through a larger purchase volume—but also by saving money and time in the management of individual contractual relationships. One supply chain director sums up how aggregating purchasing to fewer vendors conflicts with supplier diversity goals:

Historically, supply chain has been working to reduce the number of vendors that are playing in the space so that we can look to aggregate purchasing volumes to reduce cost, while at the same time looking to make correlations between the use of a product and operational efficiencies or clinical outcomes. And we've demonstrated that as we reduce the number of vendors, it's easier to start to make some of those connections and start to make decisions that are having financial, operational, and clinical outcome improvements. That's totally in conflict to an Anchor Mission strategy, because now we're looking to identify diverse or local vendors to purposely introduce into our purchasing process.

- **Risk tolerance:** Another priority that drives purchasing decision-making is the concept of aversion to risk that is ubiquitous across the healthcare sector, making it a challenge to innovate and try out creative options in the supplier diversity space. A participant from one stakeholder organization noted, “But it's really hard because many of these sectors

that will be coming together to make these things happen are really risk-adverse. The government, foundations, healthcare, universities.”

In addition to the above competing priorities, participants noted two emerging healthcare priorities that might help support local and diverse purchasing initiatives:

- **Supply chain resiliency:** Several participants noted how an increasing focus on resiliency, largely resulting from the supply chain disruptions experienced during the COVID pandemic, might help prioritize local and smaller vendors in purchasing decision-making. For example, two participants shared these reflections:

With COVID and all the PPE, we've come to understand that it's not always great to focus 100% on price versus resiliency during difficult times, right?

I was shocked that supply chain came and was like, you know, "Do you have any local vendors that can provide PPE. . . . we just can't find them?" So, that heightened my pitch: Hey, we need to localize our supply chain so that we're not at risk for these supply chain disruptions.

- **Diversity, Equity, and Inclusion (DEI):** Participants noted the increasing focus in healthcare on DEI as an opportunity for the promotion of supplier diversity and local purchasing efforts: “Every organization is recognizing the importance of having different voices and different perspectives in terms of innovation, development, and growth.” Some participants questioned whether these shifts will be strong enough to justify shifting the preeminence of cost in purchasing decisions (particularly given the workforce crisis stressing budgets of most hospitals across the country as well as continuing supply chain shortages prompted by the COVID-19 pandemic).

Complex business case for diverse and local purchasing

Multiple participants described how building a business case for supplier diversity and local purchasing efforts can help ensure that these concepts are prioritized in decision-making.

However, developing that case isn't straightforward or simple. One participant noted:

Years of work have gone into developing a business case for the work, not necessarily just supplier diversity, but diversity, equity, and inclusion initiatives.

Participants also discussed the complexities of multiple components of a business case, with most participants stressing the business case components beyond financial savings. Here are two participants' comments:

The business imperative is that not only does it impact the bottom line in a positive way, but it also creates opportunity to address the members of your community and your clients to address you know, the issues and the challenges that your employees may be facing, to address how you show up in your community.

At this point, the financial business case is not the driver. It's the understanding the social determinants of health, the health equity components, and the recognition of the larger impact. . . when you're leading with the financial, I truly think you're going to fail, it's not going to resonate in the same way because we need to think about this work differently.

Participants noted the lack of available and clear data that describes the long-term benefits of supplier diversity investments that could rigorously be used to justify an increased cost or move from a more traditional vendor. One participant said: "So in some ways you could make the argument, 'Hey, the extra 7% [increase in cost] is going to do even more work and have a greater impact.' Yeah, then the CFO will be like, 'Nice try, but yeah, No.'"

Some participants talked about some other factors that go into the consideration of a business case for this work, including:

- **Supporting Tax Exempt Status of Non-profit hospitals:** With a potential future need to continue to justify the tax-exempt status of hospitals, one argument supporting local and diverse purchasing initiatives is a more tangible way to show that the hospital system is contributing to the economics of the area by supporting local business that pay taxes, even without paying taxes directly.
- **Grant and Supplemental Funding:** Much in the same way that supplier diversity efforts evolved in government-run health systems out of a need for compliance, participants noted that there are increasing pressure from foundations and government funders for hospitals to report and set targets for supplier diversity. Having a system in place can help when competing for this type of funding.
- **Payor vs provider:** Some participants acknowledged that the business case for local and diverse procurement becomes more tangible when a hospital system plays the role of a payor since the effects of economic development in communities can be more directly tied to the system's bottom line.
- **Changing Demographics and Opportunities for Future Business:** Several participants noted the growth in diverse businesses in recent years and the likelihood for that growth to continue into the future. Having relationships with diverse businesses can be important when a hospital system is competing for market share. One participant said:

When you look at women-owned businesses, minority-owned businesses, that's the biggest growing segment of the new business creation space. So that's who we're going to be working with, we need to get ahead of it.
- **Jobs Created and more insured patients:** Many participants focused their discussions of a business case (or how we can measure impact) on the creation of jobs. One

participant directly linked the idea of job creation to a different payer mix in the hospital, albeit on a small scale:

[The owner of an MBE owner that our hospital works with] told us about how she's hiring people from the community who didn't have a job. She also said that because of the business that she's had with our system, she's able to give those employees healthcare coverage.

- **An acknowledgement past and current harms:** At least two participants described how their organization's commitment to impact purchasing was a way to reverse the "health system's participation in institutional and systemic racism and how we've left out the communities we're supposed to be supporting and helping." Another talked about how some visible changes can make a difference, for example, this change in the sustainability area:

We're trying to electrify a few of our buses because they're going up and down Main Street all day long throwing out diesel particulates into the air. It's just not good, here we are a health system. But we're doing the opposite of our mission, we are really causing harm.

- **Community Reputation:** Linked to the above concepts, some participants noted the importance of supplier diversity efforts to marketing efforts and reputation in the community. One participant noted: "People do business with the people that they know." Highlighted in the HAN toolkit, one health system spelled this out more clearly:

An important outcome of local, diverse spending initiatives is that they can elevate the profile of the hospital in the community. As the hospital increases its footprint in terms of local spending, it also increases the number of residents who come into contact with the hospital. "When those people get ill, they are going to remember 'I received that contract. . . this is where I want to get my healthcare.'

- **Alignment with other organizational goals:** Some individuals noted the linkage between local and diverse purchasing and multiple other goals—like more resilient supply chains,

innovation, stronger data analytics, and progress toward broader equity and inclusion efforts.

Leadership buy-in, resourcing and internal negotiations

Participants also discussed the issues surrounding leadership support—at both the most senior levels and in the middle where day-to-day decisions are made—and the factors that go into building that kind of support. The key themes included the following:

- **Complexities of real leadership buy-in:** Mirroring all the published best-practices on supplier diversity, all participants talked about the importance of leadership buy-in and support to building successful supplier diversity. But leadership buy-in can look like lots of different things. Participants noted that to be impactful, senior leaders must not only say that supplier diversity and local purchasing are important but must link it into the organizational strategy and mission. One participant said:

If you can't tie the work to the end game that the organization is looking for, then it becomes a definite challenge. And people see it as a nice-to-have, or a fly-by-night initiative. . . . The fact that the goals we set every year get approved at the highest CEO level really makes the diversity impact work a key component of our entire company strategy. So that's been really critical.

In alignment with other comments about the importance of CEOs and leadership teams getting regular updates, tracking progress, and seeing the data, one participant highlighted the important role that leadership buy-in can play in driving progress:

You get consultants and read the articles; they always say the same thing: "You have to have top down." . . . Top-down would be: "I want to know what's happening and I want to know where you're stuck. And then the board [of trustees] saying, "Why are you stuck? Why are we not making progress? How can I help you? Do we need to rethink the strategy?"

Several participants talked about the importance of communication in signaling real leadership support for these initiatives:

It's really driven by the mission, so you have to have leadership talking about it when they are addressing internal or external [audiences], this has to always be a topic of discussion or conversation.

My legacy now, I feel, is that we have an organizational commitment that is on our external facing website; because without that, it becomes a nice to do for staff, for sourcing teams, and for our stakeholders internally.

Other participants talked about the importance of where supplier diversity and local purchasing stack up against all the other issues and strategies at play when leading a health system. Here are two representative quotes on this topic:

If it's important, then you will signal that it's important in the same way that you signal everything else is important. And I think the programs that have been most successful. . . their corporate social responsibility activity is on par with everything else. It's on par with the quality of negotiations, it's on par with cost savings, it's on par with quality, it's on par with everything else.

What does that mean coming from the top-down? Does it just mean that the CEO says, "Yes, we support this," or does it mean that the CEO specifically makes everyone accountable for it?

Participants also discussed the importance of mid-level and senior management outside the C-Suite getting involved in this agenda-setting work. One participant described how this effort took off because of a “leading from the middle strategy” that involved getting buy-in from peer VPs and Senior Directors before bringing the initiative to the CEO and senior leadership team. Another participant summarized a concept shared by others—CEO buy-in isn’t sufficient by itself, and mid-level leaders are vital for building success:

Although the leadership, the CEO, talks about it, he or she will not be the one that actually drives the day-to-day compliance for the work. I think it's very important that you get buy-in from your executives throughout the organization.

- **Different avenues to building leadership support:** Participants reported a range of ways that their organizations have built leadership buy-in (read more in the promising approaches section). While most participants were proud of their leadership buy-in, two participants from separate health systems admitted that supplier diversity had not always been a priority for leadership, with one noting: “We've had the program for about six, seven years now. But it's never had the full support of leadership.” Both participants alluded to this being because the person in charge lacked the political leverage to drive the message to senior leadership.
- **Resources and budget:** Many participants talked about the importance of the linkage between real leadership buy-in and resources. As one example of this sentiment, one participant noted: “So the philosophical tone is one thing, but then the commitment – and when I say commitment, things like budget, right – you need a budget to run programs like this.” But many participants also noted that increasing resources for this work will be a tough sell in the current environment of severe workforce shortages and budget shortfalls.

The most commonly described resource constraint was staffing and the importance of having people with bandwidth to make real progress. Here are quotes from three participants:

When you start hiring somebody at \$72,000 a year, you start putting line items in the budget, that really speaks to the truth of what's going on and how it's being supported. Otherwise, at the end of the day, what you're asking for is really [that] people either just take this on because they have a passion about it,

or it's sort of a bolt onto their job. But that ultimately won't get you anywhere because those folks have all the other things they have to do and it's not their primary function.

I'll just put emphasis on being correctly resourced around it. One person can't do it if you have a big goal. It was great when we were just tracking and didn't have any action, but once we want to have action, an organization needs to invest in the right people to get it done.

You need dedicated resources or at least it needs to be integrated into the standard work of the team that's responsible for doing it. And setting targets, setting goals, and striving to meet them and being transparent about where you are in relationship to them.

Another resource needed was a budget for supplier diversity programming—from data analytics to memberships in coordinating organizations to consultants charged with identifying local vendors to support for capacity development programming.

A final type of resource discussed by several participants was the concept of being willing to pay more when purchasing from local and/or diverse vendors. While there were a few examples of an individual budget owner making a general concession for spending a little more in a particular category of spend, none of the systems represented by participants had determined an acceptable threshold for paying more to do business with a local or diverse vendor.

- **Driving change through internal negotiations:** Multiple participants talked about the importance of driving change and negotiating within the organization. One participant talked about how her experience as a community organizer had really set her up for her role leading impact purchasing within a health system: “it's kind of like organizing internally within the organization.” Another supplier diversity lead talked about building momentum: “to drive and move the needle, I really have to work with each functional

leader and personalize the message.” And that personalization can take significant time and energy.

Some participants talked about the need to be proactive when dealing with category owners—individuals who oversee the budget and purchasing decisions of a particular department or functional area—and other internal stakeholders because of all the other priorities that they are focused on (See HR section for discussion of staff bandwidth).

One participant recounted some advice from a mentor in supplier diversity:

This stuff is not going to fall in your lap. You're going to have to go in and you're going to have to be a little pesky about this, and you're going to have to let yourself into conversations, and you're going to have to go back to people. And it may take five, or six, or seven times to have conversations, and you're going to have to leverage your senior leadership the best you can.

[External negotiations and leveraging partnerships](#)

Given the significant number and breadth of stakeholders related to local and diverse purchasing in healthcare, many participants discussed challenges and complexities related to external negotiations and leveraging partnerships to reach common goals. The key themes included:

- **Negotiating with and influencing vendors:** Purchasing and contracting inherently require significant amounts of negotiation. RFPs can provide an opportunity for a healthcare system to share their values and intentions—but consistently using standard language requires significant amounts of internal groundwork. For example, one supply chain leader reported:

[Standard RFP and Contract Language] is that stake in the ground saying these are our values, this is what we want to work on with our suppliers. And this is what we want to focus on. So that's been very helpful as well. But you know,

that took a good two years to be able to implement and be able to get buy-in from all of our leaders.

A few participants noted the importance of the RFP process for getting input and ideas from vendors. One supplier diversity leader said:

I've learned some of the biggest lessons from my suppliers in this work because we're not the only ones asking for it and they've heard it somewhere else. And they've figured it out, they're doing it somewhere else, and they figured it out or they're developing a design that they share with us, and we leverage it. But if we never asked the question, you'll never know what can be done.

Several participants commented on how supply chain and supplier diversity professionals don't always have all the political capital needed to convince vendors to agree to supplier diversity contracting requirements and follow through on contractual terms. Having a category owner onboard as a political ally can make all the difference in getting positive outcomes:

In order to get actual compliance, you really have to work with those category owners . . . because you will get vendors that will push back. You will get vendors that will say it's hard, too hard for me to do, and if you give the vendors a way out, they don't come to the table with the solution.

Participants also talked about the importance of more informal influence with vendors, particularly the local and diverse businesses who could become system vendors. In a sentiment mirrored by other participants, one participant talked about the tension between outreach to make connections with new vendors and setting expectations for vendors that the health system is unable to fulfil:

We have started to put ourselves out there, a little bit more intentionally, so not a lot of like 'broad sweeping come do business with [my health system]' because there may not be a contract for you right now. There might not be an opportunity.

Another participant talked about the need to really listen to vendors—citing that when they started asking what was needed or not working, they were surprised by the results. Listening allowed the health system to meet real needs after they understood what the vendors actually wanted:

So, each business is different. And I think as an organization, we thought we knew what these businesses wanted. And that's not always the case, right. . . This is a local cheesemaker, they didn't want a contribution from us, they didn't want any of these funds. They just wanted us to purchase from them. But they also wanted to use [my Health System] as a marketing channel and put their name on the cheese or put a little sign outside of the cafeteria saying, "All cheeses provided by this company" for the next week, right?

- **Negotiating and Influencing Group Purchasing Organizations (GPOs):** Because of their focus on driving down costs through consolidated contracting, Group Purchasing Organizations are seen both as important partners and as barriers to supplier diversity and local purchasing efforts. Participants described how the GPO's goals of using large scale vendors and national or regional distributors can be antithetical to building supplier diversity and meeting local purchasing goals. One participant described the challenge this way:

The GPO is something we haven't cracked yet. And a lot of it is because they want vendors that are at scale and can globally distribute.

Multiple participants cited clear examples of how they were working with their GPO to identify and contract with new minority and women-owned businesses (MWBE) vendors; for example, one participant noted, "We found that having [our supplier diversity initiative] closely aligned with [our GPO] gave us the best opportunity to influence those contracting decisions to happen because we're very close to the

contracting teams.” Other systems—especially those with GPOs with less advanced supplier diversity initiatives—have had less success in getting support from their GPOs. For example, one participant described their failed negotiations with a GPO on better supporting this work: “You know, for the longest [time] we tried different angles, like, “Hey, how do we get into the GPO? . . . and it just was a big roadblock.”

One commonly cited opportunity was the need to request more support from GPOs by coordinating with other healthcare systems. Here’s one participant on that topic:

All GPOs are member-owned organizations. And they have multiple members. So, I think if instead of having each individual hospital's voice be a whisper that sometimes can be ignored or discounted.... if they can bring those, you know, 8 to 10, or whatever together and had them all sing at the same time it becomes a little bit louder. And it will become a little bit more of a roar, and you can't really ignore it.

Finally, one of the participants pointed out that the GPO can provide lists and connections and contracts, but that:

In the end, it is up to the hospital to utilize that, and also to have a plan to utilize that. So that's the one thing that I think hospitals don't do a good job at. And I think also GPOs could actually support hospitals a lot better in doing that.”

- **Intra-health system Collaboration:** More than half of the participants mentioned the value of coming together with other health systems to share best practices and potential tactics. Several participants noted the role of HAN or the GPO as a convener, while others described the utility of direct mentorship or peer-to-peer sharing among healthcare systems.

In addition to opportunities to collectively negotiate with GPOs and vendors, participants cited clear examples of regional and city-based partnerships that have had a big impact in strengthening and growing local businesses in the most disadvantaged

neighborhoods. While not raised by any participants, others (e.g., Koh et al. article) have suggested that when not aligned effectively, there can be competition between healthcare systems particularly related to credit and branding for key initiatives in these collaboratives.

- **Leveraging Supplier Diversity Networks and Capacity Building Organizations:** Finally, many participants linked the quest for scarce resources to an opportunity to partner with other economic development organizations, coalitions and councils that represent diverse and local business, and entrepreneurial support organizations. One participant stated that the healthcare system does not have to do all this work alone:

But I also think it's important to recognize that we are not a monolith, and we might not have everything that's required to support the growth and development of a small business. . . So, I almost see us as like a connector.

Table 4 summarizes the different partner organizations highlighted by participants that have played a critical role in moving this work forward. However, one participant highlighted the importance of understanding what different partners bring to the table and can offer:

There might be a lot of nonprofits and organizations that do work in the small business development space. It doesn't mean that every single one of them will meet your needs. . . . we've learned that some organizations are really good at, for example, supporting certifications and that is all that they do really well. And then there might be another organization that does a really good job teaching businesses how to pitch new elevator pitches, but that's all they're really good at doing. . . . We've come to realize that you actually have to spend a lot of time vetting and trying [them] out. How else do you know if an organization is really good at something or not.

Table 5: Key stakeholders and partners mentioned by participants

Organization	Description and Website	Mentions
Nation Minority Supplier Diversity Council (NMSDC)	In addition to third party certifications, NMSDC creates connections between minority business enterprises (MBEs), corporations, the public sector, and other MBEs, stoking entrepreneurship and growing wealth for systemically excluded communities. https://nmsdc.org/	5
Women's Business Enterprise National Council (WBENC)	WBENC is the largest certifier of women-owned businesses in the U.S. and a leading advocate for women entrepreneurs. https://www.wbenc.org/	5
State or Regional Supplier Diversity Council	The state or local chapter of NMSDC	4
Healthcare Anchor Network	Healthcare Anchor Network convenes health systems to share best practices for advancing an anchor mission approach within their health institutions, address common challenges, co-develop new tools, and identify areas where collaborative efforts may be possible. https://healthcareanchor.network/	4
Small Business Development Organizations (e.g., ICIC)	Largely non-profit organization committed to building the capacity of local, small, and/or diverse businesses. There are more than can be named and many focus on a particular location, state, or region. One of these specifically named is ICIC that provides training in cohort model to small business owners from under-resourced communities (https://icic.org/).	4
Local Chambers of Commerce	A local association that promotes the interests of business owners in a particular place, most often organized at a town, city, or metro-area level.	3
Anchor Collaboratives	Any number of collaborative efforts to apply anchor strategies through collective action.	3
Practice Greenhealth	Practice Greenhealth is a health care membership organization that provides sustainability solutions that benefit patients and employees, communities, financial security, and the environment. https://practicegreenhealth.org/	3
Health Care Without Harm	Health Care Without Harm seeks to transform health care worldwide so that it reduces its environmental footprint, becomes a community anchor for sustainability and a leader in the global movement for environmental health and justice. https://noharm-uscanada.org/	3
State or Local Women's Economic Council	The state or local chapter of Women's Business Enterprise National Council (WBENC)	2
State or Local Economic Development Organizations	Membership organizations that foster collaboration among economic development professionals	2
City or State Government Supplier Diversity Office	City or state government offices leading supplier diversity initiatives within the state or local government.	2
Local/Regional/State Coalitions of Minority Businesses	Hundreds of membership-based organizations that advocate, provide capacity-building, and otherwise support businesses in a particular sector or businesses from a particular minority group. Examples: Black Economic Council, Builders of Color Coalition, etc.	2

Table 4 (Continued)

National LGBT Chamber of Commerce (NGLCC)	Providing third party certifications for LGBT businesses, the NGLCC serves the LGBT businesses community. State and local chapters or corresponding agencies exist across the country. https://www.nglcc.org/	1
National Black Chamber of Commerce	NBBC is dedicated to economically empowering and sustaining African American communities through entrepreneurship and capitalistic activity. Many states and regions have affiliated chapters. https://www.nationalbcc.org/	1
U.S. Hispanic Chamber of Commerce	USHCC actively promotes the economic growth, development, and interests of more than 4.7 million Hispanic-owned businesses, advocates on behalf of its members, and partners with American corporations. There are more than 250 local affiliated chapters and chambers across the country. https://www.usbcc.com/	1
Veteran and Military Business Owners Association	VAMBOA is a non-profit veteran business trade association that promotes and assists Veteran Business Owners, Service-disabled Veteran Owned Businesses (SDVOB) and Military Business Owners. https://vamboa.org/	1
Clean Production Action	Clean Production Action designs and delivers strategic solutions for green chemicals, sustainable materials, and environmentally preferable products. (https://www.cleanproduction.org/)	1
Federal Government	There are two federal agencies with programs and supports for small/minority and women owned business. The US Small Business Administration (https://www.sba.gov/) and the Minority Business Development Agency (https://www.mbda.gov/).	1

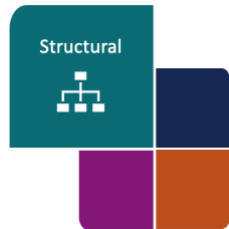
Finally, participants provided strong praise for the value of the Healthcare Anchor Network (HAN), Healthcare without Harm, and Practice Greenhealth for their convenings, technical assistance, frameworks, and detailed guidance.

[An Uncertain Future](#)

Nearly all participants hinted at the uncertainties about the future financial outlook for healthcare providers. The typical financial margins for non-profit healthcare providers are already small, with little room for increases in expenses or “nice to have” additions. As healthcare progresses through 2022 and into 2023, budget reductions and financial austerity measures are expected as COVID-19 government support slows, the economy approaches a recession, inflation soars, and the cost of labor increases due the healthcare worker shortage.

As a result, there will likely be cuts to activities and expenditures that are not mission critical or do not position the system to respond to the crisis at hand.

4.1.2 Complexities in the structural frame



Participants discussed complexities and challenges related to three overarching themes aligned with the structural frame: a) Complex and institution-specific structures and policies that govern supply chain and purchasing; b) Identification and capacity building for MWBE and local vendors that fall outside standard supply chain and purchasing structures; and c) Challenging data management requirements.

Complex and institution-specific structures and policies

All participants talked about at least a few complexities related to the way that the supply chain and purchasing processes are structured, and how those complexities create challenges for working with local and diverse vendors. These complexities include:

- **Fast moving and evolving system:** Several participants talked about the speed of decision-making in supply chain and purchasing departments, for example:
“Procurement in general, it's a really fast-moving space, although it seems like it takes forever to put a contract in place, but there's so much going on, and it is so fast.” This means that any process changes to incorporate diverse and local suppliers need to be streamlined into the existing system. One participant noted:

If a stakeholder comes and says, "I need this contract, I just need it signed and out, just do it." It might not necessarily leave enough time to say, "Well, let me look at sustainable alternatives that are out there or diverse suppliers that are out there. . . . It can be challenging to try and influence that.

Additionally, participants discussed the evolution and changes happening within supply chains that can create opportunities for process and priority changes, like incorporating concepts of resiliency into decision-making and moves toward more standardized processes and procedures that are underway in many systems.

- **Regulation compliance and high standards for quality:** Participants talked about the compliance and quality standards that underlie most hospital purchasing processes, from requirements to get clinician approval for medical supplies to the need to stay abreast of the ever-changing regulations related to a particular service, to CORI¹⁴ requirements for vendors providing services. These quality and regulatory requirements can create a barrier to entry for many MWBE vendors. Describing the overall purchasing system goals, one supply chain director explained: “We create the framework with the necessary—I don't want to say controls—but assurances that what we will be purchasing is going to be safe for clinical use.”
- **Multiple supply chains and purchasing stakeholders:** Healthcare systems procure a large number and wide range of types of products and services. As an example, UMass Memorial Health in FY 2021 managed an “item master” of 110,000 different products and did business with more than 5,000 vendors. UMMH’s VP of Supply Chain often describes the existence of not just one supply chain but multiple supply chains within the health system, included but not limited to: pharmacy, general med-surge, laboratory, specific clinical areas (e.g., women’s health, orthopedic, and pediatrics),

¹⁴ Criminal Offender Records Information (CORI) Checks. In Massachusetts and most states, these are required for any employee, volunteer, contractor, and vendors/professionals who may have access to vulnerable populations or sensitive systems.

facilities, IT, and capital planning. Each of these unique supply chains is governed by different policies, might have different regulatory requirements, and engages a different set of stakeholders.

Nearly all participants talked about the critical role that category owners and budget leaders play in purchasing decisions (and success on impact purchasing initiatives). Depending on the size and organization of the system and the extent of purchasing centralization, the number of these category owners and budget leaders can range from the teens to the 100s. Table 5 summarizes the purchasing categories/departments that participants identified when asked about the biggest opportunities for shifting purchasing to diverse and local suppliers. Two participants talk discussed this tension between supply chain and departmental or category leaders:

Table 6: Budget categories cited as areas of opportunity (in descending order of mentions)

Facilities (e.g., maintenance, housekeeping, grounds/landscaping, plumbing, housekeeping supplies)
Nutrition/food services
Information technology (hardware, resellers, support, capital)
Construction
Printing
Distribution
Consulting
Advertising and promotion/ graphic design
Transportation
Clinical Engineering
Legal services
Executive searching
Investment banking
Energy efficiency/renewable energy
Retail

Facilities departments have great opportunity for the inclusion of diverse suppliers. But oftentimes [the Facilities department] doesn't have to go through supply chain. And when they do, it's really only to complete a contract.

Some of the decisions that were made, especially in the professional services realm, were with your general council, your CIO, your CFO, etc. They were not made in purchasing. They just weren't.

- **Complex, Varying Organizational and Management Structures:** Participants described a wide range of organizational structures and staffing configurations for purchasing and

supply chain. One key theme was differences in the level of centralization and standardization among the various sized healthcare systems included in the sample. For example, two participants from two different systems give very different descriptions of where decisions are made about individual purchases:

The purchasing function is decentralized, where we have end users able to go in and trigger requisitions within our procurement platform. [Smaller, single state health system]

So, we purchase as a centralized system, meaning our purchasing happens in one location. Not each one of our hospitals purchases for their specific facility or their address, all of our buyers are centralized. [Larger, multi-state health system]

- **Standard systems and policies—or the lack of them:** An overarching trend in supply chain is to move to “more standard workflows and processes” with “regimented supplier performance programs.” Many of these standard processes were developed with a focus on lowering cost, consolidating vendors, limiting variability, and increasing efficiency (all competing priorities discussed in the political section. As a result, the existing supply chain program may be organized in a way that makes it difficult to incorporate new or innovative solutions.

Additionally, supply chain and purchasing programs are working to further standardize, centralize, and clarify processes for multiple other reasons than supplier diversity. Some of the process challenges identified by participants included: not having a quality vendor onboarding system; poorly functioning value analysis program to get clinician buy-in on product selection; and the lack of standard contracting and RFP language. For example, two participants talked about challenges in their systems that impact supplier diversity efforts.

For years I've been asking for things like: Do we have a list of upcoming contracts? Like, what is our contracting process? How can I tell suppliers what this looks like so they can be prepared? We didn't have a standard approach.

[We have] different, sometimes unstandardized processes for onboarding vendors. These are being created and updated because of the supplier diversity effort.

- **Importance of the GPO in healthcare supply chain:** Another key theme that emerged focused on the role of the Group Purchasing Organization (GPO) in healthcare supply chain processes and decision-making (see political frame for more on the topic). While all hospitals represented in interviews reported working with a GPO, different systems partner in different ways with their GPO—with two organizations outsourcing all or most of their supply chain capacity to a GPO (e.g.: “[the hospital system] created a contractual relationship where [the GPO] manages their end-to-end supply chain.” and others who only rely on the GPO for a portion of contract negotiations.

Some participants talked about how GPOs are stepping into new territory and setting up new systems to deliver more local and diverse vendor options to health system members, with GPOs functioning at varying levels of capability and partnership, for example:

So, you're finding GPOs getting into lines of business [like supplier diversity and local purchasing] that they never thought they were going to. But it's the changing landscape that says you have to step up, otherwise, you're going to be less attractive to your member who might go somewhere else.

Some specific existing opportunities for partnership, at least with some GPOs, include leveraging the power of the GPOs analytics, gaining access to lists of diverse vendors with existing GPO agreements, and the opportunity to leverage regional networks for more thoughtful local purchasing.

- **Committed and Bundled Contracting:** Several participants talked about the challenges of including smaller, local, diverse vendors in large, multi-year committed contracts that are often the norm for the biggest areas of spend in a hospital. One participant noted:

One of the concerns I have is that we have certain committed contracts through a GPO . . . if we don't hit that percentage, then there may be some consequences that we may have to pay more out of pocket for that contract . . . Especially for the food nutrition category. . . one of the easiest kinds of low-hanging fruits for diverse and local suppliers.

Other participants highlighted challenges related to bundling of contracts (e.g., when multiple commodities or services are put onto one large contract). These two types of contracts—bundled and committed—continue to be the primary structure for procuring goods and services in healthcare institutions in an effort to gain cost-savings through economies of scale and standardization.

[Vendor identification and capacity challenges](#)

Many participants discussed the challenges facing local and diverse vendors with respect to their ability to be integrated into the health systems' purchasing systems. One participant summarized the challenge this way: "We have a lot of small, diverse vendors in our local community . . . Getting them connected and getting them to actually become vendors is not easy."

- **MWBE and Local Vendor Identification isn't straightforward:** Identifying diverse and local vendors that align with hospital product and service needs can require multiple different pathways and structures. "Who's out there, and where am I supposed to spend?" is a common question asked by category leaders, budget owners, and supply

chain staff who have been tasked with increasing local and diverse spending. One supply chain leader noted:

If you go to a new department, they're going to be like, "I don't know what to tell you about what opportunities I have because I don't know who's out there. Can I give you an IT project? Well, I need a DJ for this event." So, it's kind of hard to do that matching when there's a lot of unknown or uncertainty, and so it takes a lot of groundwork to kind of, like, foundation building.

Participants noted the need to connect with a number of partnerships to help with the identification of vendors, including the National Minority Supplier Diversity Council (NMSDC), the Women's Business Enterprise National Council (WBENC), the local chamber of commerce and different state or regional coalitions for different minority and women-owned businesses (See Table 4 in the previous section). One participant said, "We will partner with anybody in terms of being able to identify diverse vendors in areas that we haven't been able to do that traditionally." Many of these organizations give access to database lists of diverse suppliers, but searching effectively can be challenging. One participant noted, "For me, I'm not on their database every day, so I don't know how to search it." Another participant noted that there are different sources of vendors depending on what you're looking for:

Each of our towns or cities have Business Chambers. . . but the smallest companies don't want to pay the membership fee to be in the Chamber. So, you're not necessarily going to find everybody through that. . . the city or the construction trade's minority organizations are going to have the more targeted list that we're looking for.

Several participants commented on the variability in what's available in different parts of the country or even parts of the state. Some participants also identified the

requirement of thinking with a future, long-term view when identifying and reaching out to vendors. For example, one supplier diversity leader said:

I'll hear about a diverse supplier and then say, 'Oh well, I know we might in the future have that opportunity, let me get them connected in with a sourcing specialist today, so they can start building that relationship for the future.'

Additionally, whether a vendor has decided to seek certification also impacts their appearance in an easily accessible source list. While certification isn't a pre-requisite for hospitals doing business with an MWBE, lists of certified businesses (often provided by the partners listed in table 4) are frequently the way that health systems try to identify new vendors. In UMMH's limited experience searching for vendors, even those receiving entrepreneurial support have often not gone through the certification processes, either because they didn't know about it, because they didn't see the value to their business, or because of the challenging and time-consuming process to get the certification. There's a similar challenge in working through the Chambers of Commerce or Better Business Bureau.

- **Capacity challenges facing MWBE and local vendors:** The two biggest challenges noted by participants for why it can be difficult to integrate MWBEs into the supply chain revolved around the issues of cost and scale. Several participants noted that small, local businesses might not be able to compete with bigger companies because of the economies of scale. For example, two participants said:

You know these smaller minority businesses and women-owned businesses can't afford to sell or even purchase at the wholesale level or deliver services that bigger institutions can, right. So, it's a matter of scale.

If we introduce a minority or local vendor, they may not have the capacity to support our entire organization. So now we need to start to make sure we

understand if we introduce a new vendor that's going to handle a certain portion spend, how do we support that?

Some of the participants noted, though, that minority- and women-owned business are not always more expensive and have led to cost-savings for some institutions (although this wasn't seen directly at the participants' hospital).

Nearly all the participants noted the requirement to adapt policies and processes to work effectively with local and MWBE vendors and level the playing field so that MWBEs can compete more effectively. One participant said, "Supply chain is used to dealing with large national businesses . . . they're new in this space. And so, there's a lot there that needs to happen to get them acclimated with our business operations." Some participants highlighted specific needs and challenges for integrating MWBEs as vendors, including these comments from 3 different participants:

If they're struggling, if they need some technical assistance, they may be afraid in letting us know or they have a hard time communicating.

When we introduced the anchor mission, we realized like, "Hey, the small businesses are not going to have the capital to float for that long. So, we have to change our payment policy so that we can pay them quicker."

Our national vendors, by and large, they're very stable, we do have supply chain disruptions and shortages. . . diverse or local vendors, they're generally more vulnerable. And they don't have the, I don't know if it's the financial capital, the human capital, to withstand either downturns in the economy or drastic shifts. So, we need to ensure that when we're working with local or diverse vendors that we can support them so they can be viable.

Several participants noted the needs of vendors specifically around business skills—and the large number of entrepreneurial and business support organizations who can provide support in this space.

Nuanced Definitions and Complex Data Management

All participants described effective data management as one of the early and/or ongoing challenges for implementing supplier diversity initiatives. Here is just one of many quotes on this topic:

I think the one piece we have not talked about is data management and measurement. That has been incredibly difficult for us to wrap our arms around, it is still not perfect, and I know that it's hard for other organizations as well.

Participants identified several complexities that contributed to the challenges of data management:

- **Tracking systems, dashboards, and multiple sources of data:** Several participants noted the need for a good Enterprise Resource Planning (ERP) system¹⁵ for tracking expenditure data related to supplier diversity and local purchasing goals. One participant summarized:

Yeah, you need to build a great ERP system, and you have to be in the design phases of that ERP system . . . we're moving over to [ERP System Brand]¹⁶, just imagine if I wasn't a part of the design phase of that, what we would have missed out on.

Another participant added a comment on the value of another recent ERP upgrade in improving their data management:

We just went through our ERP upgrade. We had a 30-year-old system in place, we've got some things that really needed to be updated, right. So, making sure that you get the data scrubs, that you understand your existing diverse supplier base, and that you continue to work with the data and get more visibility into your purchasing practices is so important.

¹⁵ An Enterprise Resource Planning system is an integrated software platform for managing a company's financial information, supply chain, human resources, reporting/compliance, and other operational data.

¹⁶ Removed the name of the ERP company to protect privacy of the participant.

Other participants noted the importance of having strong data analytic staff to create dashboards that can connect different data sources and make the available data actionable and meaningful. This helps with another challenge highlighted—that vendor data are not always clean and comparable from list to list: “One problem with this is that in our materials management database and our invoice database, the title of the vendors has to be so specific [in order to match vendors between systems].”

- **Aligning existing data to HAN and other commitment definitions:** Another specific challenge noted was aligning vendor and expenditure data with the definitions required by the Healthcare Anchor Network (HAN)—the two specific challenges noted related to defining local ownership and third-party certifications. On the first, the HAN commitment requires that to be considered “local” a vendor must be both locally headquartered (i.e., not just where a check is sent) and privately owned (i.e., not publicly traded). Two participants talked about this challenge:

I mean right now I'm trying to figure out our local spend. . . And it's come down to me . . . literally googling to find the headquarters. It's so hard, because you know where you send the check, but that's not [necessarily] the headquarters. So, if you know resources solve that problem, I'd welcome it.

HAN does have a definition of local spend and I'll just say I don't agree with it, and so we have our own definition. And we've defined it as the zip codes that we serve. If we send payment to those zip codes, that's how we classify local spend.

Another challenge raised is obtaining the up-to-date third party certifications of a vendor's MWBE status. Many of the health systems utilized a vendor, like SupplierGATEWAY or Supplier IO, to match lists of certified with the hospital systems vendor list or expenditure file. Others handle this internally through the ERP system or a

separate dashboard. Summarizing this challenge, one participant still building their supplier diversity data system stated:

I think the Devil's in the details, like the whole certification conversation. I need a full-time person to actually go and check the certification of every company to make sure that they have a certification and it's not expired. That's a whole other job that we don't have time to do right now.

- **Variable Data:** Even with strong, complete, well-cleaned data, several participants noted the challenges of the planning and tracking progress given the large amount of variability that can happen from year to year. This variability can happen because of emergency situations or even planned changes in the hospital's supply chain or footprint. For example, several participants noted that the HAN baseline year of 2020 might create some unforeseen opportunities or challenges as the supply chain recovers from COVID-19. One participant reported on how their mentorship from a mature vendor supplier diversity program helped them foresee and expect fluctuations in their data:

It was really interesting to see, that we're experiencing up and down performance each year as well. . . Things that happen in this space that you can't control, like one of our biggest suppliers lost their certification, so we can no longer count them as a diverse supplier, so it's taking our numbers really low.

- **TIER 2 and Big Vendor Data:** The final theme identified regarding data was around collecting Tier 2 data (the data on a prime vendor's spend with MWBE or local vendors). One challenge identified was that operationalizing requirements and processes can take many years. Unless reporting Tier 2 data is required in the terms of the contract, it is an optional or voluntary process. For organizations early in their supplier diversity journey, it can take years to build formal reporting requirements into all the contracts across the

system, particularly in those contracts with a 3-5 year term. Another challenge relates to the quality and comparability of Tier 2 data from different sources:

It'll be a mix because everyone has their own ways of reporting. Some come back and they say, oh, that they can't report down to the specific type of supplier or that they can't attribute it to our specific sales. But what I'm starting to notice though is that just about every big player out there, every big prime, they've got someone that's now dedicated to pulling these reports. . . they're maturing their program to respond to these requests.

See Appendix G for more some additional detail on UMMH's journey and challenges with data management.

Setting Goals and Selecting Strategies

Participants described several challenges as leadership and staff create appropriate and impactful goals for impact purchasing initiatives. These themes have been particularly influenced by conversations and ongoing discussions with UMMH staff as the teams has worked to set priorities and goals for the future.

- **Prioritization of local vs diverse vs green:** The three primary components of impact purchasing can easily be pitted against one another. Most of the literature best-practices focused increasing spend with MWBEs, and GPOs are collectively developing relationships with nationally focused MWBEs. However, the biggest opportunity for a business case for impact purchasing is by strengthening economic growth and promoting health in under-invested local communities; increasing local spend requires different strategies and partnerships than broader MWBE spending increases. Similarly, green initiatives—while outside the primary focus of this paper—require different strategies and initiatives than local or diverse purchasing.

- **Short vs long term goals:** Another complexity highlighted by participants and colleagues focused on the timeline for setting goals. Setting longer-term goals helps create vision for change and gives space to turn a ship that is slow moving (e.g., the multi-year lifespan of contracts and the months of work that can go into competing and negotiating a contract). Contrarily, purchasing ecosystems in healthcare can quickly as noted by one UMMH staff member: “Our supply chain and budget look totally different now than they did only two years ago, and it will continue to change in the coming years given the economic forecast for hospitals.” This changing context for purchasing decisions makes setting long-term goals risky if senior leadership is holding staff accountable for reaching goals set when conditions were different.

Another challenge with meeting long time-frame goals is the shift in both budgets and certifications of vendors. At least one MWBE vendor that UMMH purchased from in 2020 has been bought by a publicly traded company, another provided a special shipment of PPE in the middle of the pandemic, and a third provided items for a one-time telemedicine expansion also prompted by the pandemic. These same unique needs might not be present in future years, requiring constant attention to fluctuating data and a comprehensive view of the current situation to ensure continued progress.

- **Special Projects vs Operational Processes:** Goal setting requires trade-off decisions between one-time special projects (which may have a more visible impact in the community and among staff) or ongoing, operational purchases that make up a majority of the organization’s budget.

- **Tier 1 vs Tier 2:** Another important tradeoff for local and diverse purchasing initiatives is a focus on Tier 1 (the purchases directly from MWBEs or local businesses) or on Tier 2 (purchases made by a prime vendor with MWBEs or local vendor). Tier 2 goals and reporting require an additional layer of sophistication for reporting and management, and yet may also require less direct work from the health system, since you are relying on the capabilities of those partners.

4.1.3: Complexities in the human resources frame



Many participants highlighted complexities related to human resources, incentives, and job supports. The key themes identified include a) bench strength and the need for ownership, b) accountability, incentives, and intrinsic motivations, c) competencies, skills, and staff expectations, and d) teamwork, training, and job supports:

[Bench strength and ownership](#)

Linked to the concepts of conflicting priorities and resources in the political frame, as well as to organizational structure and staffing models in the structural frame, participants highlighted the tension felt across the organization in terms of available staff time and the need to have people take ownership of the work.

- **Time and Skills within Supply Chain and Sourcing Teams:** Multiple participants discussed how purchasing staff were busy, with supplier diversity often getting pushed further and further down the priority ladder. A few participants highlighted that contracting with diverse and local suppliers can put a bigger strain on supply chain and sourcing staff:

Smaller suppliers don't have the resources that larger competitors [have]— it's much more intense for our sourcing category leaders, for our sourcing managers to get involved and engaged in that relationship.

But the issue with bench strength doesn't only relate to time and intensity. Rather, building a pipeline of diverse and local vendors takes a different set of skills than might exist within an institution. One supply chain leader acknowledged:

It's one thing to run a business diversity program. It's something slightly different to really get granular and get into specific geographic locations and neighborhoods. And so, we realized when we looked at the team, we really didn't have, beyond the bandwidth, we didn't really have the expertise.

- **Time and Skills among budget leaders and entities:** The success of supplier diversity and local purchasing initiatives also relies on budget leaders, category owners, and entity or hospital-level leaders. One supplier diversity professional in a large system described this challenge:

We are dependent on our hospitals to get more engaged, but they can't because of where we are right now with staffing shortages and supply chain shortages. . . we're really dependent on someone getting excited about it [and] wanting to run with it at the hospital.

One participant suggested that having someone who can drive and champion the effort is needed, particularly when you don't have a fully-fledged effort and team already in existence, a topic that was raised by several others:

You can't get there until you have a champion for it and it's in your face, all the time [and] becomes a part of your work. And then, then you can take a step back, [moving] more maintenance mode, because everyone is thinking of it.

- **Need for Accountability:** Linked to the political section above on leadership buy-in, many participants discussed the need to create incentives and accountability for reaching supplier diversity and local purchasing goals for staff across the organization—

from supply chain to budget owners to VPs and executives. One participant even suggested getting down to the level of the “physicians, nurses, and surgeons” because they help pick the products through the value analysis process: “So it becomes a responsibility for them to say, ‘Hey, this is part of my goals, and I really want to find a supplier who can provide whatever product or service that happens to be diverse. Can you bring me those suppliers?’”

Several participants suggested that supplier diversity accountability measures can be linked to broader diversity, equity, and inclusion (DEI) accountability measures that are being expanded in most health systems across the country:

We’re going to be moving to have [diversity and inclusion] as a KPI for leaders. You know those things really, really drive diversity and inclusion internally. But unless you have that, it's just not going to work.

Sometimes beyond formal KPIs and compensation benefits, health systems can provide accountability in more informal ways (see the internal negotiating section above). For example, a few participants who fell under the organizational structure of a Community Investment/Anchor Mission office talked about their contribution to accountability by supporting the work, by having key roles related to supplier diversity in their own job descriptions, and by asking questions that prompt action within supply chain and purchasing.

- **Supplier Diversity Often Powered by Intrinsic Motivations:** One theme that arose in several interviews was the intrinsic motivation that fueled this work, along with the benefits derived from working on supplier diversity efforts. As noted in an earlier quote, several healthcare systems have relied on staff to take on this work voluntarily.

Many people in supplier diversity roles came to the job with a high level of passion for the community wealth-building and equity efforts that undergird supplier diversity and local purchasing. One supply chain leader noted how the work has created new sources of personal motivation and rewards, a sentiment shared by several others:

I'm probably also very proud of, and probably it's more intrinsically rewarding, it's allowed me to gain and build relationships with areas of the organization that I may not have been able to do otherwise, i.e., our population health group, our government affairs group, a greater understanding of our community outreach.

However, several participants also noted that intrinsic motivation alone can't stand up against a large barrage of conflicting priorities, emergencies, or staff turnover. And participants also noted disheartening experiences—like hearing about missed opportunities that only come around every few years that could have been leveraged to make a big impact.

Competencies, skills, and staff expectations:

Participants highlighted the following key skills and competencies, along with tasks and expectations, for the individual or team responsible for supplier diversity and local purchasing within a healthcare system:

- Skills and Competencies:
 - Self-motivated/passionate/able to take ownership
 - Team player
 - Strong communication skills
 - Ability to understand short- and long-term vision
 - Open to learning

- Cultural competency/Ability to interact and partner with individuals from multiple diverse backgrounds
- Skilled at meeting facilitation
- Able to execute and manage projects
- Tasks/Expectations
 - Report and communicate progress to Leadership
 - Build relationships with local supplier diversity and business organizations
 - Identify and meet regularly with internal stakeholders/category owners to plan, set goals, and review progress
 - Build new vendor relationships (point of contact, resources and guidance, capacity building)
 - Develop playbooks and other self-service tools
 - Leverage tools to identify vendors in specific areas
 - Analyze system-wide expenditure data (or work with a data analytics team) for tracking progress and identifying opportunities
 - Stay up to date on best-practices and opportunities/learn from other systems and partners

Teamwork, training, and job supports:

- **Need for teamwork and trust:** One theme highlighted by several participants centered on developing meaningful partnerships with key offices across the organization, specifically linking Supply Chain/Purchasing Departments to the Diversity, Equity, and Inclusion Office, the Sustainability or Environmental Stewardship Office, and the

Community Office (or Public Health, Community Benefits, Anchor Mission Office depending on the institution). Having a clear understanding of roles, resources, and goals (shared or individual) helps ensure that these relationships further the goals established for supplier diversity and local purchasing. One participant noted:

How we got there was our collaboration with departments that are deeply embedded in our community and understand the social determinants of health. . . . So, collaborating with our Diversity, Equity, and Inclusion Department and the key leaders of influence that understand the work was probably the most important thing that we've done. So, it's not a team of one, it's the team of many.

Similarly, multiple participants noted the importance of developing trusted relationships and alignment with category leaders and others who are actually executing on the goals. (See also Internal Negotiation in the Political Frame).

- **Constant effort to provide training and job supports:** One key theme highlighted by multiple participants focused on the need to spend significant energy educating stakeholders (like budget and category owners) about leadership support for supplier diversity and local purchasing, expectations and policies, and tools for being successful. One supplier diversity leader described the key messages communicated in each meeting with a new or relatively new category owner:

When I educate the owners, I'm going to the owners and saying: Hey, you know our CEO and our C-level executives talk about buying local, this is what that means, and this is how you can help. You get us to where we need to be. So, when we talk about this big \$3.5 billion [opportunity], you make up \$500,000 of that.

Participants also highlighted the importance of finding ways to make these stakeholders—like category owners or regional/entity teams—feel equipped and

empowered to incorporate a search for new local or MWBE vendors into their next RFP, for example. One supply chain leader described it like this:

It's just about meeting the people, making things user-friendly and easy for them to make those decisions. . . this is so new that we want to make the Anchor Mission choice not difficult, we [don't] want to be adding things to their plate.

But making a new strategic initiative “easy” isn’t always possible. One participant highlighted that supplier diversity staff might face some resistance with educating those budget owners because the systems are still in development:

[Our playbook] is not going to include every single question or resource needed for a sourcing specialist but it's enough, and I found whether it's intentional or not when doing some of this work with our teams, there'll be a lot of resistance because they don't have a perfect solution

The final theme in this frame focused on the need to continue building the skills of supplier diversity and supply chain staff who are responsible for this effort. One participant noted that having the “supplier diversity” credential isn’t critical for individuals filling a supplier diversity role to be successful —but that this training program provides a benefit for staff who want to grow their careers. Other participants noted the value of active participation in organizations like HAN and Healthcare without Harm to continue building competencies and knowledge related to this work.

4.1.4: Complexities in the symbolic frame



Participants identified several challenges and complexities with roots in the Symbolic Frame, including a) social and cultural trends; b) bias and perceptions limiting progress, and c) hardwiring goals into the culture.

Social and cultural trends impacting supplier diversity

Several participants noted the recent interest in supplier diversity, equity, and inclusion among healthcare systems as a result of the 2020 racial reckoning in the U.S. following the murder of George Floyd. This focus on equity and the impact of systemic racism has shifted the perspectives of leadership teams at several health systems—pushing forward new commitments and identifying new resources to support the work of supplier diversity and other anchor strategies. Huge disparities in health outcomes made visible by the COVID-19 pandemic have further fueled this movement.

Bias and perceptions limit progress

Most participants noted the fact that the success of supplier diversity can't happen without addressing the linkages between purchasing decisions and existing biases. Here are two participants on this topic:

Supplier diversity work is tied directly to diversity, equity, and inclusion. No matter if you're an individual contributor or an organizational leader, if you don't have cultural competency, if you don't have a desire to do this work, then it can lead to a lot of roadblocks.

You know about curmudgeons, everybody has them . . . this is a huge paradigm shift for these folks. It's huge. . . they're not always on board.

Multiple participants highlighted the concept that perceptions of diverse suppliers as needing special treatment or being unable to compete are grounded in “institutional biases and microaggressions.” For example, two participants said:

There continues to be this perception that because the firms have that tag of being a diverse business, that they don't necessarily have the scale, the capabilities, the resources to succeed. And I use the word, perception, because that's what it is. It's not that they don't have it. . . They're capable of working with us in the same way as other suppliers and other supplier partners.

They [diverse suppliers] didn't say, "Change the rules to give me an advantage." They're saying, "Change the rules to not make it a disadvantage. I would like a nice, level playing field. . . . It was about trying to create this leveled playing field because now, you can compete, you know, on your own merits, on your own abilities.

Participants noted that changing people's biases and mindsets can be challenging because "folks by nature do what they're used to." A few noted that supplier diversity and broader impact purchasing work needs to be clearly linked to diversity, equity, and inclusion efforts within the institution. One support organization participant noted:

And so, there's no daylight between 'here's what we're doing around diversity and inclusion' and 'here's what we're doing in quality' and 'here's what we're doing in delivery' and 'here's [what we're doing in another area].' It's treated as one other element that we're working towards. I think people react more consistently to the lack of ambiguity when senior leadership communicates that way.

[Hardwiring supplier diversity into culture](#)

Multiple participants talked directly about the need to "hardwire" supplier diversity and local purchasing into the organizational culture; only a few participants provided clear insights on how this differed from creating easy-to-use processes, consistent leadership communication, and accountability/incentives. Summing up this challenge, one participant noted, "Culture change is a big one. . . . I think everything else is surmountable, right, you can deal with everything else. It's just, you know, try to change people, it isn't easy at all."

[4.2 Common Approaches and Promising Practices](#)

This section summarizes the common approaches and practices utilized by healthcare systems to move forward local and diverse purchasing initiatives utilizing the available literature and expert interview results. I've used the term "promising" rather than "best" practices to acknowledge that context matters and that simple, single frame approaches are not sufficient for moving the needle on local and diverse purchasing efforts in healthcare. I

begin the section with the structural frame, since most solutions identified by participants aligned most closely with this category. Box 3 summarizes the key takeaways from section.

Box 3: Summary of results on common approaches and promising practices

Structural Frame  • Overcome organizational complexity by convening an internal governance council or leveraging existing team and leadership meetings. • Develop a local and diverse purchasing policy and consider some new standard processes (e.g., incorporate language in all RFPs and contracts, require including a local or diverse vendor in all RFPs, build standards into vendor score cards, and add new questions to the value analysis process). • Update purchasing strategies to more easily engage smaller vendors (e.g., break up large projects, alternative payment plans, mentor-protégé requirements, long-term contracting for local job creation, supporting aggregators) • Develop mechanisms that bring vendors in touch with the health system and develop their capacity (e.g., supplier registration portal, published bid calendar, vendor fairs, capacity building programs) • Create a dedicated team or position (but where they report to depends on each hospital system’s organization structures and priorities)
Political Frame:  • Work from multiple angles to build leadership and staff-level support for the initiative. • Get the best outcomes with vendors using a full range of negotiation tactics, looking for win-win opportunities and solutions that might not have come about without asking and pressing and listening.
Human Resources Frame  • Disseminate easy-to-use tools to that explain and simplify purchasing from local and diverse vendors, like a “Playbook” • Create staff incentives and compensation targets for executives, supply chain team members, and other purchasing decision makers.

Box 3 (Continued)

Symbolic Frame



- Find targeted ways to build mindsets of inclusivity with key internal purchasing stakeholders.
- Use an external supplier diversity council, surveys, special events, and ongoing relationships to understand the needs of local and diverse vendors.
- Tell stories like a construction or renovation effort—to increase visibility and build momentum for long term success.

Skip ahead to the next summary

Box 12: Key takeaways about the complexities of local and diverse purchasing

4.2.1 Approaches in the structural frame



Unsurprisingly, most interview participants focused on structural approaches that their organizations have taken to build and strengthen supplier diversity and local purchasing efforts—ranging from governance and partnership

structures to policies and processes to tools. Reflecting on the challenges and complexities in the other frames (such as implicit bias, unclear incentives, and misaligned priorities), one participant talked about the need to structure the system in a way that mitigates these challenges:

For us, diversity and inclusion is much more than people simply committing to behaving a particular way. Instead, have we established an environment in which the outcome can actually be achieved more often than not? Can it be consistently inclusive because it's simply engineered that way?

In the structural frame, the promising practices identified focus on a) governance and partnership structures; b) policies and contracting approaches; and c) tools and processes. Each of these is discussed in greater detail below.

Internal governance and partnership structures:

Multiple participants—with a few additional mentions in the literature—identified the benefits of developing intentional governance structures to build cohesion and track progress, particularly given the significant challenge presented in the first set of results about aligning a large and varied group of internal stakeholders.

Several participants talked about the creation of “governance councils” convened around local and diverse purchasing, sometimes also including environmentally sustainable purchasing. At one health system, this council focused on bringing together sourcing specialists in the supply chain office and the Diversity, Equity, and Inclusion Office. Another system added representatives from various departments and entities who make purchasing decisions to this group. Some governance councils had a broader focus beyond supplier diversity or impact purchasing—for example, a larger “Anchor Leadership Team” that met monthly and reviewed goals and progress related to multiple anchor strategies, including impact purchasing, investing, and hiring.

Another system described a conscious decision to utilize existing governance and organizational structures rather than create new ones specific to supplier diversity. For example, they added a standing supplier diversity/local purchasing agenda item to the existing supply chain operations team, and they brought together supply chain directors from all of the system’s hospitals along with selected operations staff from across the system (COOs, CFOs, and CMOs). The supplier diversity leader also gave a monthly update on supplier diversity both directly to the CEO and to the system’s Diversity and Inclusion Council. Another system used a similar structure through updates at the “supply chain champion’s meeting.”

In a few systems with more established supplier diversity programs, these governance councils brought together both internal and external stakeholders—including the local chamber of commerce, diverse business councils, economic development partners and others highlighted in Table 4. See Box 4 for a summary of one Supplier Diversity Council described by the participant from Cleveland Clinic.

Box 4: Cleveland Clinic's Supplier Diversity Advisory Council

Cleveland Clinic's Supplier Diversity Advisory Council meets quarterly and brings together both internal and external stakeholders. The advisory council provides an opportunity for two-way communication. Cleveland Clinic shares information on upcoming RFPs and process changes. And the system solicits advice to “make sure that the work we’re doing resonates with the stakeholders in the community.” The system also relies on the council to help with program and RFP design and to help spread the news and provide transparency to the community. Members include the Ohio Minority Council, Chamber of Commerce, Women’s Business Council, Plexus (Ohio’s LGBT council), the Ohio Veteran’s Council and representatives from some minority and women-owned businesses. Internal members include the supply chain leaders, construction leadership, HR individuals focused on job creation, and some other key leaders in the organization who control budgets for services and other spend categories.

Note: The HAN Toolkit highlights the details of another council like this one at CRISTUS Health.

Policies and contracting approaches:

Several participants described the effectiveness of developing a policy focused on local and diverse purchasing, sometimes with environmentally sustainable purchasing added in. One participant talked about how their policy helped create consensus around sustainable procurement, which for their organization includes supplier diversity, local purchasing, and environmental sustainability, along with impact investing: “Including that sustainable procurement policy in our policy library for the entire organization was a good first step for us to get over the hurdle of what sustainable procurement is. Now we've defined it.”

Multiple promising approaches were raised in interviews and the literature relating to standard processes and policies that have helped advance local and diverse purchasing goals, including:

- **Standard RFP and contract language:** One very common approach was incorporating standard language into requests for proposals (RFPs) and building diversity and equity requirements into the contracting process. Two participants described different pieces of this process:

We integrate language into our RFP template about supplier diversity and sustainability, letting suppliers know that these things are important to us. . .

[Supplier diversity] language is standardized across all of our contracts. . .it was crafted in consultation with our legal department.

This approach was particularly important for building a robust Tier 2 supplier diversity, where the hospital tracks (and even set targets or goals) how the hospital's prime vendor (sometimes called Tier 1 vendor) spend money with local and diverse vendors. One example from the literature was Parkland Health's RFP requirements for prime or Tier I vendors:

In contracts with tier-one vendors, each proposal submitted through the RFP process must include a completed MWBE second-tier participation plan. If a company does not include the plan, or if their efforts to include MWBE firms are deemed insufficient, the plan can be rated "unacceptable", and the bid can be deemed unresponsive.

Another standard requirement, particularly for construction or purchased service contracts, is requiring local or target neighborhood job creation; for example, the HAN Toolkit summarizes University Hospital's approach: "UH's construction program not only

looks to build within the local vendor base, but also requires vendors to hire from the neighborhoods targeted by UH's own workforce development programs."

- **Requiring that all RFPs include a diverse and/or local vendor:** To address Tier 1 supplier diversity goals (direct spending with MWBEs), a few systems talked about the importance of requiring supply chain or other sourcing staff to include a diverse vendor in the distribution list when soliciting an RFP:

So how do we create access for suppliers to participate in RFPs? . . . One of the key things has been making a requirement for our team: "you need to find at least one minority women-owned business enterprise that you can include in this RFP." And we don't lose anything as a sourcing team by including one, because we're giving them an opportunity to respond, rather than just shutting the door and saying, "Well, we don't think that they can support our business." . . . as the team does it over and over again in RFPs, it becomes second nature.

- **Vendor score-carding and accountability:** Several participants talked about how including language in a contract wasn't enough to guarantee success and impact—there also needs to be a way to measure compliance. Several participants described their process for "Score-carding" a vendor's response to an RFP:

In our scorecard, for example, we have weight given to supplier diversity. . . in the pre-bid meetings we tell the vendors up front what the expectations are and how we're going to be evaluating their proposals. . . I would say that's a critical step.

Others talked about the importance of "score-carding" vendors to track their progress toward established goals after the contract has been made. For example, one participant discussed how accountability helps maintain strong relationships with local and diverse organizations:

[Clear expectations are] the thing that puts the suppliers in a position to be successful. It creates a stronger relationship between the supplier and our organization because we're able to have those candid conversations around

what's not going so well or "this is the perception of your performance." And we're not doing it in a setting that's an extra meeting or that has a different name. This is part of our standard practice, it's part of our standard work. The business reviews, scorecards, it's what we do. It's the expectation of our team. So, it's no different to take a similar approach with those local and diverse suppliers.

Another participant described a process—now moved in-house—where an external partner helped monitor compliance of construction companies against standard terms:

Initially, when we launched the program, we had two external community firms that focused on construction compliance; they would send the RFP out with the language that our team approved, they would vet the general contractor's bids. We would make the final decision, obviously as the owner. They would be part of the compliance in terms of getting pay waivers and making sure that what individual companies said they would do actually was being done. Several years later, we in-housed that particular body of work.

- **New value analysis questions:** Two participants talked about how they have leveraged the value analysis process¹⁷ to promote the purchase of clinical products that align with supplier diversity or environmental sustainability goals. For example:

Our value analysis teams, especially clinical value analysis, they're the ones who are on the forefront of our national spend. That's really, really important, to get value analysis involved.

Another participant described that her health system had added some new questions to the value analysis process as a first step in having diversity and sustainability be included as part of the consideration process when changing a clinical product.

¹⁷ The Value Analysis process is discussed in the literature review (See 2.1.7 Unique aspects of healthcare supply chain complexities). In short, the value analysis process is a framework for making decisions that takes into consideration the various needs of health care stakeholders when making decisions about purchasing clinical products and supplies—from gloves to implants to equipment.

- **Creative purchasing strategies:** Several systems identified some changes that have been made to the RFP and contracting process that have made it easier for smaller companies to compete or for large companies to support community-level impacts, including:
 - **Breaking up larger projects**—especially in construction—into component pieces, both lessening the burden on smaller companies for bonding and insurance requirements and acknowledging challenges that some small organizations have reaching the scale required for the project.
 - **Setting up alternative payment plans** for small businesses that might need access to payments more quickly to make payroll or other expenses. In one system, if a vendor meets MWBE certification requirements, the vendor can be paid in 30 days instead of the normal 90 days.
 - **Including mentor-protégé requirements** in contracts where a prime vendor is required to develop the capacity of a small, local MWBE to allow them to compete in a new space.
 - **Establishing supplier mentorships programs** where larger, national manufacturers partner with smaller minority vendors to offer better pricing because of better access to materials and supplies.
 - **Leveraging long-term contracting to get large businesses to relocate** to the service area of a hospital and provide jobs to individuals from the most-under resourced zip codes.
 - **Consolidating thoughtfully to build an MWBE's capacity.** For example, getting more hospitals across the system to use a new black woman-owned florist shop

or consolidating lawn care providers to help a mentored business build their employee and equipment base.

- **Working with aggregators and distributors** focused on local and diverse source businesses. The HAN Toolkit highlights the efforts at Gundersen Health, where food service and supply chain leaders have worked to partner with and build capacity at the Fifth Season Cooperative that helps bring local food production to a scale that can be purchased by the health system.

Tools and processes

Participants described several tools and processes that have helped build and maintain momentum toward supplier diversity goals. These include:

- **Supplier registration process and portal:** Several health systems use a supplier registration portal to better manage lists of local and diverse suppliers and to link suppliers to opportunities. One participant described their process like this:

[The vendor registration portal] became the front door for doing business with [our health system]. . . the portal then creates a supplier directory. . . that is embedded now within our sourcing tool. So, when we're going out to bid for a project, [the sourcing specialist] can pull from that list and they can request my assistance in identifying a diverse supplier if needed.

See box 5 for another example of this platform launched this year by RWJBarnabas Health in New Jersey.

Box 5: RWJBarnabus Health's BuyLocal vendor registration platform

RWJBarnabus Health's BuyLocal vendor registration platform. In the 2022, RWJBarnabus launched a new online platform called BuyLocal that allows local, minority-owned, women-owned, and veteran-owned businesses to register their information and interest in doing business with the health system. As of July 2022, more than 200 businesses had registered. RWJBarnabus executive vice president and chief health equity and transformation officer said: "Through this new portal, our organization will gain instant access to local and diverse businesses and will be able to contribute to the economic growth of their communities in a very measurable way." Read more in the [Becker's Hospital Review Article](#).

- **Published bid calendar:** One health system embeds their upcoming bid calendar—anticipated dates of upcoming RFPS across the health system for the next 3-5 years—on their supplier-facing website. And, the calendar is linked within the vendor registration portal, allowing a vendor to specify their interest in specific RFPs, triggering a definite follow-up when that RFP goes out to bid. While not as focused as a published bid calendar, the HAN Toolkit described a commonly used approach of forecasting purchasing needs that could be moved to a diverse or local supplier well ahead of the actual change, since it may take some time for an institution to change vendors:

Part of the initial data scrub should be to identify when contracts will come up and which are most strategic to source locally. The interim time can be used to conduct research, vet possible vendors, and even engage in business incubation. Having this longer-term approach can help sustain efforts after the easier switches happen.

- **Vendor fairs:** Another tool leveraged by several systems is holding a “vendor fair,” “meet the buyer” event, or “local and diverse supplier day.” Whatever it’s called, the common themes involve working with partners to get the word out, bringing potential vendors together to tell them about the system’s purchasing goals and needs, and most importantly, allowing vendors to interact with the category leaders and sourcing

specialists that align with the vendor's type of business. Box 6 gives an overview of one approach at Intermountain Healthcare.

Box 6: Intermountain Healthcare's local and diverse supplier days

Intermountain Healthcare's Local and Diverse Supplier Days brought together diverse and local suppliers to learn about doing business with the health system and build relationships with purchasing decision makers. Intermountain worked with their external partners—like the local chambers of commerce, Utah Black Chamber, and other economic development organizations at the state and city levels—to get the word out to vendors throughout their service area. The message was simple: "Intermountain is open for business. We'd love to do business with diverse and local organizations, and this is how we're going to do it." Intermountain invited potential vendors to the supply chain center, just outside of Salt Lake City. And they also brought in all of their internal purchasing decision-makers. The category leaders or solutions directors sat at tables with a sign for their focus area: "Med-Surge" or "Food and Nutrition," for example. And after an educational session, all of these vendors could go around to the different tables and meet the internal stakeholders. Reflecting on these events—turned into virtual events by the COVID pandemic—Shane Hughes, the director for supplier and community relations director within Intermountain's Supply Chain said: "Those were wildly successful, we were exposed to a lot of pretty amazing organizations that not only have great products or services, but they also serve the community."

- **Vendor capacity-building programs:** At least three programs have developed targeted programs to provide capacity-building training to local, diverse vendors. Kaiser has partnered extensively with the Inner City Capital Connections Program to train dozens of cohorts of small businesses across the country, University of Maryland Medical System worked with their business school colleagues to train a cohort of diverse business owners in Maryland (see Box 7), and MD Anderson "offers an annual 'Supplier Capability Development' training where they provide a comprehensive overview of the sourcing and procurement processes within the health system, and share best-practice resources. Attendees receive information about human resources, back office support, and contracting."

*Box 7: University of Maryland Medical System's MWBE
Supplier Capacity Building Workshops*

University of Maryland Medical System (UMMS) trained their first cohort of about 20 local Minority and women-owned businesses in 2022, despite having a supplier diversity program less than 2 years old. In partnership with the University of Maryland Robert Smith School of Business (UMD Smith), UMMS supported a seven-week workshop to help build a pipeline of “qualified and viable” MWBE companies that can do business with UMMS. The first 7-week workshop focused on developing a value proposition for the Business, describing capabilities related or organizational effectiveness, financial health, and competitive advantage, and how to write a succinct capability statement for an RFP. Additional workshops will be provided on other topics identified in conversation with local MWBE vendors and stakeholders.

- **Data dashboards and reporting tools:** Whether created in-house or through an agreement with a vendor, nearly all participants talked about how a data dashboard has been vital for both identifying opportunities and tracking progress toward goals. These data dashboards categorize the spend across the organization and show how much spend is going to different categories of vendors (e.g., MBE, WBE, local, etc.) One participant said:

We’ve been able to develop dashboards and data reporting tools that can measure our baseline and allow us to have meaningful conversations with the departments to start looking at creating actionable plans to move the needle.

Dedicated individual or team to coordinate and lead the effort

Noting the diversity and number of stakeholders that need to be engaged and aligned, all but one participant argued that effective implementation required a dedicated staff member or team to coordinate and lead supplier diversity and local purchasing implementation. The one participant who didn’t argue for the importance of dedicated person commented:

Before, I used to be a big proponent for a dedicated person, but I think it needs to go beyond that. And this is what we're trying to do now, highlighting the range of staff engaged across the organization.

However, others directly disagreed with this approach:

I think, where organizations might have misconceptions . . . is that supplier diversity does not need dedicated individuals. . . folks should just be doing it. [Supplier diversity] should be a part of their job. Maybe once you get the competency embedded into the organization, it can go that way. But that's not what I'm seeing, even companies very far along. . . they still have people dedicated to it.

Participants noted many variations and opinions on where in the organization a staff member or team could be located: supply chain, within operations and a peer of supply chain, or even within a Community Impact or Community Engagement Office. See Table 6 for the way supplier diversity/local purchasing program were organized and staffed among participants and examples highlighted in the literature.

Table 7: Staffing of Supplier Diversity/Local Purchasing among participants and the literature

Where is the responsibility?	Team Composition	Number of systems
Supply Chain	Manager/Director + team with 1.5- 4 FTEs	6
No Dedicated Staff	No dedicated FTE or staff (Anchor Mission and Supply Chain conduct activities)	2
Combined Responsibility	1 combined FTE (shared between Anchor Mission and Supply Chain)	2
Supply Chain	Manager/Director only	2
Supply Chain	Manager/Director + Interns	2
Operations	<u>3-4 person team</u>	1
Business Enterprises	6+ team	1

Two participants argued for locating the supplier diversity function outside of supply chain, human resources, or an HR-focused Office of Diversity, Equity, and Inclusion:

So, it really should be that the supplier diversity leader should be the peer of the supply chain leader. Because the supply chain leader is always going to find reasons to not actually achieve this goal.

I've seen [the head of supplier diversity] organized and structured, a lot of different ways. I've seen this role report into HR, which I don't think is a good place to put it. . . This is my first role that I've had in 25 years where I sit in operations and didn't report into supply chain. . . And I think that's a good thing, because I don't have the supply chain CPO (chief procurement officer) coming to me and saying that our priority is savings . . . [My priorities] come from the Chief of Operations that I report into.

Most supplier diversity programs are housed within supply chain. None of the participants with this arrangement raised concerns about this structure—and a few talked about the benefits. For example, these two quotes pulled from the HAN toolkit highlight the insights from two supplier diversity experts:

What we have found to be a best practice is to have supplier diversity embedded in supply chain, because that is where the decisions are being made.

This placement [within supply chain] helps convey within the organization that this is a business imperative, and it helps ensure there is someone who can focus on accountability across departments.

Several participants highlighted the importance of formal or informal connections with government relations, community health, Anchor Mission and/or Diversity, Equity, and Inclusion offices. Some participants highlighted the value of convening committees or councils of internal stakeholders to support education and accountability across the organization. (See the Political and Human Resources Frame for more on a dedicated resource.)

4.2.2 Approaches in the political frame



Participants described several approaches aligning with the political frame, including strategies to build leadership buy-in, negotiate with stakeholders, and how to define a business case for local and diverse purchasing.

Building leadership support and buy-in

As previously discussed, one of the primary challenges related to the political frame—and one topic that participants were quick to highlight—was building leadership buy-in for supplier diversity and local purchasing and linking any purchasing goals into the health system’s business strategy. Here were a few of the strategies described by participants that resulted in senior leadership buy-in:

- **A “leading from the middle strategy.”** Several participants described the value of getting the language of diversity, anchor institutions, and impact purchasing into the vernacular of the organization and used by mid-level and senior leaders, even before the system’s CEO was on board.
- **Formal approach of pitching a business case to leadership.** In at least two systems, an intern or doctoral student did the background work to pull together a pitch for supplier diversity or anchor strategies more broadly.
- **Having a motivated senior leader or CEO.** Several systems saw their push toward supplier diversity come directly from the top.
- **State Regulations and Compliance.** Hospitals with public ownership reported getting into supplier diversity initially because of state regulations and compliance.

Participants also identified some key actions that helped mediate and strengthen leadership support for supplier diversity and anchor strategies. For example, several participants described how joining the Healthcare Anchor Network (HAN), signing the Impact

Purchasing Commitment, signing the 123forEquity Pledge,¹⁸ or even applying for a grant played a key role in building buy-in and getting momentum behind the work. For example, one participant described:

[Joining the Healthcare Anchor Network] really ignited the energy behind the program; it offered some structure and guidance and mission, so it helped articulate 'why' to the organization.

Similarly, one participant described how the thoughtful use of data—and a healthy dose of competition—helped elevate the importance of supplier diversity among senior leaders:

When we looked at our spend and recognized that [there] was a minuscule percentage of our overall spend going to minority- and women-owned firms, senior leadership was shocked. They're like, "Whoa, it's that little?" And we're fairly competitive. They didn't want to accept it, but we had to get over the shock and translate that into some specific intentional action around a strategy to increase the level of spend with our minority- and women-owned firms.

Stakeholder negotiation tactics

One approach that falls clearly into the political frame is negotiating with external stakeholders. One participant summed up their approach when looking for new diverse and local vendors using classic negotiation language: "We look for those win-win opportunities." Some strategies raised included asking vendors what they are looking for (resulting in more opportunities for those win-win opportunities), ensuring that all internal stakeholders are aligned when heading into a contract negotiation or status meeting with a vendor where supplier diversity is on the table, and clearly setting expectations with vendors and the

¹⁸ In 2015, the American Hospital Association (AHA) launched the #123forEquity Campaign that called on hospitals and health systems to eliminate health and healthcare disparities. As of May 2022, 1,705 Hospitals and Health systems have joined the campaign. Read more at: <https://ifdhe.aha.org/123forequity>

organization's group purchasing organization. One successful negotiation at Rush brought more local jobs to Chicago's most under-resourced neighborhoods (See Box 8).

Box 8: Rush's vendor negotiation to create jobs

Rush's Vendor Relocated a Warehouse from the suburbs to the Westside Neighborhoods. When Rush was looking for a warehousing and distribution vendor, they included some Anchor Mission Language and Questions in the RFP, following their standard practice. One vendor, in particular, seemed eager to engage with these questions and topics. That vendor—Concordance—took time to understand the details of Rush's Anchor Mission and their commitment to the Westside Neighborhood and when they responded to the RFP, they agreed to move their warehouse to the West Side, creating 30+ jobs and putting at least a million dollars of wages, benefits, and other investments into the Westside economy.

4.3.2 Approaches in the human resources frame



In alignment with the Human Resources Frame, participants identified two successful tools and approaches that helped build success in training and motivating staff.

Playbook for local and diverse purchasing:

At least three systems have developed a “playbook” for internal stakeholders involved in purchasing decisions. While this could be seen as a structural process or tool, participants talked about the value of a playbook in orienting purchasing decision makers to local and diverse purchasing goals and in empowering them to see supplier diversity as something they were both allowed to do and had the skills and tools to act on. Box 9 gives an example from Spectrum Health. Another system described how a playbook made sense because supply chain and other purchasing stakeholders were used to working with playbooks for other job-related decisions.

Incentives and accountability:

While many participants talked about the need for incentives and staff accountability, few detailed the specifics of those arrangements. One example from CHRISTUS Health in Texas published in the HAN Toolkit describes their approach of both including goals in the organization's operational dashboard (tied to executive compensation) and building goals into supply chain associate compensation targets:

Box 9: Spectrum Health's Impact Sourcing Playbook

Spectrum Health's Impact Sourcing Playbook is designed as a how-to guide for supplier diversity. The playbook is about 40 pages long, highlighting standard definitions, the system's supplier diversity goals, recommended actions and long list of FAQs. Some specific topics include how to identify vendors; how third-party certifications work (and which ones Spectrum Health acknowledges); how to prepare for and follow up after a "meet the buyers" event; how you might "split the business" to give a diverse supplier a foot in the door; and a range of other topics designed to help staff members responsible for purchasing decisions be both informed and equipped.

Two years ago, the decision was made to add supplier diversity to the company operational dashboard. That particular dashboard is published on a monthly basis to all the regional CEOs...Every supply chain associate has a performance evaluation for compensation, and they have to meet certain indicators. Supplier diversity is part of that. There's a goal for each person. As for the CEO dashboard, that is directly tied to their bonus package.

One strategy employed to build some motivation—even without formal accountability structures within the team—is by giving credit; one of the community health participants said, "And that has been my big strategy, always elevating [the supply chain staff]. . . I'm always the one to put them first, to say they did it."

4.2.3 Approaches in the symbolic frame



Participants identified several successful contributors to building a culture of inclusion both externally with vendors and within the organization.

Building a culture of inclusion:

While multiple participants talked about the importance of a culture of inclusion, few people talked about tools that can build this. In addition to linking to larger DEI efforts across the institution generally, one participant recounted one effort she was leading with her colleagues—a book club focused on DEI themes:

And so, I have been trying to reinforce that work [building a culture of inclusion], we are kicking off a book club within our procurement department; this week we're reading Blind Spot.

Another system described using a special event to help change mindsets by allowing leaders and decision-makers to see first-hand the opportunities available to work with more diverse vendors (See Box 10).

Box 10: University of Chicago Medical System's Professional Services Symposium

University of Chicago Medical System's Professional Services Symposium:

Early on in their local and diverse supplier journey, the leaders at University of Chicago Medical System acknowledged the need to think differently as an organization for inclusive business practices to take hold. One attempt taken was to launch a Professional Services Symposium—with invited participants included the president, others from the C-Suite, and a handful of local and national minority and women-owned firms providing investment banking, legal services, IT consulting, HR, and other professional services. At that time executive leaders weren't accountable to any supplier diversity or local purchasing goals. So, in addition to allowing leaders to hear about new opportunities, the supplier diversity team shared some success stories of existing partnerships already happening with diverse vendors. Recounting the value of that event, James Williams recounts: "And the CFO said, 'Oh, I had no idea. These guys can manage our money, or this other firm can do professional development work that HR was thinking about doing.' . . . Those ah-ha moments allowed us to overcome the initial barriers to using new, diverse vendors. . . and to change the perception that, oh, maybe what I thought about those firms, which are really assumptions, might not be true. I need to probably give them a chance because they might be able to bring value that I didn't even think was there."

Clear and accessible information:

At least three participants described efforts to build excitement and interest among staff by creatively and intentionally sharing success stories that raise excitement for the initiative. One supply chain leader shared:

So, we've shared a lot of these successes across the organization, and we've released press releases, to kind of share and demonstrate the “why” behind a lot of the things that we're working on. And that's been helpful, but I think we need to focus on it more and call out a lot of the leaders that are doing great work on it. . . to get some of their colleagues on board as well. So hopefully, that will get the mass moving in the right direction.

Another supplier diversity leader focused a significant number of comments on the use of data, along with a narrative of community impact, to drive engagement and help build this approach to purchasing:

Because we have the metrics, because we have the narrative, because we've been able to demonstrate success and the data. . . the convincing time has been cut in half, you know, we get support and buy-in a lot faster.

While several participants described generally the value of storytelling, narrative, and data in creating a culture that supports purchasing from local and diverse businesses, only a few recounted the methods for sharing that information—for example on an external website, leadership dashboards and priority lists, and other places that people both inside and outside the organization go to get information. Two participants said:

One key step is to ensure that information about how to work with the institution is readily accessible to potential vendors.

My legacy is that we have an organizational commitment that is on our external facing website . . . without that, it becomes a “nice to do” for staff.

Commenting on the importance of holding a big event that highlights a new agreement with a diverse and local vendor, another participant said: “It was to the point where you had a

ribbon cutting, and the alderman was there, and the mayor's office, the mayor was there, and our CEO, and it was a big deal.”

Intentional efforts to understand vendor needs:

A few participants talked about creating a welcoming environment for diverse suppliers if they want to be true to the goals of supplier diversity—for example by always following up when someone registers in the portal and specifically asking about challenges, roadblocks, and needs that the health system could help overcome. Another participant focused on the value of ensuring that the perspectives of vendors are taken into consideration when planning any system or policy changes. But taking these types of approaches not only requires resources but a decision that it will be worthwhile and valuable.

Several participants hinted at the fact that supply chain leaders might not fully grasp the realities and challenges facing small, local minority- and women-owned businesses. One effort to address this is creating a culture of ongoing dialogue (for example through an external advisory council or a survey about barriers) with vendors. Two participants recounted:

Once we figured that [there were multiple needs of partners we weren't aware of], we decided to do a massive survey just to determine, not only what the more prominent vendors' barriers were, but also what might help get through those barriers. Essentially it was a gap analysis of those barriers and what it would take to do business with our system.

The Advisory Council [allows us to have] a pulse of the community. I've never had an Advisory Council prior to coming on board to this organization, but I really like the benefits . . . I'm not developing things in a vacuum; I'm developing it with the community at the heart. You don't want to just design something that you think that might be effective, and you might be totally missing the mark.

Leveraging special projects to drive change

At least two participants highlighted the role that special projects and initiatives—often in the construction space—can have in creating change in other parts of the system. And sometimes it is easier to focus efforts on a smaller, more defined area than looking across the entire supply chain. Box 11 highlights another example from the HAN Toolkit that utilizes this approach.

Box 11: MUSC leverages construction project to drive change

The Medical University of South Carolina (MUSC) leveraged a construction project to double-down on their commitment to working with diverse vendors, focusing on those based in South Carolina. In 2014, MUSC announced a \$350 million dollar project to construct a new children’s hospital and women’s pavilion. Leadership immediately recognized the procurement opportunities this project could offer to minority- and women-owned business enterprises (MWBEs), from the construction itself, to information technology contracts, to the sale of equipment. MUSC emphasized that these opportunities would set a new standard of doing business with MWBE and local vendors. After a vendor outreach event focused on the project in October 2014, Regine Villain, MUSC chief supply chain officer, emphasized this, stating in a press release: “It was also important to reach outside MUSC to get the input and participation from key community stakeholders. MUSC has tenure within the community; it was only right to continue to promote local and minority vendors. We recognized that we needed to reach out to minority vendors and let them know: ‘We want to know what you do.’” (Quoted from the HAN Toolkit).

5. A New Model for Understanding Local and Diverse Purchasing

As evident in the preceding analysis, the nuances and complexities of supplier diversity and local purchasing in healthcare are numerous. Getting started and building an effective program takes time, dedication, and tenacity. With big variations in local economic and organizational systems, effective approaches and practices may look different from health system to health system. Still, some key themes emerged that shed light on the reasons behind these challenges and what approaches might be most effective for moving impact purchasing initiatives forward.

In this section, I synthesize a model that identifies the root causes of why it is difficult to increase purchasing from local and diverse vendors. I then explore how common approaches intersect with these root causes—affecting their success or failure—and how a multi-frame analysis provides additional insights into strategy development.

5.1 The complexities of local and diverse purchasing

Box 12 summarizes the most significant factors that impact the design and implementation of supplier diversity and local purchasing efforts in healthcare systems, organized according to the Bolman and Deal four frames. This list integrates findings from the previous qualitative analysis, together with insights from the literature review.

Box 12: Key takeaways about the complexities of local and diverse purchasing

Structural Frame



- Diverse/local businesses often lack access to capital and scale to buy and sell at a competitive price, the result of a long history of unequal access to capital and development. Creating a level playing field in the present will not immediately undo the impacts of decades (if not centuries) of unequal access to capital and wealth.
- Rapidly changing regulatory and clinical quality requirements add complexity to requirements for hospital contracts, creating barriers for local/diverse vendors to enter the market.
- The thin margins, along with social and political pressure to further reduce healthcare costs for the last 20+ years, has pushed healthcare systems to use bigger contracts to achieve economies of scale and reduce the number of vendors to save resources in vendor management.
- As contracts have shifted over time to larger contracts with nation-wide, white-owned, or publicly traded companies, hospitals have become accustomed to working with the same large, national vendors.
 - Increasing business with local and diverse vendors requires changes to systems and processes for making purchasing decisions in healthcare.
- Nearly all hospitalize utilize Group Purchasing Organizations (GPOs), which tend to inhibit opportunities for small, diverse, and/or local vendors.
 - GPOs are increasing contracts with minority owned vendors—but often focus on vendors with a national/regional scale. Some GPOs are better at this than others.

Box 12 (Continued)

- Analyzing the hospital's baseline spend with diverse and local vendors is usually the first step, but it is fraught with challenges.
 - Some key issues include: Complex and nuanced definitions for what counts and what doesn't, limitations in data sources, and need for systems and support to manage data enrichment.
- Purchasing decision-making power is shared between the supply chain office and a broad range of purchasing decision makers (requisitioners, approvers, and end-users) in every department and entity across a health system.
 - How decisions are made varies depending on the level of centralization that exists within the health system. Staff understanding of how decisions are made—even within a single system—can also vary, often due to lack of role clarity.

Identifying MWBEs and local vendors requires significant staff time, since available lists are not comprehensive or easy to use. This is often the primary focus of a designated supplier diversity/local purchasing staff member, leader, or team.

Political Frame:



- Nearly everyone agrees CEO and C-suite leadership buy-in is important—but buy-in can't just be lip service and must include adequate resourcing and roadblock reduction.
- The near future looks bleak for the bottom line of hospitals, leaving little room for non-essentials. This means linking supplier diversity/local purchasing to the business strategy of the healthcare system is more important now than ever.
- The business case for local, diverse purchasing looks different in healthcare than other sectors, and the growth in value-based payment models creates an opportunity to link local and diverse purchasing to population health strategy.
- Local, diverse purchasing is more of an exercise in negotiation and stakeholder organizing than anything else, with hundreds of potential partners, both internally and externally.
- Several political considerations—like a push for more resilient supply chains and the growing focus on diversity, equity, and inclusion—might help accelerate efforts.
- Prioritizing 'impact purchasing activities requires a few key decisions:
 - How to prioritize, distinguish and reduce competition among goals for local, diverse, and sustainable purchasing?
 - How to balance activities that improve numbers/metrics against activities that will have a bigger impact (i.e., shifting distributors or add-on MWBE layers vs targeted local activities that create jobs in under-resourced neighborhoods)?
 - How to balance special projects vs changes in operational spend?

Human Resources Frame



- People in healthcare are busy. Supply chain teams and purchasing decision makers do not have time to look for or provide extra support to a small diverse or local vendor.
 - Whether or not something is written into a job description, or a compensation plan can determine whether it gets done—and this matters at both the staff and the leadership level.
 - Intrinsic motivation often powers efforts on local and diverse purchasing but is not always strong enough to stand against conflicting priorities and emergencies.
- Educating and orienting hospital staff requires constant attention. Tools, like job aides and accessible lists of vendors, help get the job done by empowering staff to act but developing them takes significant energy and effort.
- Staff leading this effort need a range of skills, from negotiation to communication to project management to cultural competency.

Symbolic Frame



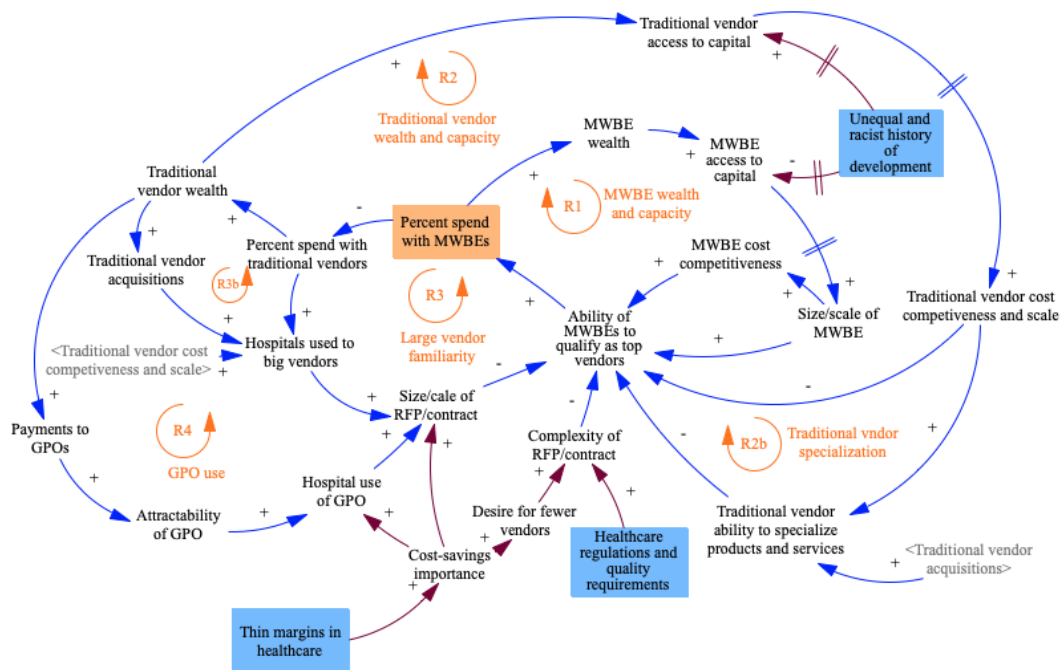
- Cultural shifts in our society impact receptivity toward local and diverse purchasing goals (e.g., antiracism, the workforce crisis, and the COVID-19 pandemic).
- Implicit racial bias and inaccurate perceptions about the quality of minority vendors create roadblocks to doing more business with minority-owned businesses. Addressing and mitigating this takes multiple approaches:
 - Clarifying linkages between Diversity, Equity, and Inclusion (DEI) and supplier diversity efforts.
 - Developing targeted ways to build mindsets of inclusivity through real connections with vendors.
- Hardwiring supplier diversity and local purchasing takes intention, including constantly telling stories, celebrating successes, and visible implementation.
- Supplier diversity and local purchasing efforts will not be successful without real linkages to MWBE vendors and stakeholders in the local community. This ensures that proposed solutions match real needs, engage vendors, and build trust.

5.2 Root causes of minimal purchasing from MWBEs and local vendors

To understand the ‘why’ behind the challenge of increasing spending with diverse and local businesses, I created a series of causal loop diagrams to visualize the relationships among the many complexities described above.¹⁹ Visualized as reinforcing loops, Figure 9 identifies four important ways that hospital purchasing structures, policies, and decisions reinforce low levels of spend with minority- and women-owned businesses.

- **Loop 1—MWBE wealth and capacity:** Hospital spending with an MWBE directly increases that MWBE’s accrued wealth and its ability to access or leverage capital. This helps build scale, size, and cost-competitiveness, allowing that business to compete for more hospital contracts. If spending with MWBEs is low, you see this play out in the opposite direction with steadily decreasing ability to do business with hospitals.

Figure 9: Causal loop diagram of the root cause of low hospital spending with MWBEs



¹⁹ Flip back to section 2.3.3 for a primer on deciphering a causal loop diagram.

- **Loop 2—Non-MWBE/traditional vendor wealth and capacity:** The same loop as above except describing the growth of non-MWBEs or traditional vendors. As hospitals do more purchasing from these businesses, they develop capacity and scale which positions them to compete more effectively for future hospital contracts. A sub-component of this loop has been a long history of mergers and acquisitions that have allowed traditional hospital vendors to diversify and specialize their offerings to hospitals, further increasing their competitiveness.
- **Loop 3—Large vendor familiarity:** As spending with traditional vendors has increased, hospitals have gotten used to doing business with these larger vendors. This has led hospitals to further increase the size and scale of contracts, making it harder for MWBEs to compete. As above, acquisitions and mergers in the marketplace and the use committed contracts that require a full service or product line to be provided by a single vendor, further cement the use of large, non-MWBE vendors.
- **Loop 4—Use of Group Purchasing Organizations (GPO):** Like the way that hospitals have gotten used to doing business with larger vendors, they have also increased the use of Group Purchasing Organizations which consolidate spend across many hospitals, again increasing the size and scale of contracts and limiting participation from MWBEs. While much of this is driven by the hospitals' interest in cost saving, there are also GPO policies that reinforce the cycle, like vendor payments for inclusion in the list of contracted vendors for member hospitals to purchase from.

In addition to these four loops, there are three historical, social, political drivers that have powered these reinforcing loops, resulting in a continued, low level of spending with minority- and women-owned businesses:

- **History of unequal development:** For decades, minority business owners have lacked access to capital, structures and supports that have been available to white, male business owners. This unequal development has added power to loops 1 and 2 (the development of wealth and capital for both MWBE and non-MWBE vendors). For minority-owned businesses, this can be traced to laws about red-lining, racism in banking, and decreased opportunity for doing business equally. Women-owned businesses have been challenged by social norms about family/childcare expectations and sexism in the workplace (and other places where decisions are made).

It is worth noting that both loops have significant delays (signified by the double hash sign). Even with access to capital, moving a business to scale and size is a slow process. With decades of unequal wealth and capacity, we can't expect the problem to be solved overnight.

- **Thin Margins in Healthcare:** Thin margins in healthcare (particularly among non-profit hospitals) and the overall political pressure to reduce healthcare costs have continued to push hospitals to achieve cost savings, often realized by building economies of scale, resulting in larger and larger contracts over time.
- **Regulations and Quality Requirements in Healthcare:** Healthcare organizations are required to purchase items that meet the highest quality standards and the needs of providers and patients. This requirement, coupled with significant regulations driving

decision-making, results in contract specifications that are increasingly complex and challenging to implement for all but a few experienced vendors.

Putting these concepts together, we can identify two primary root causes (in Lean Six Sigma language) of why hospitals do so little business with minority and women owned businesses. Externally, a history of unequal access to capital and opportunity has limited the ability of minority and women owned businesses to develop the scale and capacity to compete effectively for hospital business. Internally, hospital contracts have gotten bigger and more complex over time, largely as a result of regulatory and quality requirements, pressure to reduce cost due to thin margins in non-profit healthcare, familiarity of hospitals in doing business with big, national vendors, and the increasing use of the group purchasing organization.

Similar root problems exist for the question of why hospitals have purchased less and less from local businesses over time. The major difference from the MWBE diagram is the removal of the history of unequal and racist development policies and the additional driver of high labor costs, particularly in localities like New England (See Appendix H for a causal loop diagram for local vendor purchasing).

Achieving an anchor mission goal to jumpstart the economy and level racial inequities locally can be best realized through purchasing from local vendors owned by individuals from historically under-invested communities. Unfortunately, business that are both minority-owned AND local are impacted by the factors in both diagrams, creating even bigger challenges to overcome. Box 13 presents two stories from UMass Memorial Health that help elucidate the root causes of low levels of healthcare spending with local business or MWBEs.

Box 13: UMMH stories illuminating the root causes low levels of local and MWBE purchasing

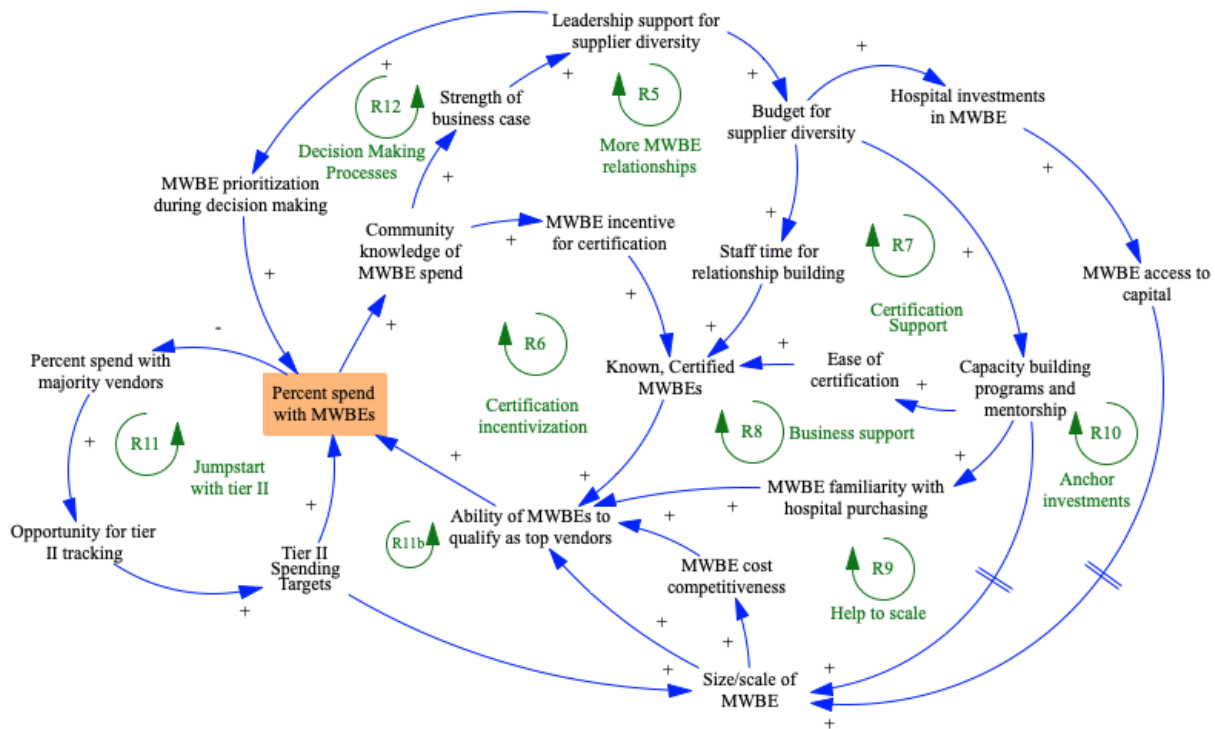
The story of Worcester Elevator Company: For decades the Worcester Elevator Company serviced the elevators of many of the hospital buildings that now make up the UMass Memorial Health system. About 5 years ago, before UMMH had an Anchor Mission, as part of a cost-savings measure, the system put out to bid a system-wide elevator servicing contract. A national, non-local company won the award. If UMMH wanted to go back to the Worcester Elevator Company in future years, there might be challenges with their ability to scale up to meet the demand of the entire UMMH system.

A system-wide environmental services contract: UMMH is currently selecting an organization to provide housekeeping services across most of the system's campuses and clinics. One of the drivers of the decision was the need to maintain strong cleanliness scores—something not equally achieved across the many entities of the system. Only a handful of large, national vendors can meet such requirements. Another driver was reducing the effort and cost required to manage multiple vendors and agreements (this also helps ease reporting requirements). Even if some activities can be sub-contracted to MWBEs, the opportunities for wealth-building of those vendors will be more limited than through a direct agreement with UMMH. In a recent turn of events, the system is now contemplating bundling this contract with food services, making an even larger contract (and a significant opportunity for cost savings, as seen by other recent health systems who've gone this route.) This RFP was the first system RFP requiring responses about DEI commitments and Tier 2 and living wage reporting and targets—presenting a real opportunity for progress despite the above complexity.

5.3 Common countermeasures to increase local and diverse purchasing

Across healthcare systems, there are several common approaches to increasing spending with minority- and women-owned businesses (MWBEs). Figure 10 depicts another causal loop diagram that outlines eight strategies—or countermeasures in LEAN Six Sigma language—often used to increase MWBE spend.

Figure 10: Causal Loop Diagram of common countermeasures for increasing MWBE spend



- Loop 5—More MWBE relationships:** One commonly reported challenge is knowing who the available MWBE vendors are that might be able to fit into the healthcare supply chain. Identifying and getting to know vendors requires significant staff time to navigate the dense field of external partners, coalitions, and individual vendors. Relationship-building can include one-on-one outreach, vendor registration portals, vendor fairs, and published bid calendars. As hospital staff build relationships with more vendors and partners, MWBEs are more likely to be included in RFPs and potentially able to be selected as the vendor. Dedicated staff time for relationship-building requires resourcing and leadership support, which comes more easily with successes in increasing spend with MWBEs.

- **Loops 6 and 7—Certification incentives and support:** Similar to the above, one step that is often missing in the vendor identification process is finding diverse vendors who are “certified” by a third party. A common strategy to correct this is to get the word out to those vendors—often through coalitions and trade groups and chambers—about the opportunity for more business if the vendor gets certified. Another approach is to help businesses go through the certification process with some technical assistance.
- **Loops 8, 9, and 10—Capacity building and support:** Other approaches to increasing MWBEs include: a) increasing the business’s familiarity and experience with the hospital systems and other large vendors (e.g. responding to an RFP or working around regulations); b) increasing the scope and scale of existing businesses to better fit the needs of the hospital through other capacity development programs and mentorship; and c) directly investing from the health system’s endowment with a business that could fit into the supply chain to build its capacity and scale.
- **Reinforcing loop 11—Jumpstart with tier II:** Another common approach is leveraging partnerships with national, large, traditional vendors to increase hospital resources going to MWBEs (through tier II or the vendor’s spend in fulfillment of the hospital’s contract) and to increase the capacity and scale of MWBEs through mandated mentorship and sub-contracting practices. This can happen without making substantial changes to the vendor selection process.
- **Reinforcing loop 12—Decision-making processes:** Another countermeasure is incentivizing or prioritizing purchasing from MWBEs when key internal stakeholders are making decisions about purchasing goods and services. This is reinforced by stronger

leadership support for local and diverse purchases, which can be increased by a stronger business case for the work and documented success purchasing from MWBEs.

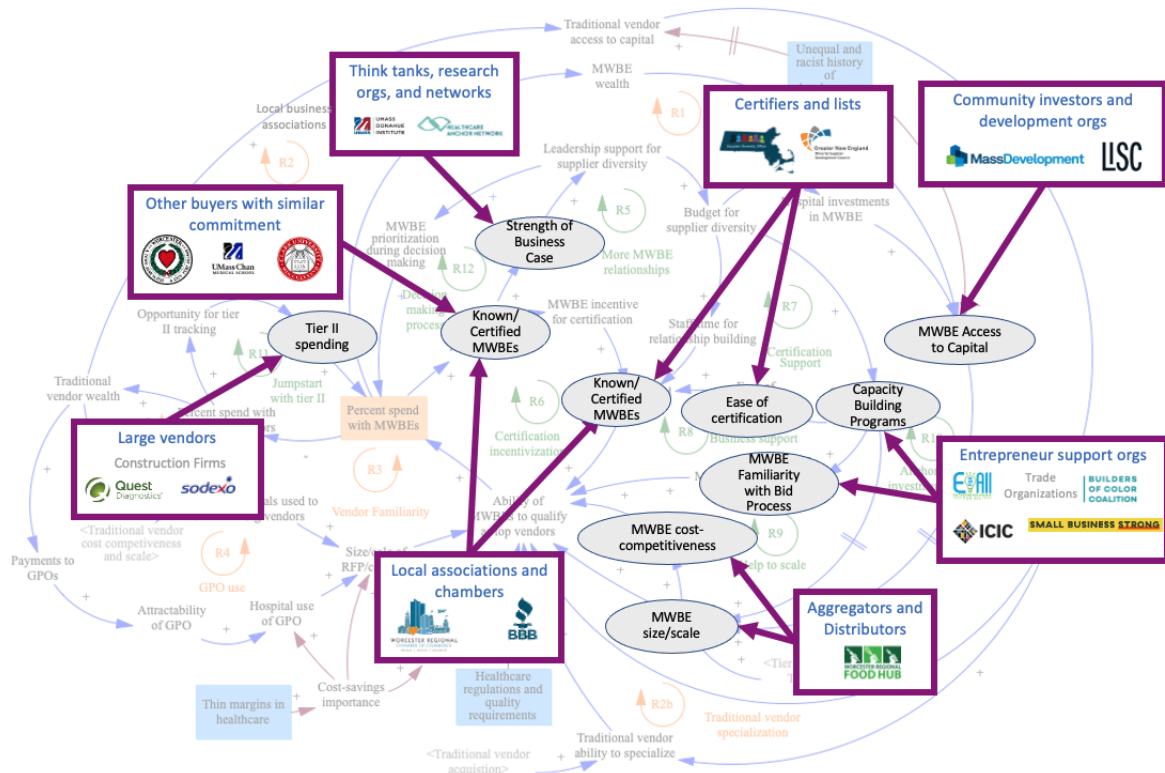
Many of the same countermeasures used for increasing MWBE spend are commonly utilized for increasing local spend. The biggest difference might be the process of identifying local businesses—since local businesses don’t need to ‘certified.’ Building a base of local businesses, however, requires a more personal relationships than when pursuing non-local MWBEs given the importance of relationships in most local communities (see Appendix H).

5.4 Putting it all together and some reframing

Putting together the two sets of causal loop diagrams described above provides a useful picture of how the countermeasures used in healthcare supplier diversity and local purchasing efforts address the root causes of low levels of spend with local and diverse businesses. See Appendix H for a full causal loop diagrams for both MWBE and local purchasing in healthcare.

The most well-developed and detailed countermeasures identified in the literature and through expert interviews nearly all focus on the external root cause of reduced scale, capacity, and familiarity with hospital bidding among minority and women-owned vendors (see loops 5 to 10 above.) Hospitals are not the only institutions working to address pervasive inequities, support local and minority business, and develop countermeasures to build the competitiveness and scale of MWBE businesses. By identifying opportunities for alignment with partners, sharing plans, and jointly building strategies, those countermeasure loops can be activated to build MWBE, and local, capacity and wealth. Figure 11 identifies some of the key areas where resources from partners can add momentum to countermeasures aimed at identifying MWBEs and building their capacity.

Figure 11: How Partners Can Help with Identification and Capacity Development of MWBEs



Two of the countermeasures acknowledge or address the root problem of increasingly large and complex contracts in healthcare. One of those countermeasures (Loop 12—Kickstarting with tier II) focuses on working with large, national, traditional vendors to increase their spending with MWBE and local vendors and implement other creative strategies (like mentorship agreements or local job creation). This countermeasure seems to be particularly promising because its impact builds off (rather than fights against) the reinforcing loop of consolidated and complex contracts.

The other notable countermeasure focuses on changing the way that hospitals make purchasing decisions internally (Loop 13—Decision-making processes). For example, healthcare institutions have begun score-carding vendors against a set of diversity and local metrics, requiring that all RFPs are shared with at least one MWBE or local vendor, or decreasing the

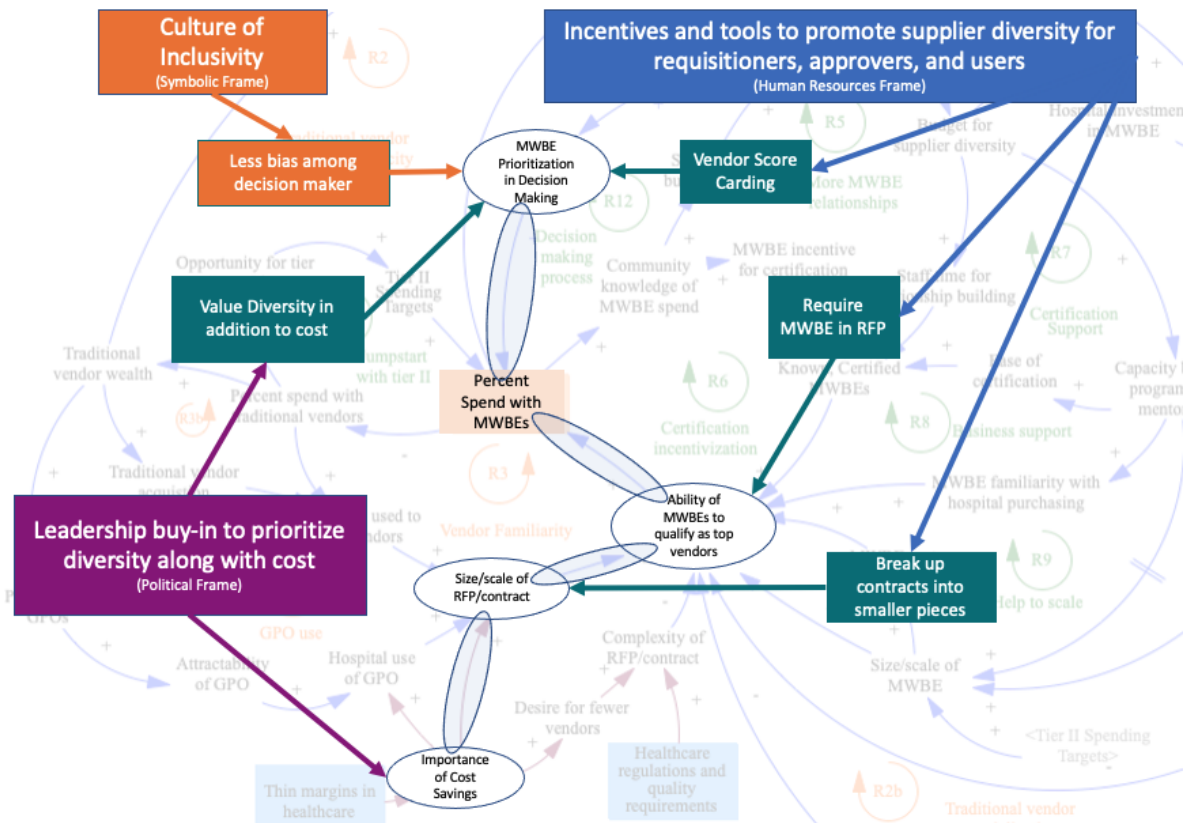
implicit bias of purchasing decision-makers. These internal changes must accompany externally facing efforts with MWBE and local vendors if the healthcare system has any chance of addressing the root problems of minimal levels of purchasing from MWBEs and local vendors.

While a few experts have described countermeasures that even more directly target these reinforcing loops, there are few examples of them actually being implemented in healthcare (e.g., breaking contracts up into smaller pieces and being willing to pay a higher cost to a diverse or local business). Making progress on these internally focused countermeasures will require action in all four of the Bolman and Deal frameworks, including: incentivizing staff to make decisions differently (human resources frame), prioritizing differently the relationship between diversity and cost (political frame), and decreasing bias among decision-makers (symbolic frame). See Figure 12 for a graphic depiction of these internal process and decision-making countermeasures overlaid on the causal loop diagram presented above.

As healthcare systems develop and sustain supplier diversity and local purchasing efforts, intervening effectively requires interrupting the multiple root causes through coordinated actions in multiple areas, in partnership with others in the healthcare sector and local community.

Finally, this model only represents the complexities and systems surrounding supplier diversity and local purchasing in healthcare at one point in time. Ongoing re-evaluation of the system—including listening and learning about the needs of MWBE and local vendors as well as hospital purchasing stakeholders—will be vital for creating meaningful, sustainable change—both in local communities and among those business owners who have had limited opportunities to access capital and build wealth.

Figure 12: Reframing internal countermeasures to increase MWBE spend



6. Implications

This section begins with a deep dive analysis into the unique considerations and ecosystem at UMass Memorial Health for the implementation of a local and diverse purchasing initiative, referred to as “anchor mission purchasing” within the organization. Drawing from this analysis and the new model for understanding the complexities of local and diverse purchasing in healthcare, I provide a set of recommendations for UMass Memorial Health’s effort to leverage their purchasing power to drive economic growth among the diverse communities of central Massachusetts. I then provide eight overarching recommendations for other healthcare systems who want to grow and expand local and diverse purchasing initiatives within their organizations and close the paper with some final conclusions.

6.1 UMass Memorial Health Analysis and Recommendations

When leaders and staff across the organization were asked about the status of anchor mission purchasing at UMass Memorial Health, the answers ranged from satisfaction and general optimism to frustration about progress. Several individuals suggested that the efforts to date have laid an invaluable infrastructure for success in the future, noting that this work isn't linear but more like a hockey stick (slow progress at first but ready to take off), a step function, or a painting taking shape only after enough brushstrokes have been made to render an image recognizable. Many pointed to the need for more clear goals and targeted activities that will move the system from theoretical planning to actual implementation.

Several UMMH employees noted that the size and composition of the Worcester and central Massachusetts economy makes it a unique place to implement supplier diversity and local purchasing initiatives, particularly when compared to the approach needed in a larger city like Boston or Chicago or Cleveland where most of the best practices and success stories have been developed. One key differentiator of a smaller market like Worcester is the heightened importance of building credibility and partnerships when establishing a new initiative. Additionally, some strategies and targeted business development efforts might lack the opportunities to scale that might be possible in a bigger city with a larger concentration of healthcare providers (for example, more creativity might be needed in trying to build a hospital laundry business or sharps disposal business since the demand from a single organization might not be sufficient to drive growth).

While the external environment in central Massachusetts is marked by several unique factors, multiple internal factors also impact UMMH's approach and strategy to implement an

anchor mission purchasing initiative. As one structural factor, UMMH decided about 5 years ago to fully outsource their supply chain function to Vizient®, UMMH’s group purchasing organization. Additionally, there is no dedicated supplier diversity staff member currently responsible for building and maintaining internal and external partnerships. UMMH has made progress in both incentivizing progress via the establishment of a senior leadership compensation goal and in prioritizing the effort as a core part of the business strategy by selecting supplier diversity as one of the system’s top 10 True North metrics. So far, the anchor mission purchasing effort at UMMH has not been connected to the voices and insights of the diverse and local vendors about whom the initiative has been developed.

Box 14 contains a summary of the unique context of UMass Memorial and the surrounding area, along with an analysis of the unique organizational and leadership factors within the health system aligned with the Bolman and Deal Four Frames. Appendix I provides additional detail on the findings of this analysis.

Box 14: Summary of results from UMass Memorial Health ecosystem analysis

Overarching Context



- UMass Memorial Health (UMMH) is the largest health system in central Massachusetts, employs 16,000 people, and buys more than \$1B annually.
- UMMH is headquartered in Worcester, Massachusetts, a city of about 200,000, about 50% of whom are minorities; the system’s network of community hospitals reaches communities throughout Worcester County and a little beyond, an area of about a million people.
- The unique economy of central Massachusetts and the mid-sized city of Worcester necessitates different strategies than might be implemented in larger cities. Some unique considerations include:
 - A strong network of non-profits, community development organizations, and organized labor—and relationships are important because everyone is connected.
 - Limited demand for healthcare specific products and services (unlike in cities like Boston or Chicago)

Box 14 (Continued)

Structural Frame



- The anchor mission purchasing committee, led by 3 executives with accountable oversight from the Chief Financial Officer, drives the anchor mission purchasing initiative.
- Membership of this committee does not contain the representatives from all the entities and departments across the institution needed to make sustainable change.
- Supply chain services within UMMH is outsourced to Vizient®; there are no formal contractual incentives for Vizient® to deliver on diverse and local purchasing targets, although feedback happens informally.
- The overall UMMH purchasing policy notes Anchor Mission as a supplemental policy. Neither the anchor mission policy nor other policies and trainings detail tactics for implementation of the anchor mission purchasing goals.
- UMMH will transition to a new enterprise resource planning (ERP) system in January 2024—a critical opportunity for updating workflows and processes.
- To date, UMMH has focused on categorizing expenditure data to understand current levels of spend with MWBEs and local vendors, but this effort has been challenged by data quality concerns and nuanced definitions for reporting.
- UMMH has not yet found a good tool or process for identifying and establishing relationships with new local or diverse vendors.

Political Frame:



- UMMH is bracing for a challenging financial future with thin margins and little room for non-essentials; linking anchor mission purchasing to organizational strategy is more important now than ever.
- In April 2022, UMMH included supplier diversity as a True North Metric—One of the 10 measures tracked at the highest level of the organization. However, uncertainty abounds among staff regarding anchor mission purchasing's true importance and priority level.
- There are lots of external stakeholders to engage (see Figure 15 for a picture of them all) and limited bandwidth within UMMH staff for relationship management.

Human Resources Frame



- UMass Memorial Health set a FY 2022 supplier diversity executive compensation goal, incentivizing executive and senior leaders to support the initiative; however, there are limited accountability measures like job description language for mid- and staff-level purchasing decision makers.

Box 14 (Continued)

- There has only been limited orientation to anchor mission purchasing for staff not directly engaged through the anchor mission purchasing committee.
- No local and diverse purchasing tools or job aids have been developed or shared with purchasing decision-makers.

Symbolic Frame



- UMMH is working to build a more inclusive and diverse culture through multiple approaches, like employee resource groups, implicit bias trainings, and utilizing an ‘equity pause’ when making leadership decisions.
- LEAN/Six Sigma continues to gain ground at UMMH, prompting more opportunities for innovative thinking and process improvement to support anchor mission purchasing.
- The UMMH anchor mission purchasing effort has to date been largely disconnected from the insights and experiences of minority vendors in the community, putting success at risk.

Given this unique ecosystem at UMMH, the following seven high-level actions should propel the UMMH anchor mission purchasing effort forward in the coming months and years.

1. Update organizational structures to align anchor mission goals with standard purchasing workflows:

- Utilize the Anchor Mission Purchasing Committee for high-level strategy, coordination, accountability, and process improvement.
- Move the implementation to existing supply chain and operations teams (and when needed special working groups/sub-committees).
- Create and fund a mid-level “anchor mission purchasing coordinator” position to manage the effort, collaborate with internal stakeholders, and be a primary connector to external partnerships. If this isn’t feasible, develop a staffing plan for managing internal and external partnerships and relationships.

2. Strengthen the linkages between anchor mission purchasing and the UMMH business strategy; incentivize progress among senior leaders.

- Continue to track anchor mission purchasing data as one of the system's ten True North metrics through 2025.
- Continue to include an annual senior leader compensation goal focused on anchor mission purchasing.

3. Orient, empower, and incentivize mid- and staff- level UMMH purchasing stakeholders on the anchor mission purchasing goals, policies, processes, and tools.

- For UMMH Requisitioners, Approvers, and other Stakeholders—develop anchor mission KPIs and job description language, tools (like a mini-playbook describing the goals and suggested approaches) and tell stories about progress to recognize and build motivation for staff.
- For Supply Chain Services Team Members (Vizient® employees)—incorporate anchor mission goals formally into the contract between Vizient® and UMMH, create goals/KPIs for all supply chain services team members, and incorporate anchor mission into standing supply chain services meetings.

4. Find creative ways to interrupt the cycles that limit the ability of MWBEs and local vendors to compete for healthcare contracts.

- Explore innovative ways to create a more level playing field for local businesses and MWBEs (e.g., cut the contract into smaller pieces and/or incentivize a model that pairs an MWBE with a larger, more experienced vendor).

- Work closely (and leverage contract negotiations) with some of the largest UMMH vendors to not only have them report their spend with MWBEs and local vendors, but also to set targets and implement more impactful and creative solutions collaboratively.

5. Continue updating the UMMH purchasing policies, processes and systems with anchor mission purchasing goals in mind.

- Develop and incorporate anchor mission language into the bid and contracting process (e.g., finalizing and incorporating anchor mission language as a standard into all RFPs and contracts, incorporating an equity pause when making decisions about the terms of an RFP or the selection of a vendor, including local and diverse vendors when sending out an RFP, and updating the value analysis process to incorporate anchor mission questions).
- Build out the Supplier Gateway vendor registration process and data management portal to make data usable for decision-making.
- Leverage the Workday® transition during 2023 to set up systems, expectations and workflows that support anchor mission purchasing goals.

6. Engage and listen to diverse and local vendors, both directly and through the councils, coalitions, trade organizations, and business associations that represent them, aligning with the community development mantra “Nothing about us, without us” to ensure that all plans incorporate the voice of those impacted.

- Establish a supplier diversity or anchor mission council (perhaps convened through the Chamber of Commerce or another partner to reduce the staffing burden and create opportunities for collective impact).
 - Prioritize building and sustaining direct relationships with a few partners (e.g., City of Worcester, Greater Worcester Chamber of Commerce/North Worcester County Chamber of Commerce, MassDevelopment, Massachusetts Supplier Diversity Office, Greater New England Minority Supplier Development Council, and the Central Massachusetts Center for Women and Enterprise).
 - Build a communication strategy for vendor outreach to demystify the UMMH purchasing process, provide timely information on future opportunities, and facilitate two-way communication.
7. **Kickstart the anchor mission purchasing effort by leveraging the upcoming Beaumont Property renovation** to build momentum, create internal awareness about anchor mission purchasing, establish external partnership, test new targets and language, and begin compiling a narrative about how anchor mission purchasing contributes to the UMMH business strategy.
8. **Commit to telling stories**—both to UMMH caregivers and the broader community—about UMMH’s relationships with local, MWBE vendors. This will build momentum and motivation internally and, externally, will increase visibility of new potential vendors and strengthen UMMH’s brand as a community healing partner.

Note: Appendix J contains an expanded version of these recommendations, including the recommended individual or organizational structure owner for each recommendation or sub-recommendation.

6.2 Recommendations for Other Healthcare Systems

The following recommendations—while built from the UMMH recommendations—lay out a flexible path for other healthcare systems to take while establishing and expanding impact purchasing initiatives. These should be adapted to the unique structures and context of each institution.

1. **Develop an internal organizing, implementation, and leadership plan** that aligns with the unique structure and culture of your organization.
 - Consider convening internal council that includes representatives from supply chain, as well as key departments like facilities, IT, and other prioritized opportunity areas.
 - Link impact purchasing to your business strategy by linking to your organizations goal and mission.
 - Provide adequate resources to the effort—building and maintaining relationships with the large number of internal and external stakeholders requires significant staff time to be done effectively.
2. **Orient, empower, and incentivize both senior leaders and mid-level staff** (particularly those in a supply chain function or those who make purchasing decisions within a department, office, or entity) to move the institution’s impact purchasing goals forward

through compensation targets, job descriptions, trainings, and tools (like an impact purchasing “playbook”).

3. Engage with diverse and local vendors, both directly and through the councils, coalitions, trade organizations, and business associations that represent them, aligning with the community development mantra “Nothing about us, without us” to ensure that all plans incorporate the voice of those impacted.

- Get to know the local organizations in your area to prioritize which organizations most closely align with the health system’s impact purchasing goals.
- Consider utilizing some of the promising approaches utilized by several of the organization’s interviewed:
 - Convene (or join a collaborative) supplier diversity council for engaging a broader range of external stakeholders in two way-communication,
 - Hold a local and diverse supplier vendor fair to orient potential vendors to your purchasing system and build relationships between vendors and purchasing decision-makers.
 - Leverage a vendor registration portal, published future bid calendar, and other tools to make it easier for vendors to navigate your system’s purchasing processes.
- Don’t worry about doing all the local and MWBE capacity building yourself—there are lots of organizations out there with a common goal. Find the one or two you want to work with and put together a joint effort.

4. **Identify innovative and creative ways to interrupt the cycles limiting the ability of MWBEs and local vendors to compete effectively.** Consider some of the examples highlighted in Box 15.

Box 15: Promising ways to interrupt cycles that limit MWBE competition

5. **Build and strengthen internal processes and systems to support your impact purchasing goals.** For example:

- Generate and maintain useful and actionable data (e.g., use your data to forecasting bids or examine upcoming opportunities with different purchasing decision makers). Leverage the data insights from other health system (e.g., participating in HAN

- Break up a larger contract or project into smaller pieces.
- Set up alternative payment plans.
- Include mentor/protégé requirements in awards to large, traditional vendors.
- Establish and support mentorship agreements.
- Leverage long-term or consolidated contracting to allow a business to relocate locally or ensure long-term viability of an MWBE or local business.
- Work through aggregators and distributors to increase buying/selling power of MWBE and local businesses.

impact purchasing monthly calls) to help avoid pitfalls common across systems.

If you have an upcoming ERP upgrade, use it to create efficiencies in the system's data collection and management process.

- Make changes to your standard RFP and Contracting Processes to normalize identifying and considering diverse and local vendors. E.g., require include a local or diverse vendor when distributing an RFP; ask standard questions in the RFP about diversity, equity, and inclusion or other impact purchasing goals; incorporate impact purchasing goals into vendor score-carding/selection; and include impact purchasing language and targets in standard contract language.

6. **Kickstart your organization's impact purchasing efforts by focusing early on one or two few high profile and visible projects** (like an upcoming construction project) that will build momentum, test strategies, establish new partnerships, and give your team practice working together.
7. **Work closely with some of your systems' largest vendors** to both report their spend with MWBEs and local vendors, and to set targets and implement more impactful and creative solutions utilizing the growing expertise and capacity of some large healthcare vendors related to supplier diversity.
8. **Tell stories and document the journey.** This will help build motivation among staff, link this work to broader equity and inclusion efforts, and increase the desire of local and diverse businesses to do business with your health system.

6.3 Conclusions

Increasing business with diverse and local businesses cannot be accomplished without acknowledging the complex, historic, political, and social factors that have made it harder for black and brown residents in our nation to accumulate wealth, launch and grow businesses, and develop scale and capacity. Additionally, the thin margins in non-profit hospitals and the regulations focused on ensuring quality care have placed significant pressure on hospital systems to increase the size and complexity of hospital purchasing contracts. Combined, these factors have made it increasingly challenging for diverse and local businesses to successfully compete for hospital contracts against large, national companies who have been consolidating their wealth and capacity over decades.

But that doesn't mean that change isn't possible. It just takes seeing the whole picture and coordinating a multi-pronged (or multi-frame) approach to the problem. And this approach means not only addressing bias and decisions to level the playing field in the present but also working to unravel those decades of pressure that have resulted in the current system

One of the key requirements of a multi-pronged approach is a clearer definition of the 'why' behind the work of supplier diversity and local purchasing. This business case can be firmly rooted in the concepts of justice and inclusion (aka. the acknowledgement that supplier diversity and other anchor strategies is the right thing to do) but it must also speak to the realities of the health system's business model and bottom line. Leaders in healthcare supplier diversity efforts must continue to flesh out the components of this business case building from the concepts that doing business with diverse and local businesses drives innovation and resiliency in the supply chain, allows hospital's to deliver more culturally competent care, strengthens the hospital's brand and reputation in the community, allows hospitals to comply with increasing regulations and reporting requirements, and provides a sense of purpose and motivation for the hospital's workforce.

But even with a strong business plan, some external forces threaten the success of these new and growing local and diverse purchasing initiatives—namely the impending financial crisis and historic workforce shortage facing healthcare systems across the country. Times of austerity require difficult decisions for leaders—including cutting anything in the list of 'non-essentials'. Many hospital systems have yet to truly integrate supplier diversity and local purchasing efforts into the core business strategy of the system, increasing the likelihood of reduced resources and focus on supplier diversity.

As a further exploration of this topic, Richard and his colleagues (2015) measured how supplier diversity initiatives impacted both long-term profitability and short-term productivity in sectors with various levels of resources. In sectors with limited resources and slow growth, supplier diversity was linked to increases in productivity; while in sectors with fast growth and plentiful resources, productivity actually decreased in organizations with supplier diversity. This aligns with anecdotal evidence at UMass Memorial Health that anchor mission efforts create purpose and meaning for employees which in turn is linked to better staff productivity (and perhaps supplier diversity efforts are less of a driver if the employees are actively contributing to the company's growth). The authors also found a reduction in long-term profits in institutions with supplier diversity efforts in resource poor, stagnant sectors but an increase in profits in quickly growing and well-resourced sectors (this makes sense if the biggest profit driver of supplier diversity is expanding the organization's customer base, something that only happens in a growing industry).

The healthcare sector at this point in time doesn't fit perfectly into one of these two categories. Perhaps healthcare systems—particularly those non-profit entities that are growing and expanding their book of business like UMass Memorial Health—might see increases from supplier diversity both in short-term productivity (from increased staff purpose and motivation during this time of burnout and tight budgets) and in long-term profits (from the healthcare system's continuing expansion into new areas, a changing patient base with more employed individuals, and/or new businesses that want to come to UMMH for their care). However, measuring this theory will take future research and evaluation.

As healthcare systems are feeling increasing pressure to launch local and diverse purchasing efforts, many face roadblocks in getting started. One of the first steps taken by most healthcare systems is to scrub data and build data dashboards—but this process is not simple and often requires combining data from multiple sources, enlisting a vendor for enriching data against lists of certified vendors, and matching your existing data to complex and nuanced definitions. Hospitals new to the effort should be ready for the challenge and stay focused on utility over perfection. And there is a great opportunity to learn from the experiences of others who have gone through this process recently, for example through the knowledge sharing platform of the Healthcare Anchor Network.

Another key challenge faced early in the supplier diversity journey is the lack of a clear and easy to use information source for identifying new potential vendors. But there are some common solutions—like building relationships with the certifying agencies or investing in a vendor registration portal. And once that work to identify businesses begins, additional resources from a broad range of partners can be brought in to increase the capacity, scope, and scale of those businesses.

A final challenge is that supply chain leaders and purchasing decision makers in healthcare are busy; even with strong intrinsic motivation, leaders can easily get fatigued dealing with the first two steps above. Decisions about resourcing and incentivizing the initiative easily differentiate health systems who will make steady progress and those that will flounder to move the effort forward.

And the work can't stop there. Leaders and staff need to take a thoughtful look at the internal policies and processes for how decisions are made within the health system alongside

externally focused efforts to identify vendors, get them certified, and build their capacity to respond to an RFP.

These internal and external solutions draw on skills and approaches in each of the Bolman and Deal Four Frames. From a **structural** perspective, healthcare leaders need to update purchasing processes and structures (like adding standard language about diversity, scorecards for choosing vendors, and novel contracting structures that enable MWBEs to compete effectively), ensure adequate staffing to handle the relationship-intensive work of connecting with MWBEs, and build data systems that support action and decision-making. From the **human resources** perspective, hospital leaders need to make sure that staff at multiple levels (both within the supply chain office and in departments that make purchasing decisions) are empowered and incentivized to make these changes and seek out opportunities for diverse and local businesses. There are opportunities for staff of multiple levels to take **political** action—the most senior leaders play a key role in describing how impact purchasing fits into the strategy of the organization—and therefore how diversity might stack up against cost or quality when staff are making a determination on what to buy; at other levels, negotiations with vendors large and small—and alignment with a large host of external stakeholders—can multiply the effort and create opportunities that weren't immediately available. Finally, leaders can establish local and diverse supplier efforts as an important **symbol** of the healthcare system's larger commitment to diversity, equity, and inclusion efforts by continuously telling stories about the effort as the project unfolds.

Given the tumultuous weather and every changing nature of healthcare supply chain, future and sustained success will require continually changing speed and direction—not only

with hospital staff who make purchasing decisions but in authentic conversation with local and diverse vendors and the councils that represent them. All together, these small but coordinated movements might just be enough to turn the healthcare purchasing ship in a tight channel, moving hospitals further along their journey toward improving health by strengthening local economies and breaking down structural inequities.

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Appendices

Appendix A: History of Supplier Diversity (in more detail)

Eventually growing into a core businesses strategy of thousands of firms across the US and world, the concept of supplier diversity began in the US with the civil rights movement of the 1960s. Signed into law by President Johnson, the Civil Rights Act of 1964 legislated the equal inclusion of black and brown citizens in the nation's economy and society, particularly as employees and customers. Later that year, President Johnson signed executive order 11246 which required government contractors and subcontractors to expand job opportunities for minorities.

By the early 1970s in the US, affluent—mostly white—residents had moved out of cities and into the suburbs, taking with them the wealth and capital that had once held together city neighborhoods (O'Connor, 2007; Shah & Ram, 2006). Certain policies implemented by the federal government—primarily the creation of the mortgage insurance system and the passing of the Social Security Act of 1935—had encouraged this demographic shift. One scholar notes: “With the federally paved march to the suburbs at full tilt and programs of rural modernization well underway, central cities and rural towns were continuously losing population, revenues, and the hope of survival” (O'Connor, 2007).

The Nixon campaign's civil rights agenda and plan for improving the conditions in the nation's cities focused on strengthening “black capitalism”—the idea that creating additional economic opportunity for black residents might quell urban unrest (NMSDC, 2018; Shah & Ram, 2006). On March 5th, 1969, Nixon signed Executive Order 11458 that established the Office of Minority Business Enterprise (OMBE, renamed the Minority Business Development Agency in

1979) within the Department of Commerce. Two years later, he signed Executive Order 11625 which provided a definition for a Minority Business Enterprise (MBE), expanded the scope of OMBE to include the provision of grants for management and technical support to MBEs, authorized the creation of the Small Business Administration, and directed federal agencies to develop a plan for an MBE federal contracting program (MBDA, 2021).

Throughout the Nixon and Carter Administrations, Congress passed several laws, often introduced by Congressman Parren Mitchell (D-Maryland 7), that created set-asides for minority business enterprises and expanded existing set-asides to businesses owned by women, veterans and other disadvantaged populations (NMSDC, 2018). Most notably, Public Law 95-507 required that any government contract over \$10,000 contain a set-aside for MBEs and other disadvantaged businesses, something previously only encouraged by law. These federal laws were replicated and sometimes expanded by state and local governments across the country (Shah & Ram, 2006).

In 1968, General Motors became one of the first businesses to establish a formal supplier diversity program, motivated largely by a desire to comply with regulations but also driven by the Detroit riots and innovative leadership within the company. Others in the auto (Chrysler and Ford) and other industries (IBM, AT&T, and others) followed, realizing that more effort was needed to build up and partner with MBEs in order to comply with the new and growing government regulations at the time (NMSDC, 2018).

By the early 1980s, the federal government's policymaking around supplier diversity slowed considerably. Additionally, a focus on preferential treatment for minority suppliers in federal contracts attracted legal attention that both reduced the use of set-asides and made it

more difficult to justify existing set-asides (NMSDC, 2018; Shah & Ram, 2006). But even with less government support, supplier diversity efforts continued to grow and expand as business leaders identified new benefits of working with a more diverse set of suppliers, like access to customers (NMSDC, 2018).

Established in 1972, the National Minority Supplier Development Council (NMSDC) played a critical role in supplier diversity efforts by serving as an intermediary platform for connecting corporations to MBEs, and vice versa. Many credit the work of NMSDC for catapulting supplier diversity forward through the 1990s and 2000s by setting standards and common principles, creating the concept of certifications, developing trainings and tools, and creating mechanisms for communication and networking (Adobor & McMullen, 2007; NMSDC, 2018; Worthington et al., 2008). In 1997, the Women Business Enterprise National Council (WBENC) took on a similar role for women-owned businesses (Crump, 2020). Other networks and recognition programs—like the Billion Dollar Roundtable established in 2001 to celebrate corporations who have spent at least \$1B with minority and women-owned businesses—have contributed to the growth of supplier diversity initiatives by further incentivizing excellence and innovation in the field (Crump, 2020; NMSDC, 2018).²⁰

²⁰ The NMSCD developed a quite well-done video series that traces supplier diversity through the decades, complete with interviews with key leaders and contributors. If you're interested in more nuance than my high-level summary, it's worth a watch! <https://nmsdc.org/history-supplier-diversity-minority-business-development/>. Additionally, the Hire Ground Podcast Series has several episodes tracing the history and trends in supplier diversity. <https://hireground.io/hire-ground-podcast/>.

Appendix B: UMass Memorial Health FY 2022 Strategy

Despite the challenges of the ongoing COVID-19 pandemic, UMass Memorial Health must continue its evolution to become New England's pre-eminent

integrated health care delivery system. Our promise is to

be a system that can deliver high-quality care to

individuals with acute illness and injury, while also

improving the health and managing the cost of care for

populations. Our promise is to be a system that

transforms high-level quaternary care through

innovation, while also transforming neighborhoods by addressing key social determinants of health.

Our Fiscal Year 2022 strategic plan focuses on four key strategic areas that will allow us to provide

high-quality, high-value care while creating the best possible work environment for our caregivers.

We will do this by leveraging our innovative spirit, our academic partnership with UMass Medical

School and our highly engaged and relentless workforce. Below are the four overarching strategies

and supporting operational actions that will guide our work in the coming year and beyond.



I. Our Patients: Our promise is to provide the highest quality, safest, patient-centered care to all patients, using our foundation of innovation and drive to always improve.

We will meet our promise by taking these actions:

- Fully adopt and operationalize Innovation Station as our continuous improvement platform.
- Give all caregivers training opportunities in the principles of Lean and our process improvement framework.
- Develop and execute entity-and-department-level quality and service improvement plans aimed at achieving top decile performance with comparable groups on all quality, safety, patient experience and health equity metrics.
- Create a Patient Access Center to ensure an efficient scheduling process that is supported by standardized provider templates, robust and accurate decision trees and efficient referral, financial clearance, and operational processes.

- Develop a comprehensive approach to inpatient flow and care delivery by utilizing all beds across the system and keeping appropriate levels of care for patients in a community hospital setting.

II. Our People: Our promise is to recruit and retain the best caregivers; ensure every employee has a world-class caregiver experience; and provide a safe, supportive, and inclusive work environment.

We will meet our promise by taking these actions:

- Strengthen current recruitment protocols to hire the best caregivers with additional focus on increasing diversity representation at all levels.
- Develop and execute a plan to manage our short-term and long-term staffing crisis.
- Develop and execute an equity seed program to promote inclusion, expand innovation and collaboration to promote equitable care and support caregivers of color.
- Establish a Career Development/Internal Pipeline program/committee structure that fosters advancement for all caregivers with mitigating strategies to overcome internal gaps to advancement that particularly affect diverse caregivers.
- Increase support for Employee Resource Groups (ERG) and increase participation of senior leadership at ERG meetings.
- Implement an equity and anti-racism training program for all leaders and managers, as well as a broader unconscious bias training for front-line caregivers.
- Implement an accountability framework for Standards of Respect, monitoring for usage.
- Fully leverage U Matter Central and enhance our caregiver recognition platform.
- Launch a system-wide Diversity, Equity, Inclusion and Belonging (DEIB) council to advance our DEIB goals and meet the unique needs of caregivers during this difficult moment in health care.

III. Our Community: Our promise is to improve the health of the population of our region by addressing the social determinants of health, enhancing our population health management capabilities, and ensuring equitable care for all.

We will meet our promise by taking these actions:

- Develop and execute workplans for the four pillars of anchor mission work that will explore additional community investments; hire individuals from vulnerable neighborhoods in our service areas; expand our purchases with minority and women-owned businesses; recruit more caregiver volunteers to help the community; and recruit at least one additional community organization to join our anchor mission efforts.
- Through data collection and analysis, education, and outreach, implement culturally appropriate community health transformation interventions that will improve care through community-linkage prevention models.
- Community Healthlink will provide clinical intake response to urgent requests for integrated care and specific services to address social determinants of health for clients within 24 hours and routine requests for services to clients within 10 business days.

- IV. Our Future: Our promise is to become a fully integrated care delivery system, deploy an innovative, systemwide approach to care delivery; and leverage digital health & virtual medicine platforms to improve care – all to ensure our future long-term sustainability. We will meet our promise by taking these actions:**
- Streamline breast cancer screening, diagnosis, and care across the system.
 - Grow our chronic disease management programs at the Medical Center and community hospitals, with a focus on diabetes, endocrinology, multiple sclerosis, rheumatology, osteoporosis, and geriatrics; fully utilize our new multidisciplinary clinic at HealthAlliance-Clinton Hospital to house chronic disease management services for the north country.
 - Increase enrollment in Mass Advantage – our affiliated Medicare Advantage program and grow our health insurance company footprint.
 - Build a comprehensive Hospital at Home program.
 - Execute our digital health, virtual medicine, and remote patient visit strategies.
 - Develop and execute a plan for the purchase of an Enterprise Resource Planning (ERP) application to manage all core finance, supply chain and human resources processes.
 - Develop and execute our 10-year master facility plan that will include an eastern region strategy to address Mass General Brigham’s outpatient facility in Westborough.
 - Explore and execute mergers and acquisitions that make us a more integrated health care system.

Appendix C: The Healthcare Anchor Network Impact Purchasing Commitment

To request a copy of the HAN Impact Purchasing Commitment—please contact info@anchornetwork.org.

Appendix D: IRB Exemption Letters



HARVARD

Human Research Protection Program

Harvard T.H. Chan School of Public Health
Office of Regulatory Affairs and Research Compliance
90 Smith Street, 3rd Floor
Boston, MA 02120
Federalwide Assurance FWA00002642

Notification of Modification / Update Exemption Determination

December 16, 2021

Stephanie Doan-Soares
sdoan@hsph.harvard.edu

Protocol Title:	Listening to Experts: Lessons Learned for Healthcare Impact Purchasing Efforts
Principal Investigator:	Stephanie Doan-Soares
Protocol #:	IRB21-1345
Submission #:	MOD21-1345-01
Funding Source:	None
IRB Review Date:	12/16/2021
IRB Effective Date:	12/16/2021
IRB Review Type:	Exempt

This Modification / Update continues to meet the criteria for exemption per the regulations found at 45 CFR 46.104(d) (2). As such, additional IRB review is not required.

The documents that were finalized for this submission may be accessed through the IRB electronic submission management system at the following link: [IRB21-1345](#)

The determination that your research is exempt does not expire, and you will not file annual renewals. If changes to the research are proposed that would alter the IRB's original exemption determination, they should be submitted in ESTR by using the Modify Study button. If unsure, contact the Harvard T.H. Chan School of Public Health IRB office.

Questions?

If you have any questions, leave a comment on the ESTR Workspace. For instructions on how to enter a comment in the system and notify the Review Specialist/IRB Coordinator, visit the ESTR Support Site – Communicating with Staff (<https://estrsupport.fss.harvard.edu/communicating-with-staff>).

Feedback?

If you have feedback on this submission, or your IRB review experience, we would love to have your thoughts! Please complete the survey below. It should only take ~5 minutes of your time. Thank you!
https://harvard.az1.qualtrics.com/jfe/form/SV_9WWsmv635LB82p0

University Area IRB <http://cuhs.harvard.edu>
Harvard Longwood Campus IRB <http://www.hsph.harvard.edu/orarc>

HRP-510d: Template v5/15/2020



APPROVAL

November 19, 2021

Stephanie Doan
sdoan@hsph.harvard.edu

Dear Stephanie Doan:

The IRB reviewed the following submission:

Type of Submission:	Initial Study
Review Type:	Exempt
Title:	Stephanie Doan, HSPH, IRB21-1345, Listening to Experts: Lessons Learned for Healthcare Impact Purchasing Efforts
Investigator:	Stephanie Doan
IRB ID:	STUDY000000093
Funding:	Name: UMASS MEMORIAL HEALTHCARE
Grant Title:	None
Grant ID:	None
IND, IDE, or HDE:	None
IRB Review Date:	11/19/2021
Documents Reviewed:	• Doan-Exempt Consent Script-v2.pdf • Doan-Expert Interview Questions-v2.docx • IRB21-1345 Stephanie Doan-V3.docx • Recruitment and Followup Emails-v3.docx • Stephanie Doan Correspondence_for_IRB21-1345.pdf

The IRB approved this research effective on 11/19/2021.

In conducting this research, you are required to follow the requirements listed in the Investigator Manual (HRP-103), which can be found by navigating to the IRB Library within the IRB system.

IMPORTANT: Access to the Legacy eIRB Archive closes at **5pm on Friday, February 4, 2022**. Study teams must download copies of materials for which they are likely to need ongoing access in advance of this deadline. Visit the Job Aids section of the RMS eIRB SharePoint site for the Legacy eIRB “What to Download” information folder for materials to support this process: <https://umassmed.sharepoint.com/sites/RMS/IRB>

Sincerely,

Allison Blodgett, PhD, CIP
Director of IRB Operations

Appendix E: Expert Interview Semi-Structured Interview Guide

Listening to Experts: Lessons Learned for Healthcare Impact Purchasing Efforts

PI—Stephanie Doan

Semi-Structured Interview Questions/Prompts

*Bold questions shared in advance with Participants

- 1. Please describe your involvement in impact purchasing efforts (diverse, local, and sustainable procurement efforts) at your organization?**
 - How long have you been involved in impact purchasing efforts?
 - How long has your organization been involved in impact purchasing?
 - Have you been involved in impact purchasing efforts at other organizations? If yes, what was your role and focus?
- 2. What efforts and initiatives have been most successful in moving forward your organization's impact purchasing efforts (e.g., were specific goals established and what were they? Did you target specific types of purchases that were easiest to convert?) Why were these efforts successful? How did they work to create change?**
 - Is there a success story that has been compelling in furthering your efforts?
 - What have been some steps or actions that were most important in your success?
 - Are there tools or services that have supported your success?
- 3. What have been the biggest challenges in your impact purchasing efforts? Why? How have you mitigated or overcome these challenges?**
 - Policies? Stakeholders? Silos or connections?
 - What are some strategies you've tried (successfully or unsuccessfully) to overcome these challenges?
- 4. Has your system developed a business case for doing this work? What is the 'why' behind your impact purchasing efforts?**
- 5. How has your organization structured its impact purchasing efforts (e.g., where does the leadership sit, how are supply chain staff involved)?**
 - Where does the responsibility sit within the institution?
 - Do you have a Diversity, Equity, and Inclusion Office (or something similar)? Are they involved? If so, how?
 - How are supply chain staff engaged or trained?
 - How is leadership engaged? Trained?
 - Are there any specific policy or structural changes you made? Did this require any budget support?
 - How do you work with your group purchasing organization (if you have one)?
 - What external relationships or partnerships have you leveraged for your impact purchasing efforts? Which have you found most beneficial? Why?

- Examples: Chambers of Commerce, consultants or vendors, government agencies, community development organizations, collaboratives, etc.

Further questions if time is available (these questions will not be shared in advance):

6. What advice would you give for organizations just getting started on impact purchasing?
 - Leadership
 - Vision and Goals
 - Structures
 - First Steps
7. What do you see as possible future directions of impact purchasing among healthcare institutions?
 - What are some upcoming opportunities?
 - What are some upcoming challenges?
 - What are some steps that could be taken now to prepare for the future?

Appendix F: Verbal Consent Form

This was shared with interview participants via email and referenced at the start of each interview. Before the interview, verbal consent was received from each participant.

Permission to Take Part in a Human Research Study

Listening to Experts: Lessons Learned for Healthcare Impact Purchasing Efforts

Principal Investigator: Stephanie Doan

You are being asked to take part in a research study.

This research is being conducted to learn about best practices and lesson learned for impact purchasing efforts in healthcare organizations. Specifically, we are interested in learning about specific tools and approaches that have been used by healthcare organizations, challenges and pitfalls to implementing impact purchasing efforts, and insights about how to move forward impact purchasing in the healthcare industry. You are being asked to participate in this research because of your experience leading and implementing impact purchasing efforts within your organization.

Your participation in this study is voluntary. You can decline to participate in any part of this study for any reason and can end your participation at any time.

If you take part in this study, you will be asked to participate in an audio-recorded 45-60 minute semi-structured interview. Specifically, you will be asked a number of questions about your organization's impact purchasing efforts and your recommendations for other healthcare systems working to leverage their purchasing power to drive social impacts like community wealth building and equity outcomes.

The possible risks of participating in this study include feeling uncomfortable as you reflect on challenges and missed opportunities. You may reveal sensitive information about your organization's efforts. The study staff will deidentify the ideas and examples you provide unless you give specific permission for a quote, story, or piece of information to be attributed to you and/or your organization. However, a breach of confidentiality could occur due to unforeseen circumstances.

While we cannot promise a direct benefit from participation in this research, the findings combined from all participants will be shared with you at the end of this study; you might be able to use this information to improve your organization's purchasing efforts. Additionally, by participating in this study, you will have the opportunity to process your own experience and distill some reflections that could be useful for leading future strategic impact purchasing efforts.

If you have any questions about this study, you can contact Stephanie Doan (sdoan@hsph.harvard.edu, 717-575-0575)

Thank you again for your time and participation

Appendix G: Data Challenges for UMMH

The anchor mission purchasing pillar committee has put significant effort into measuring how much of the system's spend is going to minority-, women-owned, local, and other vendors, uncovering some critical challenges for starting up a local and diverse purchasing initiative, even just at the data analysis and planning phase.

UMMH has tried two different tactics for understanding this current spend). The first approach was sending the UMMH vendor list to a third-party vendor to "enrich" the data by matching vendor names to available lists of certified MBE, WBE, and other categories of vendors. UMMH's data analytics team then built a dashboard in Tableau linking that vendor information to spend data that could be viewed by cost center and type of purchase. However, when that vendor stopped offering this once-a-year enrichment service, UMMH added a new Vizient® service into the current contract—a partnership with SupplierGATEWAY to enrich data, manage dashboards for viewing the data, and host a vendor registration portal. Unfortunately, the data initially generated via the SupplierGATEWAY tool from FY 2019 and FY 2020 don't match the data from the previous vendor—highlighting the challenges of building and maintaining quality data. There is still substantial work to be done to ensure data integrity.

Related to the issue of data quality is the issue of actionability. Most of the effort to date on data has been for the purposes of reporting and tracking. The next step—leveraging this data to inform decision-making—requires a different set of skills and tactics. It's unclear whether the existing team contains these skills or whether others will need to be engaged to move this effort forward.

Another challenge has been staying true to the complex definitions set by the HAN for measuring progress toward the Impact Purchasing Commitment (IPC). The goals for MWBE and local spend are set by the IPC as percentages of the health system’s “addressable spend”, which was all the money spent by the system except for specific categories where there might be limited opportunities for shifting business to MWBE vendors (see Box). A few specific issues have made developing quality data challenging or limited potential impacts:

- **Construction vs Capital:** According to the IPC, ‘addressable spend’ excludes construction or capital items associated

with a construction project but includes non-construction capital items. With the current ERP system used at UMass Memorial Health, there is not an easy, non-manual way to delineate between these two categories. Further complicating things, the goals for MWBE spend did not include construction (since signatories set a separate construction-specific goal), but goals for local spend do include construction.

- **Missed opportunities:** UMMH staff have discussed how some of the exclusions, while designed to make the goal more achievable, might also reduce the incentive for the system to explore opportunities in excluded areas. For example, there could be small

Box: Understanding Addressable Spend

UMMH Total FY 2021 Spend:
\$1.057 Billion

UMMH Addressable FY 2021 Spend:
\$559 Million

Addressable Spend Category Exclusions:

- Prime Pharmaceutical Distributor (\$216 M)
- Construction (\$74 M) [Note, included for local spend goals]
- Insurance (\$22M)
- Leases (\$16M)
- Blood and Organ Sourcing (\$12M)
- Physician Agreements (\$12M)
- Utilities (\$11M)
- Employee Reimbursement (\$9.5M)
- Med Group/Physician Orgs (\$3.2M)
- Government (\$3.2M)
- Professional Assoc (\$1.9M)
- UMMS (\$934K)
- Community Health Centers (\$653K)
- Unions (\$604K)
- Tax (\$558K)
- Universities (\$442K)
- Community Non-profits (\$350K)
- Non-profit Hospitals (\$240K)

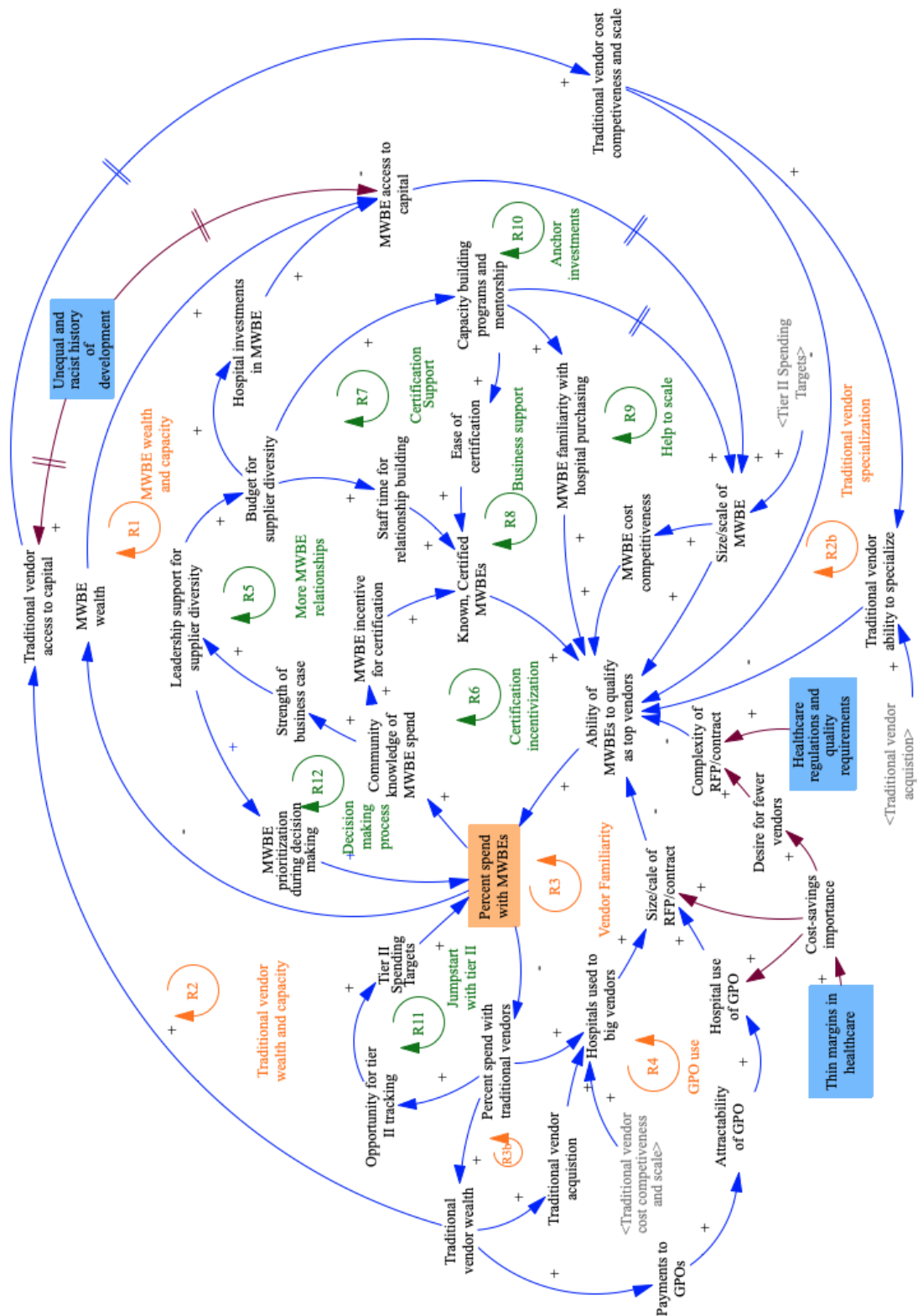
amount of pharmaceutical spend that could be moved from the prime distributor without putting the volume-based contract at risk. Another example is the category of employee reimbursements, which might present significant opportunity: for instance, a manager could order flowers or gifts for a departing or sick co-worker or get catering for a staff recognition lunch processed as a reimbursement rather than a purchase order or credit card item, an acceptable practice within UMMH policies.

Similarly, there are several complexities and considerations with the HAN IPC's definition of local spend. First, the IPC focuses on non-publicly traded, locally owned, and locally headquartered businesses; there is no current system for ensuring all three of these requirements are true without manual checking. Right now, the easiest automated way to determine whether an organization is local is using the zip code where the payment is sent. The SupplierGATEWAY's vendor registration system could potentially provide all needed data, but this would require making changes to the system. Another challenge with local spend is determining what is meant by "local." The IPC gives two options: target neighborhood (predetermined zip-codes based on equity data) and regional (the service area of the system). In a mid-size city like Worcester, zip codes are large and don't overlay well with the most historically disadvantaged neighborhoods, making the target neighborhood option problematic. (UMMH uses census tracts to delineate target neighborhoods for the other anchor mission pillars; however, there isn't an easy way align census tracts to the information on vendor location since this would additionally require geocoding on top of zip codes. Similarly, while defining UMMH's service area is straightforward, leadership also wants spend tracked at the larger New England region given the importance of its financial health.

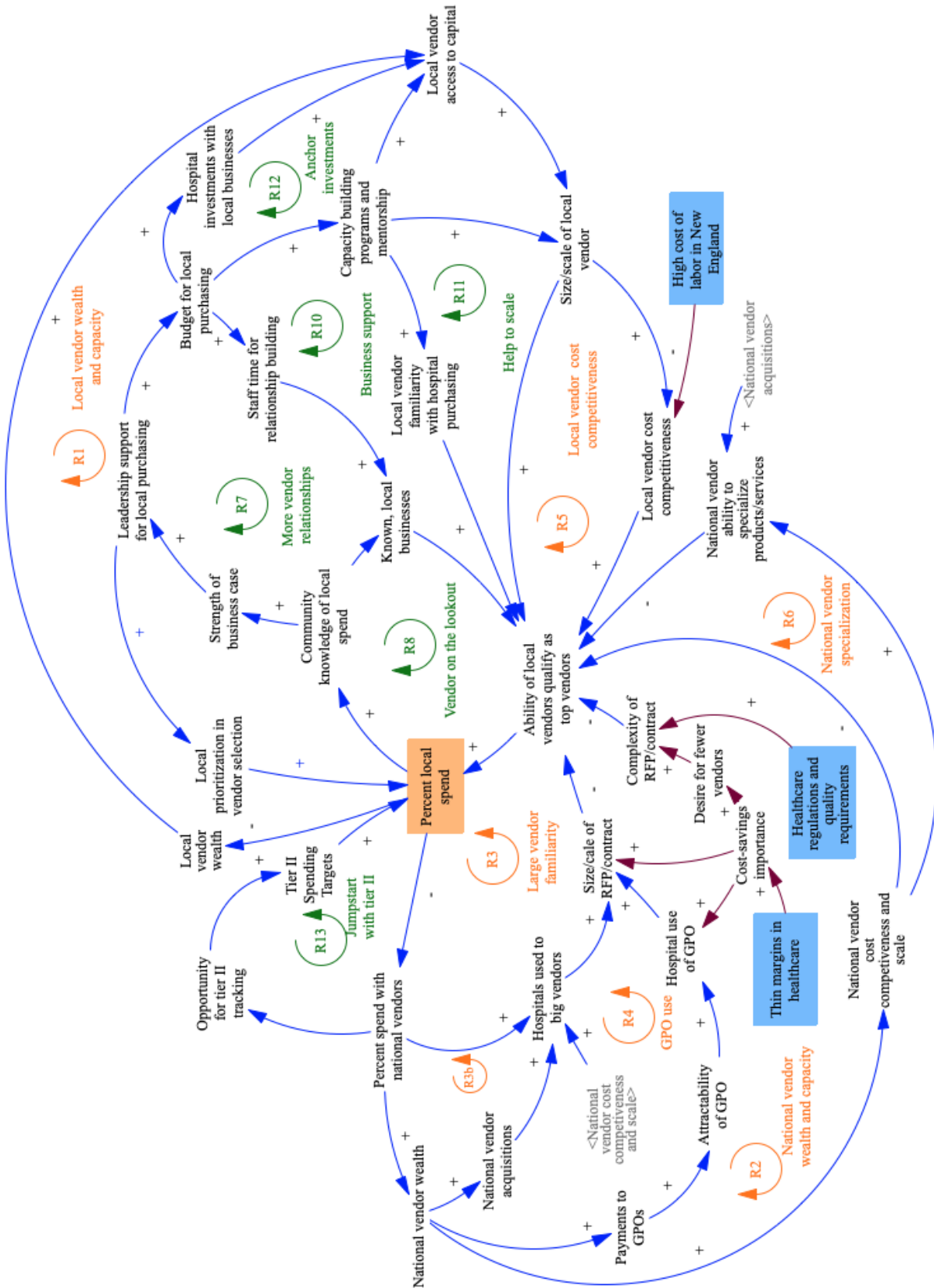
While multiple metrics and targets are designed to deal with the nuance of the work, the large number and complexity of metrics causes the health system to spend more time and energy on reporting than on actually driving change.

Appendix H: Causal Loop Diagrams

H.1 Full Causal Loop Diagram for Supplier Diversity/MWBE Purchases



H.2 Full Causal Loop Diagram for Local Purchasing



Appendix I: UMass Memorial Health Ecosystem Analysis

As described in Section 2.2.1, UMass Memorial Health (UMMH) is the largest health system in Central Massachusetts; the system manages 1,117 licensed hospital beds, employs about 16,000 people, and purchases about \$1B in goods and services annually. About 28% of the system's reimbursement claims during FY 2021 were covered by Medicaid and 36.5% by Medicare. UMass Memorial Health began its formal journey to build more diverse and local suppliers only in the last few years when it joined the Healthcare Anchor Network (HAN) and signed of the Impact Purchasing Commitment (see Section 2.2.3 Healthcare Anchor Network's Impact Purchasing Commitment for more background).

UMass Memorial Health is headquartered in the mid-sized city of Worcester, Massachusetts, with a population of just over 200,000 according to the 2020 Census. The second largest and fastest growing city in the Commonwealth, Worcester saw a 14% increase in population over the last 10 years; similarly, there was overall population growth of 8% in Worcester County, the area that roughly corresponds to the UMass Memorial Health Service Area.²¹ See Table 7 for a snapshot of population and economy of both the city and county (*U.S. Census Bureau QuickFacts*, 2021).

Worcester has long been a city of immigrants, with 30% of the 40,000 population in 1870 designated as foreign-born, mostly from Ireland. Today, more than 20% of the city's

²¹ The primary and secondary service area for UMMH covers all of Worcester County but also extends a few zip codes into Middlesex County to east around the Marlborough Hospital. While by some definitions this area is still central Massachusetts, some residents in this area consider themselves part of the Metro-West area of Boston. This is yet another complexity for understanding the economy of the area—and identifying the correct partners and stakeholders to engage in the work to promote equitable economic development in the community.

population is foreign-born but from a much more diversified set of countries (the most predominant countries of origin in 2010 were Brazil, Vietnam, Ghana, and Dominican Republic, although the population make up continues to change quickly). Highlighting the importance of minority and immigrant owned businesses to the fabric of the Worcester economy, in 2016, more than 35% of business owners were foreign-born, a larger share than would be expected from the population estimates. Most of these businesses are in the food service sector (71% of foreign-owned businesses), but others align with administration and support services (28%, including landscaping one of the top businesses in this category), retail (13%), construction (9%), and transportation (6%) (Worcester Regional Research Bureau, 2018).

Table 8: Quick facts about Worcester City and Worcester County, Massachusetts

	Worcester City	Worcester County
Population	206,518	862,111
Under 18 years	19.0%	20.9%
Over 65 years	13.6%	16.1%
Foreign-born	21.0%	12.4%
Language other than English spoken at home	35.4%	20.0%
Black or African American alone	13.0%	6.1%
Asian alone	7.2%	5.4%
Two or more races	0.5%	2.3%
Hispanic or Latino	23.1%	12.2%
White alone, not Hispanic or Latino	54.5%	75.7%
Firms, total (2012)	13,085	61,953
Women-owned (2012)	4,105 (31%)	19,245 (31%)
Minority owned (2012)	3,775 (29%)	7,583 (12%)
Total Hospital Beds	1,028	1,476
UMMH Hospital Beds	749	1,038

While foreign-owned businesses are the fastest growing sector of the economy, growth in downtown Worcester is resulting in rising rents and other symptoms of impending gentrification that could impact the number and future of some minority-owned businesses. Additionally, a strong patchwork of non-governmental organizations, faith-based organizations,

organized labor, and developers, and foundations has laid the infrastructure for effective, community-driven development and capacity-building efforts.

The size and composition of the Worcester economy makes it a unique place to implement supplier diversity and local purchasing initiatives, particularly when compared to the approach needed for developing new initiatives in a larger city like Boston or Chicago or Cleveland where most of the best practices and success stories have been developed. As one of the most important differentiators noted by UMass staff, initiatives involving multiple partnerships requires attention to relationships and building credibility with stakeholders in a way that might not be required in the same way when working in a larger market like Boston. Relatedly, some strategies and targeted business development efforts might lack the opportunities to scale that might be possible in a bigger city with a larger concentration of healthcare providers (for example, more creativity might be needed in trying to build a hospital laundry business or sharps disposal business since the demand from a single organization might not be sufficient to drive growth). All of these factors inform the implementation of the UMMH anchor mission purchasing initiatives and impact ability to make significant progress.

Structural frame analysis



Most of the unique complexities for UMass Memorial Health’s diverse and local purchasing efforts fall within the structural frame—including the unique way that the purchasing and supply chain functions are organized (including the outsourcing of supply chain services to Vizient®), purchasing policies and processes, the system used for data collection, and the process for identifying local vendors. Each of these is discussed in detail below.

Organizational structures for purchasing

Much of the implementation and strategy work for anchor mission purchasing is accomplished through the anchor mission purchasing pillar committee—a subcommittee of the anchor mission steering committee (see section 2.2.2 for more information). The anchor mission purchasing pillar is co-led by three executives in the UMass Memorial system (VP for Supply Chain, VP for Facilities at the Med Center, and President of two Community Hospitals) and includes representatives from more than 10 departments across the system, including supply chain, IT, legal, and the medical group. When UMMH adopted the HAN’s Impact Purchasing Commitment in 2021, the Chief Financial Officer signed the commitment and agreed to serve as the most senior executive sponsor for the initiative. The anchor mission pillar committee formed several working groups in 2022, including groups focused on data, policies and contract language, large vendor relationships, local vendor engagement, and several department specific efforts. However, the anchor mission purchasing committee remains a separate body that has not been integrated into the larger UMMH purchasing organizational system, a complex set of stakeholders and end-users of purchased products and services.

Resulting from multiple acquisitions and mergers in the last twenty-five years, the overarching organizational structure of the UMass Memorial System is complicated. Many Medical Center leader play roles within the parent health system, resulting in matrixed reporting. For example, the Medical Center Chief Financial Officer oversees Supply Chain Services, even though this office provides purchasing support to all entities in the system.

Another complexity (described in greater detail in the following section) is the unique relationship between UMMH and Vizient®, the vendor that manages the centralized supply

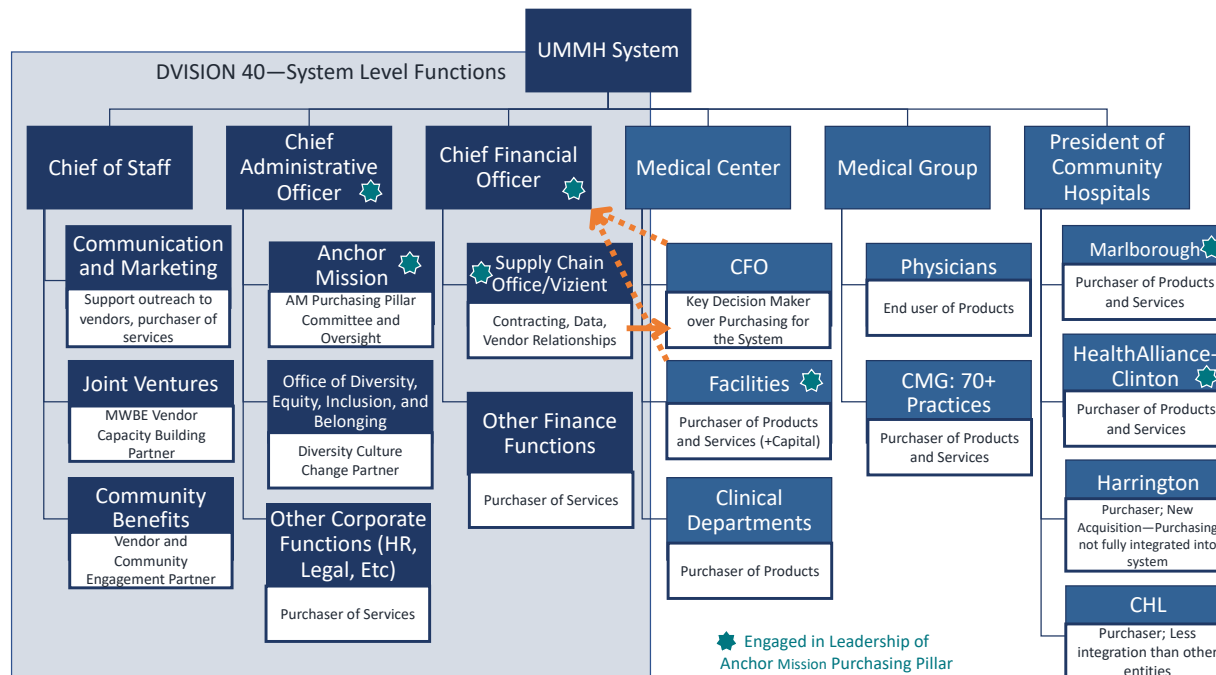
chain and purchasing for health system. UMMH entities utilize Vizient's services at varying levels—for example, Harrington Hospital—acquired by UMMH in the summer of 2021—is in the process of transitioning into the UMMH purchasing system but still maintains an in-house purchasing director. See Figure 13 for a high-level depiction of some relationships within the system, noting that this is a simplification of an even more complex system.

As with other systems, UMMH engages many purchasing decision makers across the system. A few unique aspects of these relationships include:

- **Value Analysis Process undergoing an overhaul:** Like most healthcare systems, the supply chain services office manages a value analysis program that engages clinical staff to ensure that all clinical products meet the quality and useability needs of clinicians and patients. UMMH leaders acknowledge that there are significant shortcomings in the existing value analysis process; the supply chain services office is planning an overarching reorganization of the program in the coming months.
- **Complex relationships with large vendors for many facilities services:** Facilities, a key area of opportunity for anchor mission, purchases multiple services (from food service to housekeeping to laundry to grounds maintenance to fleet maintenance). For some of those services, the health system works with a large vendor to manage spend in the area. The national vendor Sodexo manages food services (both patient food and the cafeteria) for the Medical Center, but many of the food service employees work directly for UMMH and food purchases are charged directly to the hospital budget. Thus, Sodexo leadership must be engaged, along with UMass Memorial facilities staff, in the effort to

procure food from more local and diverse vendors. UMMH maintains similar types of agreements in other hospitals and for other services like housekeeping.

Figure 13: Simplified structure of UMMH Purchasing Stakeholders



Outsourced and centralized supply chain office

In the last seven years, UMass Memorial Health transitioned from having a decentralized, in-house purchasing function to a consolidated, outsourced purchasing function. In 2016, UMass Memorial Health entered a relationship with Vizient® to manage the health system’s supply chain with a goal of reducing costs and improving supply efficiencies through automation and other tech-enabled solutions. An in-house revamping of the supply chain function would have required significant investments in recruitment, training, and IT systems; Vizient® offered a “turn-key” solution that enticed senior leaders who were tasked with updating the system. In the new structure, Vizient employees—who are also issued UMass Memorial badges and email addresses—provide contracting, vendor engagement, and other

support to UMass Memorial Health. Vizient® has delivered on their promise of automated systems and cost savings, with automated purchases going from less than 50% in 2015 to more than 82% by 2018 and initial cost savings of \$32 million, surpassing the 5-year goal, in only 3 years (Vizient, 2022).

The most senior Vizient staff-member—who maintains the title of VP for Supply Chain for UMass Memorial Health—plays a key leadership role in the implementation of the UMMH Anchor Mission. Until recently, only one Vizient staff member other than the VP for supply chain was engaged in anchor mission purchasing. To date, no KPIs or specific targets related to Anchor Mission Purchasing have been included in the contractual terms that outline the services Vizient® will provide to UMMH, although the value and importance of these initiatives to the organization has been communicated in several more informal ways.

Some leaders and staff involved in day-to-day purchasing relationships with Vizient described a challenge in getting help and support from the company; several highlighted the fact that many of the people who work on the UMMH account from Vizient are “down in Texas” without local insights and relationships; some also talked about Vizient as a “black box,” with UMMH departmental or entity staff involved in purchasing having little understanding of what happens within the supply chain office. UMMH staff often view Vizient® as a monolith organization, without understanding the different parts and offerings of the organization (e.g., the UMMH supply chain services team, the team that provides more traditional GPO services, the supplier diversity office, and the Northeast Purchasing Coalition (NPC).

Purchasing policies, processes, and systems

UMass Memorial Health, in partnership with Vizient®, has built an evolving system to manage purchasing decisions, create efficiencies for requisitioners and approvers, reduce costs and ensure quality. At the highest level, the “UMass Memorial Health Purchasing Policy” lays out the requirements and guidelines for making purchases across the health system. The policy covers the following topics: requirements for being an authorized purchaser (requisitioner or approver), thresholds for different levels of approval, the use of the Pathways Material Management System, procedures for the purchase of services and non-catalogue products, RFP purchases for supplies not covered by the group purchasing organization contracts, and requirements for new vendors.

This policy does not include any direct mentions of supplier diversity or local purchasing language, beyond a link to the newly approved Anchor Mission Purchasing Policy outlines the system’s commitment to increasing local and diverse purchases, building capacity of local and diverse businesses, and updating processes and systems to support those goals. However, while the anchor mission purchasing policy makes a clear statement about the goals, it does not outline the tactics and approaches needed to implement the policy. Currently, none of the supplementary policies and trainings related to purchasing currently include any content about the UMMH anchor mission purchasing goals and/or tools.

The Pathways Material Management (PMM) System serves as the enterprise resource planning software for purchasing, receiving, accounts payable, inventory and distribution. PMM is used by requisitioners for ordering stocked items (that are maintained in the distribution center/warehouse inventory), ordering non-stock items, and requesting the purchase of other

specialty items and services not already logged in the system. There is no existing mechanism within the PMM system for flagging or prioritizing items that are produced or distributed by a minority- or women-owned business (MWBE) or a local business.

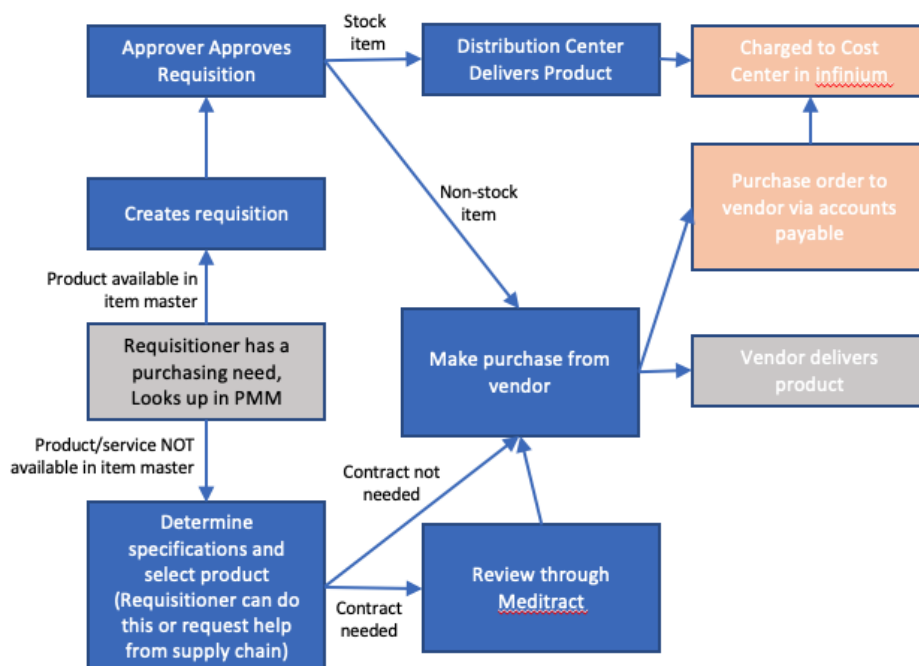
PMM does not offer a vendor registration and management system, a major limitation for vendor outreach and relationship building. When the anchor mission purchasing committee began a campaign to inform vendors of the new anchor mission goals, there was no way to identify the email contacts of all the system's recent vendors. Also, some requisitioning happens outside the PMM platform, with authorized users purchasing directly from the vendor platform (for example, from Staples for office supplies or Grainger for housekeeping supplies). Adding additional complexity, the PMM system communicates with: a) the financial system Infinium® under the oversight of the Financial Services/Account Payable Office for processing payments; b) the MediTract® system for approval and review of contracts; and c) the human resources system for obtaining approval. See Figure 14 for a very simplified rendering of the process for purchasing a product or service that does not go out to bid.

In January of 2024, all of this will change. UMMH will transition to a new Enterprise Resource Planning (ERP) system—Workday®—which will house purchasing and requisitions, vendor information, financial services, and human resources systems within a single system. This provides a significant opportunity for the future, but also reduces the motivation to invest in and build solutions and improvements within the current systems.

This year, UMMH released its first (and, so far, only) RFP with specific anchor mission purchasing language. While the development of standard RFP and contract language is a commonly cited best practice in the literature, UMMH staff found it difficult to identify existing

language used by other healthcare organizations (at least on partner cited legal concerns as a key roadblock to sharing language).

Figure 14: Very simplified overview of the purchasing process for non-bid items and services



Data categorization and management

The anchor mission purchasing pillar committee has put a significant effort into measuring how much of the system's spend is going to minority-, women-owned, local, and other vendors. This process has uncovered some critical challenges and complexities for starting up a local and diverse purchasing initiative, since so much of the early work on supplier diversity involves understanding current levels of spend and who existing MWBE and local vendors are.

After about 3 years of effort and only within the last week, the UMMH has finally begun to feel confident and comfortable with local and diverse spend data management, now managed through the SupplierGATEWAY platform. The next step in data management at

UMMH is finding ways to make the data usable and actionable for decision makers across the system. See Appendix G for more detail on the data challenges and complexities encountered by UMMH’s anchor mission data team.

Unique context for identifying local, diverse vendors

As with other health system, stakeholders across UMMH continually ask: “What are the local, diverse vendors we can do business with.” In the national vendor space, this question is easier to answer because Vizient® has made efforts to identify and develop contracts with MWBE distributors and manufacturers that meet healthcare supply chain needs on a national or regional scale. But locally—in the UMMH service area or across the state—there isn’t a single good resource for identifying certified MWBE businesses or not-yet certified MWBE businesses. Table 8 below highlights a few sources of information on local businesses (and some of the limitations associated with those lists). UMMH has not developed an easy way to consolidate the information across all these lists into something readily useable by a supply chain staff member or departmental requisitioner.

Table 9: Local sources of available vendor information

Data Source/List	Challenges/Considerations
Dunn and Bradstreet Business Listing	Comprehensive, but lots of non-operating businesses with too high level of detail to be useful. MWBE status self-reported and with limited quality, requires subscription (but can work with MassDevelopment to access using their subscription).
Chambers of Commerce	The Greater Worcester Chamber of Commerce boasts 2000 affiliate members. After the availability of health insurance on the exchange, the ROI for joining the Chamber was diminished, and many Chambers of Commerce have struggled to recruit members, particularly those owned by women and minorities.
Better Business Bureau Listing	Business Listing and accreditation program, requires vendor to get accredited/upload information for a good quality listing.

Table 8 (Continued)

Massachusetts Supplier Diversity Office	The Massachusetts certifying body for MWBEs. A growing list, but not close to full coverage of the estimated MWBEs in the state, largely due to many businesses outside of construction or other sectors with significant government contracts not seeing a ROI for going through the certification process. While Certification is free, the process is time-consuming and challenging for a small business owner.
City of Worcester Diverse Business List	A self-reported list maintained by the city that contains a few hundred vendors. Limited marketing and validation of the list.
SupplierGATEWAY Vendor Database	The SupplierGATEWAY database includes several hundred vendors located in the UMass Memorial Service area (business that that have registered on the portal for doing business with any of SupplierGATEWAY's clients). This list hasn't been curated for healthcare or for Central Massachusetts.
Third-Party Certifying Organizations (NMSDC, WBENC, etc.)	Maintain lists that can be accessed by corporate members. To date, UMMH has not joined the NMSDC, WBENC or other supplier councils.
Entrepreneurial Support Organizations (ICIC, Small Business Strong, etc.)	Organizations like the Worcester Food Hub, ICIC, Commonwealth Kitchen and others who help small businesses grow maintain lists of program graduates and mentees. These lists are diffuse and difficult to access without a personal connection or time searching the internet.

Upcoming Projects and Opportunities

Several UMMH staff identified the opportunity to leverage the upcoming renovation of the Beaumont Facility as a key opportunity for anchor mission purchasing. Previously a long-term care center adjacent to the medical center's university campus, the facility was acquired by UMMH in 2021 to expand the medical center's inpatient care capacity through the addition of 200 medical-surgical beds. This project is currently undergoing determination of need approval by state regulators.

Political frame analysis



This section explores the unique political considerations at play both internally within UMass Memorial Health and externally in the stakeholder ecosystem of Central Massachusetts.

Strategy integration and budget outlook

With both the approval of the UMMH Board of Trustees and the CORE leadership team composed of the top executives in the organization, the anchor mission purchasing commitment—or the Healthcare Anchor Network’s Impact Purchasing Commitment as it is called in other parts of the of this paper—has received the highest levels of formal support within the organization. To add more attention to the effort, in April 2022, a supplier diversity goal was added to the list of ten True North Metrics tracked monthly by the executive leadership team, significantly raising the visibility and importance of the anchor mission purchasing initiative. However, several UMMH staff suggest that anchor mission purchasing still fits into a “nice thing to do” category rather than a strategic initiative tied to the value proposition and business strategy of the organization.

As with other non-profit healthcare systems, the austere financial outlook for FY 2023 and beyond will likely limit the appetite of UMMH leadership for “nice to have” additions to hospital operations. This financial situation tremendously raises the importance of defining the rationale behind anchor mission purchasing and elevating its relationship to the UMMH business strategy.

Finally, there continue to be outside pressures for UMMH to further develop its supplier diversity and local purchasing reporting and implementation capabilities. For example, the Massachusetts Senate is currently considering a bill (S.270) that would require anchor institutions (hospitals, colleges and universities, etc.) to provide an annual report to the MA Supplier Diversity Office including an overview of activities undertaken to support supplier

diversity and spend with MWBEs and local businesses (Massachusetts Legislature, 2022).²²

Similarly, some state-funded contracts and grants recently received by UMMH have required supplier diversity reporting and targets.

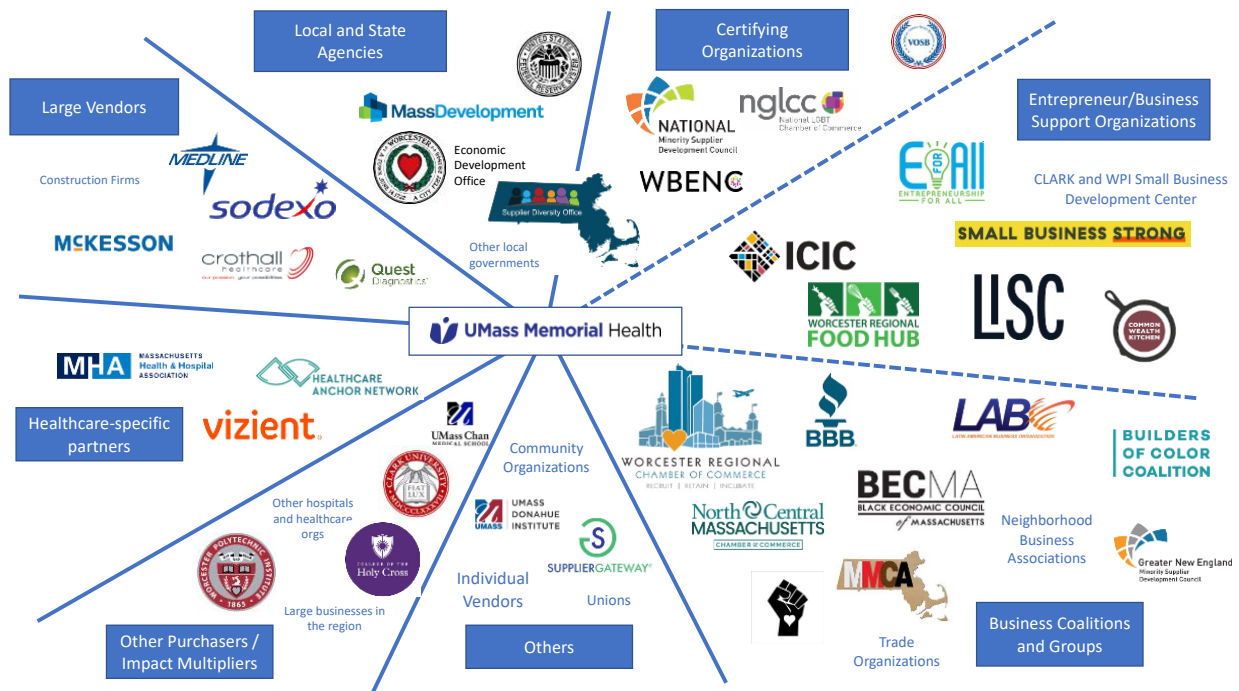
Stakeholder engagement and collaboration

As noted above, Worcester has a strong network of community organizations and businesses with an interest in building economic opportunity in central Massachusetts. Effectively navigating and inviting partnerships, along with clarifying priorities and alignment, with many of these stakeholders will be vital to the long-term success of this initiative. Figure 15 highlights the key external stakeholders for UMMH's anchor mission purchasing efforts.

Several UMMH staff members identified the need to link anchor mission purchasing work more directly to the local and minority vendors UMMH hopes to engage, noting that this supports the important value of authentic inclusion in economic development. Finally, given the mid-sized economy of Worcester previously described, UMMH staff noted the importance of collaborative efforts among larger purchasers in the region toward the end goal of building strong and resilient businesses in the region.

²² The major provisions of this bill regarding supplier diversity have also been incorporated into several larger bills focused on economic development making their way through the state house (HB 4720, 4977, and 4864). Unfortunately, the outcome won't be known before the finalization of this thesis.

Figure 15: Stakeholder map for UMass Memorial Health anchor mission purchasing



Human resources frame analysis



This section explores the human resource considerations impacting the UMMH anchor mission purchasing efforts, including incentives, motivations, orientation, and tools.

Incentives and motivation

UMass Memorial Health has utilized one key strategy to incentivize movement and progress on Anchor Mission Purchasing—the inclusion of an FY 2022 executive compensation goal based on a modest increase in spending with minority- and women-owned businesses. The FY 2022 target has been set as a \$500,000 increase over FY 2021, the equivalent of about 5% of the \$10 million increase set for FY 2025. While meeting the goal seems likely, but the downside of not meeting the goal has increased senior leadership’s attention to the effort as the end of the fiscal year approaches.

UMMH staff identified a similar challenge raised in other health systems—the lack of bandwidth or time to devote to anchor mission purchasing implementation. Within the supply chain office, several staff have been assigned to support the 2024 ERP transition, and there are vacancies in all departments across the health system. In general, staff—particularly those below the executive/director level—have not been incentivized to put their time and energy toward the anchor mission purchasing initiative. Except for a temporary administrative fellow, no UMMH or Vizient staff members have language about anchor mission purchasing built into their job descriptions. Those staff who do commit time and energy to the effort are largely internally motivated to work on equity-related efforts within the institution.

[Training, orientation, and supports](#)

Across UMMH, only a small percentage of purchasing requisitioners and approvers have been oriented to the anchor mission purchasing goals. However, there are several existing information sharing and training structures that could be leveraged to orient the staff that make and approve requisitions within the UMMH system to the anchor mission purchasing goals, including:

- **Team Huddles and Operational Leader Meetings:** There are several existing, regularly scheduled meetings for operational leaders and staff that could provide a forum for orienting staff and training on developed tools and processes. Additionally, as part of the LEAN methodology, all teams hold huddles to brainstorm and implement ideas that improve quality and efficiency.
- **HUB page:** UMMH has developed a new anchor mission purchasing page on the HUB, the intranet for UMMH. Across the system, the communications department is working

to increase the utility of the HUB so that it becomes a go-to source of information and tools about all aspects of work at UMMH.

To date, neither the anchor mission purchasing committee nor supply chain services have developed tools, trainings, or process guidelines that would make implanting anchor mission purchasing goals easier for purchasing decision makers across the system.

Symbolic frame analysis



This section explores the symbolic considerations impacting the UMMH anchor mission purchasing efforts, including existing culture-change efforts underway at UMMH, storytelling and reputational issues, and observations on the mindset for conceptualizing the issues of supplier diversity.

[Existing culture-building efforts underway at UMMH](#)

Building and sustaining a culture of work that integrates anchor mission purchasing “into the drinking water” of how purchasing is performed needs to be incorporated into several other culture-building initiatives happening across the UMMH system. Below are a few of those initiatives, noting their current or potential linkages to anchor mission purchasing.

- **Diversity, Equity, Inclusion, and Belonging:** With a new office established in 2021, there are several efforts underway to strengthen and build a culture that promotes diversity, equity, inclusion, and belonging, values that undergird local and diverse purchasing and other anchor mission efforts. The concept of an “Equity Pause” to be taken before major decisions has been one concept that has resonated with leadership and could be applied to anchor mission purchasing. Additionally, a new implicit bias training is being developed—and has been piloted in HR and some other areas—that could have strong

implications for limiting the effects of bias on purchasing decision-making. The office also manages several employee resource groups (ERG), including an African American ERG, Asian-American ERG, and Veteran ERG, designed to foster a diverse, inclusive workplace; these ERGs might have insights and relationships with local businesses that could become vendors of UMMH.

- **LEAN and Innovation:** When Dr. Eric Dickson became the CEO of UMMH in 2011, he instituted a Lean/Six Sigma approach to change management and process improvement across the organization. While many thought this might be a leadership fad that would die out, the values of innovation, identifying the root cause of a problem, and continuous improvement have continued and flourished. By 2022, more than 100,000 ideas had been implemented through the Innovation Station online idea board platform. Through Innovation Station and UMMatters Central (a platform for online staff recognition), staff are recognized for their idea generation and implementation. Several UMMH staff discussed the need for constant iteration, reflection, and strategy alignment within the anchor mission purchasing initiative as it moves into the future; maintaining momentum will at least partially be driven by the receptivity of reflection and innovation among staff.
- **Broad anchor mission culture building efforts:** The anchor mission implementation team at UMMH is constantly looking for opportunities to integrate the anchor mission into the mindsets, culture, and standard way of doing business. Every week, an anchor mission stakeholder orients new staff to the anchor mission goals and efforts. The bi-monthly anchor mission steering committee meetings—open to anyone with an

interest—tend to feel more like “revivals” than like meetings and provide a chance for reflection, connection, and discussion about the values underlying the work. With the looming healthcare worker crisis, the system leadership is beginning to see the value of the anchor mission in building work-place purpose for employees, a key tool for both retention and recruitment. Building anchor mission values into purchasing decisions might be one key to adding “purpose” to the work of those engaged in purchasing decisions and even the end-users who can trace back an item in their hand to the well-being of their neighborhood.²³

[Storytelling, reputation, and community engagement](#)

To get broader anchor mission efforts embedded into the culture of UMMH caregivers, the communication team has developed significant content and stories for internal and external audiences. While big external communication pushes about anchor mission purchasing have been limited, UMMH now has an overview of the anchor mission purchasing commitment on the web that can continue to be built out as the program develops, along with the potential to utilize the social media and press connections of UMMH’s marketing team.

To date, the external communication and community engagement around anchor mission purchasing has been limited. This was largely driven by a desire to get the internal

²³ On July 19th, 2022, Doug Brown (Chief Administrative Office and President of Community Hospitals), Rick Siegrist (Chair of the Board of Trustees and Harvard School of Public Health Professor), and I presented a session at the American Hospital Association’s Leadership Summit that summarized UMMH’s journey and tactics in building an Anchor Mission. Most importantly, the session put this work into the context of the workforce crisis—and the science around purpose in the workplace. For more on this, you can read the recent article by McKinsey (<https://www.mckinsey.com/business-functions/people-and-organizational-performance/our-insights/help-your-employees-find-purpose-or-watch-them-leave>) and the report on worker burnout by the Surgeon General (<https://www.hhs.gov/surgeongeneral/priorities/health-worker-burnout/index.html>).

processes and systems moving. However, without engaging community voices and members from the start, UMMH is at risk of building solutions and approaches that do not fully recognize the needs and insights of local and diverse business owners.

Appendix J: Detailed Recommendations for UMMH

Note: Each item includes (in blue) a recommendation for who should implement the recommended action.

- 1. Strengthen the linkages between anchor mission purchasing and the UMMH business strategy;** incentivize progress among senior leaders.
 - Continue to track anchor mission purchasing data as one of the systems ten highest level True North metrics and as an annual senior leader compensation goal. [\[AM Executive Sponsors\]](#)
 - Develop clear language that clarifies the system's commitments to leveraging purchasing power both to buy more locally and from MWBEs [\[AM purchasing committee/co-chairs, with AM team and Communications\]](#)
- 2. Utilize the Anchor Mission Purchasing Committee for high-level strategy, coordination, accountability, and ongoing process improvement;** implement through existing purchasing structures (and sub-committees if required)
 - Move the day-to-day operations of Anchor Mission Purchasing to existing supply chain and operations teams—and when needed special working groups/sub-committees—to ensure alignment and incorporation into everyday workflows and approaches. [\[AM Purchasing Committee and Co-chairs\]](#)
 - Maintain the strong level of senior leadership engagement through anchor mission purchasing co-chairs and executive sponsorship. [\[AM purchasing executive sponsors\]](#)
 - Engage more mid-level and staff-level caregivers—both Vizient contracting staff and UMMH department purchasing stakeholders—involved in decision-making via the anchor mission purchasing committee. This will help with reach and ensure more ideas grounded in the reality of purchasing processes are incorporated into strategy and countermeasure development. [\[AM purchasing committee/co-chairs\]](#)
 - Increase use of Lean Six Sigma tools and thinking to drive change and track progress, including periodic and ongoing review of the root causes and countermeasures. Periodically have this group engage with the stakeholder group below. [\[AM purchasing committee/co-chairs, AM purchasing coordinator\]](#)
 - Monitor and plan for the sustainability goals in the soon to be created Sustainability/Green Committee but provide opportunities for periodic sharing across the committee both through some shared membership and updates during committee meetings. [\[AM purchasing executive sponsors\]](#)
 - Finalize a set of indicators and targets to track in each AM purchasing meeting, other meetings, and to report to Anchor Mission executive sponsors. [\[AM Purchasing committee\]](#)

- Create and fund a mid-level “anchor mission purchasing coordinator” position to manage the effort, collaborate with internal stakeholders, and be a primary connector to external partnerships. If this isn’t feasible, develop a staffing plan for managing internal and external partnerships. [\[AM Purchasing Executive Sponsors\]](#)
 - This coordinator should report into either the system or medical center CFO, or to the anchor mission team (or whatever larger structure will be developed to organize the system’s work around equity and our community). Alternatively, this individual could report to either the VP for government and community relations or the VP for corporate relations. I would not recommend having the coordinator report to the Office of Diversity, Equity Inclusion and Belonging given that office’s current focus on HR-related efforts, nor to the Vizient/Supply Chain Services team due to the significant part of the coordinator’s role that would be involved in representing UMass Memorial Health with local, community partners.
 - While the position would certainly gain value from a more senior leader filling this role, a director or lower position is recommended due to the realities of budget challenges for UMMH. Some key competencies can be found in the section “Competencies, Skills, and Staff Expectations” on page 80 but the biggest need is for someone who will jump in, get work done, and form relationships internally and externally.

3. Orient, empower, and incentivize UMMH purchasing stakeholders on the anchor mission purchasing goals, policies, processes, and tools; move responsibility beyond senior level leadership to engage more mid-level and staff-level individuals engaged in day-to-day purchasing decisions.

- For UMMH Requisitioners, Approvers, and other Stakeholders:
 - Develop KPIs and job descriptions on Anchor Mission purchasing for purchasing requisitioners and approvers throughout the system. [\[AM committee with HR\]](#)
 - Develop trainings and tools to orient leaders, requisitioners and others to the anchor mission goals and provide meaningful tools and information for addressing those goals through their work. Start with a mini-playbook describing the goals and some initial steps that can be taken. [\[AM purchasing coordinator with AM purchasing committee\]](#)
 - Create standing agenda items about anchor mission purchasing in operations staff meetings (e.g., CFO and budget meetings, Med Center department and clinic manager meetings, CMG manager meetings, etc.). [\[AM purchasing coordinator with AM purchasing committee\]](#)
 - Highlight examples of ‘Anchor Mission Purchasing Champions’ who successfully utilize tools and create MWBE and local vendor opportunities on the HUB and in other communication efforts. [\[AM purchasing coordinator with AM communication team\]](#)

- For Supply Chain Services Team Members (Vizient® employees)
 - Incorporate anchor mission goals into UMMH’s expectations and terms of agreement with Vizient® rather than having anchor mission purchasing as an optional add-on. [\[AM purchasing executive sponsors\]](#)
 - Over the next 1.5 years, consider incorporating these into updated terms when doing an update of the contract for another purpose.
 - For long-term success, incorporate as a key feature of the contract between Vizient and UMMH when it’s renegotiated in FY 2024.
 - Add anchor mission purchasing goals/KPIs into expectations of all Vizient supply chain contracting staff supporting UMMH. [\[Supply Chain Services/Vizient with AM purchasing committee\]](#)
 - Build Anchor Mission purchasing into standard meetings for supply chain team staff. [\[AM Committee with Vizient Leadership\]](#)

4. Innovate creative ways to interrupt the cycles that limit the ability of MWBEs and local vendors to compete for healthcare contracts.

- Explore innovative ways to create a more level playing field for local businesses and MWBEs (e.g., cut the contract into smaller pieces and/or incentivize a model that pairs an MWBE with a larger, more experienced vendor).
- Work closely (and leverage contract negotiations) with some of the largest UMMH vendors to not only have them report their spend with MWBEs and local vendors, but also to set targets and implement more impactful and creative solutions collaboratively. [\[AM purchasing committee, AM purchasing coordinator, Supply Chain Services/Vizient\]](#)

5. Continue updating the UMMH purchasing policies, processes and systems with anchor mission purchasing goals in mind.

- Develop and incorporate anchor mission language into the bid and contracting process [\[Supply Chain Services/Vizient and AM Purchasing Committee\]](#), specifically:
 - Finalize standard Anchor Mission Language for RFP and contracts and create versions specific to the various supply chain needs across the hospital, particularly IT, construction, purchased services in facilities, etc.
 - Institute an ‘equity pause’ when making decisions about an RFP or contract award—explore ways to codify this into the process. Two key places where this should be explored is when determining the specifications of the contract and when making a final contract decision.
 - Identify whether there are any diverse or local vendors who could respond to each individual RFP and ensure they receive the RFP details.
 - Incorporate key questions about whether a product is produced locally or by a diverse vendor (along with environmental sustainability) into the value analysis process during the upcoming revamp process.

- Set anchor mission targets with large vendors during contract negotiations, track vendor progress toward standards and expectations.
- Create a calendar to forecast upcoming purchasing needs across the system and make that available at least to the Anchor Mission Purchasing committee and key partners, if not publicly.
- Build out the SupplierGATEWAY vendor registration process and data management portal so that the data can be trusted and useful for decision-making. [\[Supply Chain Services/Vizient and AM Purchasing Committee\]](#).
 - Set up sessions to review MWBE and local spend data and train on the use of the SupplierGATEWAY dashboard and vendor database with different operational and budget leaders within the system. Once held initially, these should be held on at least an annual basis.
 - Learn whether this is the best tool for vendor communication and deploy if determined to be the most effective.
 - Clarify processes for data reporting that are currently conducted in an ad hoc manner (quality Tier II data, chemical use in furniture, sustainable food, etc.) to reduce future burden
- Leverage both the Workday® transition during 2023 and the re-negotiation of UMMH’s contract with Vizient® in 2024 to set up systems, expectations and workflows that support the goals of UMMH’s anchor mission purchasing goals. To do this, tag a few members on the design team to be responsible for this (e.g., the current data lead within Supply Chain supporting this effort). [\[Supply Chain Services/Vizient, Executive Sponsors, IT\]](#)

6. Provide opportunities for real listening to the needs and concerns of vendors and for engaging with the broader groups of councils, coalitions, trade organizations, and business associations. This aligns with the community development mantra “Nothing about us, without us” and the concept of ‘going to the Gemba’ to ensure that all plans incorporate the voice of those impacted. [\[AM purchasing coordinator and steering committee\]](#)

- Establish a supplier diversity or anchor mission council--perhaps convened collectively with the Greater Worcester Chamber of Commerce and/or the City of Worcester to reduce the staffing burden and create opportunities for collective impact—for getting feedback from a broad range of local stakeholders [\[AM purchasing coordinator\]](#)
- Prioritize building and sustaining direct relationships with the following partners [\[AM purchasing coordinator\]](#):
 - City of Worcester (Sustain partnership)
 - Greater Worcester Chamber of Commerce (Expand Partnership) and the North Worcester County Chamber of Commerce (Establish Partnership)
 - MassDevelopment and the Massachusetts Supplier Diversity Office (Expand Partnership)
 - Greater New England Minority Supplier Development Council (Establish Partnership/Join as Member)

- Central Massachusetts Center for Women and Enterprise (Establish Partnership/Join as Member)
 - Build a communication strategy vendor outreach to demystify the UMMH purchasing process and provide timely information on future opportunities. [\[AM purchasing coordinator\]](#):
 - Leverage UMMH's CFO's role on the Vizient board to advocate for Vizient to increase contracts with MWBEs for all members, create more opportunity for business to be split so MWBEs can meet scope requirements, reduce payment levels for MWBE businesses to be included in Vizient's book of business, and other solutions to decrease scope and complexity requirements that bar MWBEs from entering the market [\[AM purchasing executive sponsors\]](#)
- 7. **Beaumont as a Kickstart:** Kickstart the anchor mission purchasing effort by leveraging the upcoming Beaumont Property renovation to momentum, create internal awareness about anchor mission purchasing, establish external partnership, test new targets and language, and begin compiling a narrative about how anchor mission purchasing contributes to the UMMH business strategy. [\[AM purchasing committee, AM purchasing executive sponsors, AM purchasing coordinator, capital construction\]](#)
- 8. **Storytelling:** Commit to telling stories—both to UMMH caregivers and the broader community—about UMMH's relationships with local, MWBE vendors. This will build momentum and motivation internally and, externally, will increase visibility of new potential vendors and strengthen UMMH's brand as a community healing partner. [\[AM purchasing coordinator, communication team\]](#)