SutureExpress

Supply Chain Leaders

Welcome to our second edition of Supply Chain Leaders, a series of articles featuring interviews with healthcare supply chain executives from around the country. Collectively, this series provides real-world perspectives on challenges faced by healthcare supply chains and innovative solutions being deployed to address them. If there are particular issues you would like to see discussed in upcoming articles, please email them to me at Jay.Istvan@SutureExpress.com.

- Jay Istvan, CEO of Suture Express, Inc.

In this edition of Supply Chain Leaders, I spoke with Tony Benedict, Vice President of Procurement and Supply Chain for HonorHealth, about some of the challenges and opportunities he has faced through the years in leading the supply chains for both not-for-profit and for-profit hospital systems. He also discusses challenges faced in managing medical device implants and in the coordination of care under the Accountable Care Act (ACA).

Tony, can you briefly describe your background and experience in supply chain?

I've been in healthcare since 2010. I've had the opportunity to work in both for-profit and not-for-profit systems. Prior to that, I worked for Intel doing true global supply chain management working with suppliers in Asia, Latin America, the Philippines and China. I traveled the world doing supplier development, raw materials manufacturing, logistics of materials and capacity planning in our factories as well as the suppliers' factories. My responsibilities also included matching supply and demand across 28 manufacturing facilities (Fabs) and 40 different assembly test sites around the world. It was a great experience, and I couldn't have had a better supply chain education at any college.

As the Vice President of Procurement and Supply Chain for HonorHealth, what is the scope of your responsibilities?

I am the Chief Procurement Officer in the sense that anything we write a check for goes through my group – all dollars spent by the health system in any department are contracted through my organization.

Does your department manage services as well as supplies?

Yes, we are responsible for all services including pharmacy and IT. This includes services like outside construction, facility and environmental services, cafeteria services and anything we outsource. The only service my team isn't responsible for is physician contracting. Something like a Medical Director agreement goes through another department.

What are your objectives? How do you tell if you are doing a good job?

First and foremost I am responsible for engaging vendors and working with them to establish pricing for a product or service. Our goal is to free up the time the departments spend on negotiations and contracting. That is important because they are not experts with negotiation. By approaching our supply chain at a network level, we reduce the vendor base for products and services to achieve better pricing than any individual hospital could. That is how we measure our savings on each product or service and ultimately our success.

When you evaluate savings, do you look at the total cost for a product or service?

Yes. I came from outside the healthcare industry where we looked at "total landed cost" for everything. In healthcare, we take it a step further and evaluate the "total landed implanted cost." In other words, what does it cost for us to implant the device or product into the patient? It is a highly regulated environment, which is slightly different than the manufacturing world.

Reflecting on your experience at Vanguard (a for-profit system), are there differences in culture, process and priorities between not-for-profit and for-profit systems?

Yes, the folks in for-profit systems, from the C-suite to mid-level directors, are more versed in the financial operations of their departments. In not-for-profits, they are less financially oriented and often have to be trained in basic financial operations. But, that's quickly changing because not-for-profits have to maintain a certain margin to stay in business especially in light of Medicare reimbursement cuts that will be taking place over the next ten years.

Are there any characteristics of HonorHealth that might not be obvious to our readers? For example, I think the recent merger is something worth noting in the context of this article.

I came from Vanguard, which was a 12-hospital system that, through acquisitions, grew into a 28-hospital system and eventually an 80+ hospital system when it was bought by Tenet. At HonorHealth, we were two small systems – almost mom and pop shops – and we became big by virtue of the merger. A lot of the structure, process and financial controls were not in place when we merged, and cultural change was more significant. On the bright side, it is a new beginning where we are writing our future. We are big enough to finance innovation and small enough to move faster than the marketplace. It feels a lot different from where I came from.

Please talk more about the job of managing the supply chain including challenges, insights and innovations?

I employ the Pareto rule, which focuses on categories that represent 80% of the dollars spent throughout the health system. Often there are 12 to 18 categories that represent 80% of the dollars spent on the supplies and pharmacy side. On the services side, it is more than that but you can narrow down the categories to a handful of focus areas. Since HonorHealth is in a fee-for-service environment, the majority of our money is spent in the operating room, the cath lab and interventional radiology. We also have a bone marrow transplant unit, which has a large drug spend. We consider how much we are doing in-house versus outsourcing as well as how we approach biomedical engineering and things like that. By considering these factors, we get a strong sense of where our money is being spent, and then we develop cost reduction strategies that will impact the first eighteen months post-merger.

What are one or two categories where HonorHealth has made significant improvements?

Most systems today look at implants to figure out how much more they can squeeze out of them. This can include joints, spine, stents or ICDs. Everyone is looking at those categories to figure out what the costs of the components in the supply chain are in addition to the unit price. It's important to consider the "invisible" side of the equation, which is the cost to manufacture and ship the products

About
Tony Benedict, CPIM, CBPP

Tony Benedict is the Vice President, Procurement & Supply Chain for HonorHealth. In this role, Tony is responsible for managing all vendor contracted relationships for the health system.

With more than 25 years of experience in supply chain management in the healthcare and manufacturing industries, Tony understands the critical role supply chain strategy plays in improving patient care. His priority is to ensure that HonorHealth understands the total landed implemented costs of each product and service that it utilizes. He works with each of the health system's departments to manage their supply chain needs to ensure they receive the best products and services at the best price.

Benedict received a Bachelor's in psycho-biology from Albright College and a Master's in Business Administration with a specialization in finance and operations from University of Pittsburgh Katz Graduate School of Business. He is an adjunct professor and has taught Project Management at Arizona State University. Tony is a board member for the Association of Business Process Management Professionals (ABPMP).

to the local distribution center and then to the hospital. We also consider the sales components and how much of the sales cost adds value (clinical support) versus how much of it is sales commission upselling (fluff). The parts we (the provider) don't see is the reverse logistics, which are delivering instruments before the case, then picking them up once the case is completed. When you start breaking it down you can see where the true opportunity lies. That is really where many supply chain professionals, including myself, are spending the majority of their time.

What makes implants such a challenge?

Lack of transparency is the biggest challenge for implant and medical devices. In other industries, you can go online and easily find what a product costs to make, and you already know what it costs to buy. The device manufacturers hide all of that, which has to change for the healthcare industry to have full transparency and collaboration. You can't have the device manufacturer

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continuing to enjoy anywhere from 60% to 90% margins while providers are still pushing 2% to 4% margins on the non-profit side. Without transparency, there is a benefit to the device manufacturer and not a lot of benefit to anyone else. The device industry would clearly argue that point, but there are very few comparative studies between device manufacturers that say "Company A's device and Company B's device are equivalent." That's intentional. At the end of the day, if companies are comparable, then they would be considered a commodity and providers would have full transparency. Then the cost of healthcare in the device space would go down dramatically as a function of true free market pricing.

Are there manufacturers that are trying to innovate in that regard? Either offering greater transparency or providing options for the level of sales rep involvement and, therefore, lowering the cost of the device?

There are a number of startup companies entering the industry with that perspective in mind. Especially in spine, where they are offering an alternative. Unfortunately, the bigger companies outspend the start-ups by paying higher advisory fees to physicians or they end up buying out the start-ups. For example, Stryker bought out the MAKO robot, which was a robot for orthopedic total joint surgery, and made it a truly (Stryker only) closed system. Then a startup, Bluebelt, developed the Navio robot, an open platform that allows you to perform total joint surgery with any vendor's implants. Smith & Nephew quickly bought them out and has indicated that they will make it a closed system. This is what is wrong with the industry because innovation gets bought out and becomes a proprietary closed platform. That has to change.

As you think about medical devices specifically, what process does HonorHealth use to create a balance between economics, clinical benefits and physician preferences?

We have a robust value analysis process that considers all available literature for the disease and the device or the supply related to that disease. We look at safety and outcome data and ensure there is appropriate training for both nurses and physicians. Physicians are also credentialed to do the procedure. Then we look at reimbursement and the cost of the device, the acute episode and the overall economics of the procedure. Now we extend that analysis to the "bundle," which is the potential cost if we implement a device and if there is a readmission. So the total cost of care now extends beyond the acute episode. This approach is broader than we've taken in the past and the economics require collecting data outside of the hospital. We are also in the process of building an analytics platform to collect the appropriate data for population health.

How big is the challenge of building an analytics platform for population health? Where do you get the data for a broader population so you can look at outcomes for different devices or procedures?

We obtain data from the hospital as well as the physician's practice that provided the service, whether it is owned or not, from the electronic medical record (EMR). The linking of the two is where the challenges exist. It is easier to link practices you own with the hospital's data than it is to link independent physician practices to your network. One of the reasons we went with EPIC as our EMR provider is that it has interoperability at both the practice and hospital levels. We encourage all our physicians to use EPIC, and we are trying to leverage our purchasing capabilities to provide them discounted licenses so we can easily connect with them. That process is evolving.

About HonorHealth

HonorHealth is a non-profit health system serving a population of 1.6 million people in the greater Phoenix, Arizona area. The network encompasses five acute care hospitals, an extensive medical group, outpatient surgery centers, a cancer center, clinical research, medical education, two foundations and community services with approximately 10,500 employees, 3,700 affiliated physicians and 3,100 volunteers. HonorHealth was formed by a merger between Scottsdale Healthcare and John C. Lincoln Health Network. HonorHealth's mission is to improve the health and well-being of those served.

HonorHealth's vision: To be the partner of choice as we transform healthcare for our communities. Learn more at www.HonorHealth.com.

As you look toward the next three to five years, are there any emerging issues that you feel will be important for hospital supply chains?

The Health Insurance Portability and Accountability Act, a law that states that when you leave your employer and work for another employer you can take your medical insurance with you, will be an issue. Conceptually it's a good thing, but I am not sure it's effective in practice.

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You have to collect longitudinal patient data, regardless of where they live. Consistency of care when a patient moves can also be an issue and I don't think there is any regulation to help with that. My fear is that the government will try to regulate that as opposed to letting the market figure out how to solve the problem on its own.

So, the data collected by one system doesn't usually make it to the other system and the healthcare strategy employed by one system might be totally foreign to the patient's new system?

Yes, think of it this way. If a patient lives in Michigan and visits Phoenix (snowbirds) from October to April and they are on Medicare, it is pretty easy to make that transition (for payment) because all providers accept Medicare. But, if the patient is not on Medicare, their provider will likely be out of network causing a coverage issue the Affordable Care Act, or insurance coverage provided by the healthcare exchanges, do not address. The ACA created a market of narrow networks where you have to use your network to keep the cost of care down. The biggest issue is care coordination, or the continuation of care because the provider doesn't know the patient's history.

Do you think regulation will solve the issue or will the industry be able to resolve it without regulation? Did the Affordable Care Act solve the problem?

No, it didn't. I think it created a bigger problem. Or maybe it exposed a problem that was already there. I don't think government regulation will solve the portability issue either.

Tony, thank you for sharing your time and insights with us today.