SutureExpress

Supply Chain Leaders

Welcome to another article in our Supply Chain Leader series. For this article I interviewed John Strong, a seasoned supply chain veteran with extensive experience in acute care and GPOs. The primary theme for this interview focuses on the evolution of contracting strategy.

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.

Please provide a summary of your background as it pertains to supply chain management.

I spent the first half of my career in supply chain management roles at acute care hospitals, including time at Lutheran General Hospital in Park Ridge, Illinois. Lutheran General was a great employer because they allowed us to do a lot of interesting things like outsource the supply chain to other hospitals, consult and create a self-distribution product in the 1980's.

The second half of my career focused on group purchasing. I spent eight years at Premier, Inc. when it was a $500 million group purchasing organization, which we grew to $16 billion. I was the founding President and CEO at Consorta, a $5 billion group purchasing organization serving more than 350 hospitals. I also spent time working for the New York Hospital Association. For the last five years, I've been consulting and doing board work. I've been very blessed to experience every aspect of the supply chain except working for a medical device manufacturer.

From your perspective over multiple decades, how has the contracting relationship between providers and suppliers changed?

It's evolved in a number of ways - some good and some challenging. First, most providers still have a keen focus on price, while most suppliers are focused on volume and gross profit.

That has become the focus of contracts over the last 20 years, which is partly to be expected but it's also made these relationships highly transactional. What's missing from these transactions are personal relationships. It's important to have personal relationships with suppliers so that in critical times the buyers have people they can call, trust and depend on during an emergency.

In the 1990's, supply chains in many other U.S. industries became collaborative, frequently sharing resources and information. This helped the economy by collaborating on product development, sharing cost structures and providing joint benefits from more efficient supply chains. The duration of many supply contracts extended from 3 to 5 years. This collaborative phenomenon has not yet taken hold in the hospital supply chain. It is very transactional. Most supply contracts have one year durations.

It sounds like you believe a transactional oriented bid process is viable but it's important to invest in a long-term relationship with the chosen supplier. Is this correct?

For many product categories there isn't the willingness to invest the time in collaboration so the relationship becomes transactional. In some instances vendors and products change because people are simply looking for the best price.

These cost pressures are being driven by the Affordable Care Act and other healthcare changes. Across the nation, hospital systems and independent hospitals are looking to cut as much as 20% of their budgets with the belief that if they do, they can make their Medicare business profitable. So, there is almost a total focus at some hospitals on cutting prices without considering what the consequences of those decisions might be for the supply chain.

For those hospitals that can't cut budgets to this extent, is there a possibility that they will no longer offer Medicare?

About John W. Strong, Principal at John Strong, LLC

John has been instrumental in furthering the professionalism, ethics and practice of the healthcare supply chain. He is a 39-year veteran of the healthcare industry with leadership experience working with healthcare providers, suppliers and service providers, and group purchasing organizations. In 2011, the Bellwether League (the Healthcare Supply Chain Hall of Fame) honored John for "his outstanding contributions over the years to healthcare supply chain management, development, innovation and leadership."

As an independent healthcare consultant with a diverse set of clients, John works with large medical device manufacturers, as well as start-up and smaller medical product companies on strategic planning, sales, education, marketing and national accounts strategy. In addition to his consulting practice, John serves on the adjunct faculty of the Sheldon B. Lubar School of Business, at the University of Wisconsin in Milwaukee.

John retired from Nexera, Inc. a wholly owned subsidiary of the Greater New York Hospital Association, where he was Senior Vice President of Management Services. For more than 10 years he also served as the founding President and Chief Executive Officer of Consorta, a $5 billion group purchasing organization serving more than 350 hospitals. Before joining Consorta, John held senior executive positions at Premier, Inc. He also held senior management positions at Lutheran General Hospital (LGH) and served in middle management supply chain roles at two acute care hospitals in the Midwest.

He's also President of Greenhealth Management, which operates the Greenhealth Exchange, a company owned by large health systems dedicated to accelerating the adoption of green and more sustainable products in the healthcare supply chain. John also serves on the boards of the Bellweather League and Champion Healthcare Technologies.

That might be a bit too draconian, but I think through healthcare consolidation, particularly in urban areas, we are transitioning into a system of "haves and have-nots." If you look at an urban area like Chicago where there are some large, well-managed healthcare systems that are profitable, they have the ability to grow and serve the Medicare population. On the other hand, there are standalone hospitals in many parts of the country that are left out of consolidation and are at risk for closure because their patient population has been absorbed by larger healthcare systems that are better equipped to service that population, or their patient population is aging and becoming more dependent on Medicare. In the next five to 10 years I think you can expect this trend toward hospital closures to continue. We will also see hospitals repurposing from acute care to emergency or outpatient centers.

I would imagine that if you are a larger system you are able to negotiate better rates with payers and enjoy scale benefits that provide lower cost per patient, and other savings. What are the biggest benefits of being part of large system?

In addition to what you mentioned, geographic coverage is also important because it's coveted by healthcare insurers. If you look at the proposed merger between North Shore University Health System and Advocate Health Care in Chicago, one of the fears of the Federal Trade Commission is that their market power, specifically on the North Shore of Chicago, would be much stronger than it is today giving the hospital systems greater leverage to negotiate with insurance companies.

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The health systems disagree, but regardless, the theory remains the same, the greater the geographic coverage the more effective it is for individual health insurers to contract with big health systems.

I also think there are scalable economies for high expense items that sometimes get over looked like energy, water and other high cost goods, services and materials. If you look at the bigger mergers that have occurred over the last few years, supply chain has played a big role in the consolidation. Almost immediately the supply chain executives begin looking at the high cost products to identify ways to standardize volume. It's not always possible but people are certainly looking for those scales of economy whether through their group purchasing organization (GPO) or in many instances going outside the GPO and contracting on their own.

What are the top four or five supply chain synergies that create efficiencies and increase volume as a result of a merger?

In a larger system that is geographically concentrated, such as Advocate Health Care, there are tremendous synergies not only in cost reduction but also in improved service via distribution and with other service providers on a larger scale in a high-concentrated area. Synergies and costs savings could also include things like snow removal, landscaping and the acquisition of commoditized products.

Some of the larger IDNs across the county have moved toward a self-distribution model or partnered with a single distributor. IDNs like Dignity Health and Essentia Health have created their own GPO. Sarasota Memorial and Lee Memorial Health System, for example, have created a shared service center to combine economies of scale around distribution and supply as well as to consolidate central processing, food preparation and repairs of biomedical equipment.

If IDNs continue to create their own GPOs, what impact will this have on the GPO industry?

Good question. As you know, GPOs are evolving and moving into outsourcing of supply chain services, data metrics and consulting. High compliance and having the right purchasing strategy in place for a particular group of products is significantly more important than volume alone, so you are seeing an evolution to regional purchasing groups (RPG). Currently there are about 150-200 RPGs in the U.S. Many are associated with a national GPO, but some are not, while others are becoming the size and scale of large GPOs. I think it's a risk for national GPOs because some of the services that they provide today will migrate into the RPG and they will begin contracting themselves.

RPGs can drive better compliance and they can also, instead of having a multisource contract, select a single vendor, which typically leads to a lower price point. I think the challenge for many, but not all of the RPGs, is that they are focused on price. My question is, what's next for the RPGs? Medical suppliers say that about 18 to 24 of the RPGs around the county deliver on their promise of compliance, sole source contracting and other sourcing factors. So, I question the long-term viability of these other RPGs.

Would you extend that same analysis to GPOs in that those that enforce compliance are more likely to thrive and those that don't will face challenges?

Yes, I've always believed that compliance and contracting strategy trump volume. If you look back over the last 20 to 30 years, there have been multiple consolidations of GPOs in the industry. In the last year there have been consolidations which amount to $80 or $100 billion. This is a lot of money but if you have multisource contracts with all of your suppliers you aren't demonstrating volume – and if you can't move the volume – your pricing is going to be sub-par.

I'm very fond of HealthTrust Purchasing Group's business model and strategy because they have stuck to a sole-source, highly-committed, volume-contracting process over many years. As a result, many healthcare systems across the country consider them a leader when it comes to driving volume and price compared to other GPOs. In my view, it's the compliance of their model and ability to deliver volume to vendors that makes them stand apart. No disrespect to the other GPOs as they have fine programs, but I think everyone would agree that HealthTrust has set the standard for the highest compliance within the remaining national GPOs.

Many providers are taking on more risk for patient outcomes because of population health and the Affordable Care Act. Do you think GPOs are trying to play a role in this with risk-based contracting?

I think we are at the bleeding edge, not leading edge, of risk-based contracting in healthcare because we lack a tremendous amount of data from both suppliers and providers. I recently reviewed several risk-based contracts and unfortunately they were not truly risk-based where there is a shared value and risk. Rather, they were in favor of the suppliers and driven largely by purchase volume. In my view, risk-based contracting doesn't include purchase volume at all. It includes factors such as cost for readmission, costs associated with the redo of a procedure and other factors.

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The other issue is that while some manufacturers will replace a device or a limited number of devices, they aren't looking at the whole cost of the healthcare provider which extends beyond the device to areas such as total treatment cost of the patient when they are admitted, not to mention if the patient is readmitted within 30 days. I haven't seen how those things get factored in yet. Part of the reason they are not being factored in is that it's challenging to determine the cause of readmission. Hospitals can claim that the readmission might be caused by a device, but it could also be something the patient did or a hospital-acquired infection.

We also need stronger EMR data to support the supply chain. We are at the very early stages of risk-based contracting and there is still a lot to learn. I think in regards to medical devices it's going to be a long process. In pharmaceuticals it's a bit different because there are common NDC codes and generic names allowing you to determine if the treatment works. It's likely that risk-based contracting will ramp up more quickly in pharmaceuticals than in hospital products and medical devices.

As you look forward over the next five years, what do you see as the biggest emerging issues, beyond contracting, that should be on the mind of supply chain executives?

I think there is a big need for stronger information technology in our industry. Many supply chain departments don't have access to the best information technology because of the costs of installing EMRs and other priorities. I think it's short-sighted not to invest in these resources.

I also believe we are going to see more "bolt on" solutions for information technology. One example would be the rapid adoption of UDI technology, which will lead to better patient record keeping as well as improved patient and staff safety and the ability to better track products throughout the supply chain. We don't have a good visual picture of where products go from the time they hit the receiving dock to when they are implanted in the OR.

Hopefully, over the next five years we will see EMR providers working more closely with supply chains so that the true cost per procedure or per clinician can be measured. I think we are at the doorstep of this but we aren't very far into it. I also think we will see more and more physician involvement in the supply chain because they are beginning to recognize the value of product efficiencies.

The other big challenge is training and education of the next generation supply chain management leaders. Organizations like AHRMM and others are trying to do more in this space but it's going to take a village to ensure we have the leadership needed for the future.