THE HEALTHCARE LEADERSHIP EXPERIENCE with LISA MILLER

EPISODE 3

Purchased Services with VIE Healthcare

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Lisa Miller (00:55):
Hi, this is Lisa Miller and I have special guests today on the Healthcare Leadership Experience. I have Rich Dormer, Brian Covert, and Pandu Mitre from the VIE team. We're going to have a conversation about purchase services and really specifically around: are you getting the best pricing or really a false sense of security? There's a couple of different components to the conversation today as it focuses around where we look to for cost savings or what some of our metrics are for cost savings and just maybe some of the assumptions or some of the areas that we consider not opportunities for savings. We're going to address those four particular areas we're going to talk about in more detail. We're going to talk together with this team, amongst there's a few other of us, of our team who aren't here, but who work on purchase services, but I've invited these guys into the conversation today and to the podcast.

Lisa Miller (02:11):
So, we can just talk through these four areas of maybe avoiding that false sense of security and really preventing missed opportunities — because I'll tell you what, we continue to work in this purchase services space, and they're just some significant opportunities. These are opportunities that we're achieving even after some of these have been reviewed as no-cost opportunities —no-cost savings opportunities — have been reviewed because they've been benchmarked in other places. It's still a ripe area, particularly now, with the challenges we are faced with the pandemic. If you really want to go uncover cost savings, I would really go back to, or go deeper into, purchased services. So I want to start off by asking Rich Dormer to jump in and talk with us about the categories in purchase services, because it's an interesting

space. Rich, if you can give us those six categories. There's two that most people really don't look at — and maybe some examples within the six categories, just give the audience some ideas of what is a purchase services spend?

Rich Dormer (03:30):
Great, thank you Lisa. Again, the six categories and how Vie separates out the different purchase services we have, one, is clinical services. Could be something like wound care, lithotripsy. Facilities and sport services is the second category. This obviously ties into any of the HVAC, and then any of the supply chain services and applications that are used there. Then we have the third category is finance, HIM, rev cycle. You have the ICD-10 coding, outsource coding, and then any of the debt collection and any types of financial tools that are being utilized. Then you have biomed and service & maintenance as our fourth category. So these are the clinical equipment services — as well as any types of service that being applied to any equipment in the clinical areas. Then our fifth category, is IT; telecoms, telehealth, and obviously your traditional telecommunications services — but also from IT, you have a lot of the systems that support the organization and in the bigger areas that's been increasing a lot recently, especially with COVID, there's a lot of the telehealth and tele-ICU and telestroke.

Rich Dormer (04:48):
Then our sixth category is administration and HR. A lot of the workforce management solutions are under the HR. And then as far as the administration, one of the biggest areas that we're seeing recently is on the physician services side, and as far as the groups such as you see anesthesiology, emergency medicine, pathology. Another area under this is joint venture agreements — specifically a couple of recent ones that we were working on, radiology and wound care, and these agreements are really complex. To just look at it in agreement and determine if there's opportunity is, it's really just impossible. It's the same as just looking at the invoices, there's a lot of information that needs to be collected from the PNL, net patient revenue, and also some of the professional compensation benchmarks that are really critical to look at the entire picture and understand what the opportunity is. Then obviously, there's the ability to negotiate the best pricing and best fees and the best subsidies — but all that is important to obtain from those critical financial drivers.

Lisa Miller (06:06):
Yeah. Thank you, Rich. I want to point out that a lot of these areas, if you go deeper

into purchase services spend, and if you start looking at some of those outsource position services — like you talked about the JV agreements — they become more complex, they need expertise. There's to be deep financial forensic reviews, deep expertise in knowing these services and all the components that need to be analyzed. This isn't a linear analysis; it requires a lot of understanding of where the money is flowing to and from, and the expertise to understand those services and how they may interact.

Rich Dormer (06:48):
Right. And based on a number of OR rooms and available minutes — as well as, what is the underlying hourly...hours that you're using to come up with a compensation baseline. These are the things that — if you're just shooting in the dark — you go to have conversations with the physician groups and the leadership there, you're not going to get anywhere, you'd be laughed out of the room. So it's important to understand really what are the critical drivers and put the plan together — and then collectively get the buy-in from the organization, but just because these agreements, these relationships, are very important for organizations. Obviously this is emergency medicine, this is your emergency department, leadership, this is pathology. These are the leaders within your organization, but they're also purchase service. It's an outsource agreement. So there's a lot of sensitivity around it as well.

Lisa Miller (07:40):
Yeah. And I just want to make one comment about that. Sometimes organizations like us to come in — particularly around these physician outsourced agreements — like you mentioned, or JV, because we get to not only do those forensic analysis, we do those reviews on subsidies, reviews on compensation or services — but we also get to be that buffer because hospitals need to look at those agreements, and you want to compensate for those services and certainly compensate them well — but there is also a requirement that these agreements have a deeper audit component to them and they need to be fair market value, so they need to have an annual review. But it also puts that buffer because it allows us to then be talking to the physicians and doing the negotiations and asking the questions, and really providing those services and kind of helping the hospital, maybe stay out of it a little bit.

Lisa Miller (08:43):
We know that hospitals got to ensure they're paying a fair market value pricing on

these agreements, and sometimes it's better to have an independent consultant or firm that's helping support the hospital and these arrangements and these analyses. We've seen that very helpful for hospitals and having us in the process. So, I'm going to jump right in, into this whole conversation of, are you getting the best pricing or is it a false sense of security? We've been talking a lot about this to our clients, and there's four areas of really where we want to explore. This conversation again specifically relates to purchase services, and so the first area is GPOs, and GPOs are a valuable part of our ecosystem in healthcare. They are definitely important for hospitals. I often say, is that there's going to be various pieces of the puzzle or tools in the tool set for hospitals to use for their financial improvement and GPOs are one of them.

Lisa Miller (10:01):
They're not the only one, many should be used. There's a lot of great innovative companies that are providing ways for hospitals to look at their agreements or look at their spend and look at value analysis. I encourage hospitals to really look outside of their GPO for additional second opinions and advice. But in purchase services spend, it gets very tricky because a lot of these agreements aren't... The hospitals aren't getting the best pricing. And because we think, "Well, they're our GPO agreement, it's the best pricing. We might get an admin fee share." But in many times that we're seeing a lot of issues as it relates to getting best pricing, because they are very regionalized in nature, very service oriented, and a lot of those price points need to be done really at a hospital or health system level. I know Brian, you work on quite a bit of these agreements, whether it's EVS or dietary, or where you've seen them on a GPO agreement, and it's really has cost the hospital quite a bit more money versus having their own independent direct agreement.

Brian Covert (11:22):
Yeah, that's exactly right. It's extremely difficult to negotiate a one-size-fits-all purchase service agreement — especially in those areas that you mentioned, EVS and food services. Oftentimes what happens is, if we look at food services as an example, some of the broader terms will be negotiated. The GPO agreement might cover what your food cost share back is, or it might limit a fringe rate benefit. But if you're not looking at the customized service requirements of the location, and you're not looking at the profit & loss statement as a whole, it becomes easy to cost-shift, to put additional costs as direct expenses. There's no possible way to do a one-size-fits-all agreement for food services that can fit all of the unique requirements of each individual location, do so at a best in market or competitive rate.

Lisa Miller (12:18):
Yeah, there is... I think you've had two different conversations you had shown me where there's a bucket of spend and dietary, it's like a catchall. And where money kind of gets moved around, but this catchall really ends up being a place where you particularly dive in and you really require this catchall bucket to be itemized.

Brian Covert (12:43):
That's exactly right. That's looking at reimbursed direct expenses. So I gave the example previously of capping fringe benefit rates, but if a particular location, a vendor is unable to meet that, they can take components of those rates and put them through as a direct expense, whether it's some kind of insurance premium or employee training or anything that could be argued as a direct expense. Some component of a healthcare premium or anything like that can be put through as a direct expense, and they can still meet that required broad fringe rate benefit that the national contract requires.

Lisa Miller (13:29):
Yeah. And I don't know, we don't throw in a whole lot of detail, and the admin fee share is an aspect of the GPOs of the safe harbor. So the hospitals can get access to contracts that they have negotiated in scale, the pricing exist, and so that admin fee share from the vendors is shared to some degree with the hospitals, depending on the arrangement. But we've also found where those admin fee shares or the admin fee costs on a dietary agreement or example, really could increase the costs because they're passing that cost through.

Brian Covert (14:09):
Yeah, and that's exactly right. So if you are negotiating your food service agreement and you push for an itemized PNL and you look in your direct expense buckets, you'll see that these providers are building it right in typically — or they're putting it in some administrative bucket, administrative overhead costs. And if you ask for specificity there, they'll share with you exactly what those costs are. You may have to push for it, but typically dollar for dollar, whatever GPO fee they're paying is built right into your profit & loss statement, it's built right into your expenses. So, you are paying for that.

Lisa Miller (14:46):
Right. Brian, thank you. It's really about these service agreements that have to be pulled apart, looked at by the detail to really understand what those cost drivers are,

and typically these services are very one-on-one rate or two-to-one rate and think that's all. Brian, talk a little bit about why that's probably a false sense of security, just looking at a one-on-one or two-to-one rate for dialysis.

Brian Covert (15:25):
Yeah. So dialysis is very complex, and it's very regional. It's probably one of the most regionally-affected areas of costs that you could contract for in the hospital. It has to do with a number of factors. When we're benchmarking dialysis, not only are we looking at the volumes and the one-on-one and two-to-one rate, but we're looking at things that affect those rates and that affect the cost structure of the provider. So, the availability of dialysis nurses in the area, the presence of competition, the specific setup and requirements of the location, what other services are being provided, do they give adequate space to do two-on-ones? Is it all bedside? So there's so many different factors that go into a dialysis rate. It's nearly impossible to just look surface level at a two-to-one and one-on-one rate and say, you're at A, you should be at B, without considering those factors.

Lisa Miller (16:22):
Yeah. I see a lot of times that we're getting benchmarks just for that. I also, I see it quite a bit and I just, I'm like, wait a minute. That it's not that over simplified. Like there's so much more to it when you gave it, you did a great job at explaining the other factors. So, we'll hear, "Oh, we've already benchmarked our dialysis and we've got great rates." Then we start asking these questions and then we do additional reviews and we're able to identify other opportunities, but that's a great example of where you might have a GPO agreement for dialysis or a regional agreement, but that still needs to be examined as an independent hospital. So thank you, Brian. Next we're going to move to RFPs. We love RFPs. We work with many of our hospitals to put together.

Lisa Miller (17:13):
We have our own methodology and our RFP, which is very streamlined and it accelerates that time and gets that analysis completed or out to the vendors in a shortened period of time. We think RFPs are great — whether you go right to renegotiation, because sometimes there's a reason to go right into and renegotiation versus having RFP, but there's certain times when RFPs do matter and they're important. How we analyze RFPs or how we really put them together is also important, because again — just because an RFP is put together, doesn't mean you're getting the best pricing. A lot of times, depending on how that RFP was put together, whether or not your hospital has a 12-month past utilization put

together and developed, and as part of the RFP, that's key because if you're only put it in 40% of your spend or only a couple of elements, you're not going to get the biggest value or the best value.

Lisa Miller (18:27):
We've had a couple of hospitals where we were asked to kind of jump in to help support the RFPs. They took maybe a one or two months sampling and we went back and said, “Well, we're going to go ahead and give you a 12 months extensive line item, detailed utilization, so we can build that RFP, so you capture the most value”. But Rich, do you want to talk a little bit about RFPs and sense of, just because you put together an RFP does not mean you're getting the best price and where some of those issues may come up with, in terms of an RFP that doesn't deliver the most savings it could.

Rich Dormer (19:07):
Right. And you mentioned the historical data and just understanding utilization. Obviously, that's a huge piece and which we see a lot of gaps in some of the RFPs that we've analyzed after they've been done. But, you also want to understand the current contracts and obligations, as well as the optimal goals of the why you're doing the RFP, right? That should be clearly outlined in the RFP, and then, that should be developed by really interviewing the internal stakeholders that are requesting the RFP. It shouldn't just be this general template and then sent out — there should be some reason why an RFP is being done. It shouldn't just be defaulted, but then the other party, the other side of it, is when those bids are coming back and really just getting that comparison down.

Rich Dormer (19:56):
Now, part of the strategy on an RFP before it's being sent out, is putting all that together in a succinct Excel spreadsheet, Word document, so when the vendors get it, they clearly know how to respond. The directive is to fill in the specific areas, based on the utilization, based on the contract, based on the optimal goals of your organization. Then once that information comes back, we see it, no matter how strict you can be on filling out information to vendors, either don't understand it, or aren't willing to do it, but still there needs to be that comparison. It's very important...

Rich Dormer (20:38):
We do see a lot of times where that comparison between vendors is not done accurately —just because some of the cost drivers are in the terms and not

necessarily laid out in the price file that's sent back. So, that's the biggest area that we always see, is to make sure that all of the terms and all of the price files, everything is put together — and then a vetting out process with each of the vendors is important as well, just to make sure and clarify what their intent was and what is actually being communicated in the RFP.

Lisa Miller (21:11):
Yeah. I love that you brought up two good points, is that frontline insights. Just because you had a contract for many years, and it may seemingly be something that's going to go into renewal, but just getting some feedback, asking some questions. I'm always amazed by when we do talk to those frontline users, these different issues come up, different facts come up, insights come up that really are very material to negotiating or putting together an RFP that has meaningful financial, operational, or clinical value. So, that's really important. The other thing that you mentioned, and I think it's a probably the biggest opportunity, is bid analysis — and how you analyze that, the bids, is really important, and sometimes we'll create spreadsheets and documents that have to be completed in our format.

Lisa Miller (22:14):
So the vendors can't complete it in their format because we want to make that analysis as streamlined as possible — but we also recognize that, different vendors will have their own structure, or they're going to put together a model differently, and we've got to analyze that bid analysis. That's the other opportunity in our fee is the accurate analysis and bids. So the third area, which this has come up more and more, and I think that this is probably the biggest, unfortunately, I want to say problem — but it's the biggest misleading area in purchase services spend these days, is these broad and irrelevant benchmarks. Purchase services spend just like your PPI spend, you need to go down to the component level, but the service line item level, and the only way to benchmark is on the line-item basis.

Lisa Miller (23:24):
So, we're seeing and hearing more about, "Well, we've benchmarked. We're getting benchmarks from our..." They'll say again, "Our dialysis spend by bed size. So we've got a benchmark of being able to analyze our dialysis spend by bed size to other hospitals." I often say, my first comment out is, "You wouldn't benchmark your PPIs by bed size." I mean, that would never happen, right? So why are we looking to benchmark by bed size for dialysis or for wound care, or for dietary or net patient revenue. Those factors do not have a correlating analysis, and even if they were to give you some sort of directionality, you would still have to go to the invoices. So we

say, just go right to the invoices, get line-item benchmarking. And I'll tell you what the problem is. If you think about it while I'm benchmarking by bed size, which bed size is it? Is it staff bed?

Lisa Miller (24:30):
Is it Medicare beds occupancy? I mean, we had a hospital had 70 beds. If you looked up their bed size, let's say they had 370 beds, but they kept 70 beds as an office. So who's determining what bed size? So, this is such, unfortunately, a bad metric. It's an irrelevant metric, and it's causing harm because if you say, "Well, there's no opportunities because we compare great on bedsides for wound care. We do great in bedside compared to food services." You're missing out on this opportunity by not going to the invoices and analyzing the details. It's such a dangerous metric because hospitals need cost savings now more than ever, and companies are trying to create broad benchmarks. This is not an... Purchase service is not for the faint of heart.

Lisa Miller (25:28):
This is difficult, roll up your sleeves work, and it's not work for throwing up an easy benchmark by putting one number and divide it by the other. This work requires a deep line-item invoice analysis, and deep subject matter expertise. So, again, I can't stress enough that, where you get your benchmarks, who's doing the thinking behind those benchmarks, why are they doing it, is it easy to create? "Oh, we have a benchmarking tool." Is it easy just to put something in a tool or is it truly meaningful? Benchmarks have to be accurate, they have to have specificity. You've got to be able to take that benchmark and negotiate with a vendor. Could you take a benchmark based on bed size and take that to a vendor and renegotiate it? Of course, you couldn't.

Lisa Miller (26:33):
Could you take a detailed line-item strategy with a thoughtful plan and explanation of why those line items should be priced differently? That's absolutely. So, I'm very passionate about this because I can't tell you how many hospitals are having a false sense of security, or they're not looking at these areas of spend, because somebody said — based on bedside, based on net patient revenue — that benchmark is a good benchmark. The fourth area is the contracts completed, so there's nothing more to do upon until renewal. So Pandu, I don't know if you want to talk a little bit, I think it would be nice to hear from all of us as we kind of wrap-up on this podcast.

Lisa Miller (27:22):
You do a lot of work with our technology and extracting those line-item details and programming the contracts in and providing the measuring and monitoring service. So you see it probably more than any of us, why that... Well, we've just completed the contract a year ago. There's two years left in the agreement. So, you know what, we're going to skip reviewing this versus "We need to review our contracts every year" — but can you talk a little bit about what you see, and maybe why that might give somebody a false sense of insecurity, just thinking I did that contract and we have two more years left on it and we'll review it then.

Pandu Mitre (28:03):
Yeah. I mean, I think it's common for us to get a contract and constantly monitor it by extracting invoices and probably 95% of the time that we extract invoices just to check these contracts, to make sure they're aligning, there's issues. A lot of the issues we run into sometimes might be because they just haven't been reviewed or they haven't been coded to the contract correctly. Other times it's just because they were never coded to the contract correctly in the first place, so the vendor is just not aware of it. It's really common to see issues midterm, which is why we tell our clients that we highly recommend that they review their agreements —even if they're not up for renewal right away, because it's extremely valuable to them. Yeah.

Lisa Miller (28:52):
Yeah. And I love that, you talking about having those reviews during term. We're used to saying, "Okay, we have a 3-year agreement. 6, 9 months before the agreement, we're going to assess it, review it." And sometimes if you are doing a deep analytical historical review, you'll find errors and then you probably find that service has been off contract. You can't go back and get a credit for off contracts then you possibly could for the credits. But if you are having a process where you were evaluating your contract performance — quarterly or annually — you're going to catch these things in real time. You're going to keep those cost savings, and you may even be able to go even further from the initial cost savings that you identified. Rich, you want to speak a little bit about contracts completed and we're going to wait until the renewal?

Rich Dormer (29:49):
Right. And there's two parts to this really, from a responsibility standpoint, when there's a sourcing event and the supply chain, it's working with the department and they're successful in putting a new contract in place. Then the focus goes to other

agreements, right? So then it goes back to the department, but the department has a lot that they have to manage and oversee. Typically, what we find is there's a disconnect just on the managing of the contract and the pricing— just because you do have the two, and then you also have AP. So it's usually shifted over who's responsible for managing the agreement. When you start to get the scales of some of these healthcare organizations and this, the amount of spend that comes through, it's just impossible for one group to do it.

Rich Dormer (30:38):
Especially when that group it's not their main focus. So, that's when we see a lot of these challenges are managing it. Then there's a whole industry now on just reviewing contracts and reviewing invoices and AP audit — but it's really these AP audit firms, it's failure work. It's just because the department finance and supply chain collectively — from a management of the contract, and management of the invoices, the management of the deliverables on the agreement — are just not taking place at the level that it should. Therefore there's a whole niche service now for AP audits that are for the foreseeable future, just because of the amount of size and volumes that are coming through on the invoices.

Lisa Miller (31:27):
Yeah. And it's so true, Rich, right? So we built into, particularly on the purchase services side, we built into knowing that they're manual to reconcile, unless you work with Vie, we've got an automated way to do that, but they're basically manual to reconcile. These reviews, line-item reviews, can't be done. Some of these invoices have tens of thousands of line items. So it's physically impossible, really, for people to know what every single line item price should be versus the contract. So they usually analyze it by 10%, give or take. They see a spike, then they're going to dig into it.

Lisa Miller (32:08):
Now we built into the industry, AP audit firms who have to help us with failure work, and we say, you know what — we want our hospitals to be high-performing hospitals with high-performing contracts that are measuring, monitoring in real time. There's a fee to pay for that failure work. It's a lost money opportunity at the time when you're overpaying and then paying for another company and then the resources to support that company. So there's a big cost to pay for not having a measuring and monitoring system. Yes, there is an investment, but that investment is far less than having to lose the money, then trying to recapture it, and then pay to recapture it.

Rich Dormer (32:56):
Right. Just one other piece on that is that a lot of those AP audit firms are not understanding the complexity of some of these agreements. There's opportunities that are missed from a credit standpoint or from an adjustment. Plus, you're looking at what is off-contract, because they're not really looking at what products are off-contract. They're just looking at what's on-contract as incorrect pricing. So there's a whole other piece there. If you rely on AP audits alone, you're missing out on a lot of cost savings opportunities and credit opportunities.

Lisa Miller (33:26):
Yeah. So we say, let's have real-time optimization, real-time reviews, real-time ensuring that items are on the contract, real-time ensuring that the price is accurate. You want to operationalize those purchase services spend. So you have real-time measuring and monitoring, and you will capture a tremendous amount of cost savings, picking up on errors. I mean, I don't think we can overstate how important it is to have a real-time measuring and monitoring program on your purchase services spend.

Rich Dormer (34:06):
And just think, if half of your spend, half of your amount neighbors spend you have, if it's off by a penny, immediately supply chain knows, AP knows, the difference — it's a red flag. It gets asked to be looked at and before it gets paid, right? So any type of price increase, any type of mistake on the invoices, on sutures, endo, implants, all your supplies and PPIs immediately, but on the purchase service side, you could go months, years, with an incorrect price and no one will know about it.

Lisa Miller (34:42)
Yeah. We could probably give everybody so many stories, but the one always pops up in my head is, where we were performing, helping a hospital renegotiate one of their medical waste agreements. So our process is always going back 12 months for the invoice data so that we can see the real utilization. So we can benchmark with line-item detail. We were looking at the line-item details, and there was one line item that had a 10 times $3,400, and the $34,000 price buried into what read “regulated medical waste” invoice and it just said “price increase”. That invoice was paid, but to Rich's point, if that had been a PPI or somewhere else, that capital, that would have flagged $34,000 not to pay. This invoice was paid. What's fascinating is this hospital has a categorization tool that they use, and that month it was a dip, it was a lowest month out of all the spend.

Lisa Miller (35:43):
So nobody would even have looked in that month because the categorization is just, they're just directional. So it was a dip, it was one of the lower months of the year, and yet there was a $34,000 billing error that was paid. If you think of compounding that by eight, nine, 10, 20, 50 times all over the hospital and all these different purchase services, you see the opportunity where measuring and monitoring and putting a program in place is so essential. You want to be real-time monitoring your purchase services spend.

So I just want to thank you for listening today. It was great having Pandu, Brian and Rich on the podcast today. We've enjoy talking about opportunities and our work to listeners. So you'll hear us a few other times having these discussions, and we're also going to have a few other of our analysts and subject matter experts. We have a Telcom IT, a guest from VIE, Jacqueline Oberst, will be on a show in February as well as guests from hospitals and within and outside the industry. So thank you for joining us today.

THE HEALTHCARE LEADERSHIP EXPERIENCE with LISA MILLER

MEET LISA MILLER

It's important for hospitals to have a clearly defined cost savings strategy with purchased services as a component to that strategy. We provide our clients with a focused roadmap to achieve those savings through our expertise since 1999

Lisa Miller launched VIE Healthcare Consulting in 1999 to provide leading-edge financial and operational consulting for hospitals, healthcare institutions, and all providers of patient care.

She has become a recognized leader in healthcare operational performance improvement, and with her team has generated more than $720 million in financial improvements for VIE Healthcare's clients.

Lisa is a trusted advisor to hospital leaders on operational strategies within margin improvement, process improvements, technology/ telehealth, the patient experience, and growth opportunities.

Her innovative projects include VIE Healthcare's EXCITE! Program, a performance improvement workshop that captures employee ideas and translates them into profit improvement initiatives, and Patient Journey Mapping®, an effective qualitative approach for visualizing patient experience to achieve clinical, operating, and financial improvements.

Lisa has developed patented technology for healthcare financial improvement within purchased services; in addition to a technology that increases patient satisfaction through front line insights.

Lisa received a BS degree in Business Administration from Eastern University in Pennsylvania and a Masters in Healthcare Administration from Seton Hall University in New Jersey.

She is a member of the National Honor Society for Healthcare Administration – Upsilon Phi Delta. Her book *The Entrepreneurial Hospital* is being published by Taylor Francis.

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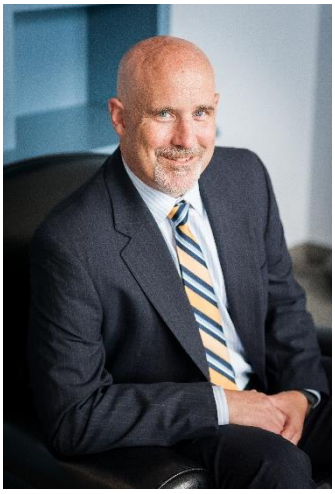
MEET RICH DORMER

Healthcare Margin Improvement Expert, Chief Operating Officer.



Richard Dormer serves as VIE Healthcare's Chief Operating Officer and Healthcare Margin Improvement Expert. In this role for over 13 years at VIE Healthcare, Rich identifies and implements dramatic cost savings for VIE's clients. He has extensive expertise and knowledge of hospital expenses across the organization.

Rich's specialty is high costs implants in the Operating Room and hospital Purchased Services, where he has worked collaboratively with VIE's clients to save over $290 million during his tenure. Rich also specializes in hospital decision analytics and his ability to analyze big data sets to uncover true costs and cost savings opportunities is unparalleled in the industry.

Prior to joining VIE, Rich spent nine years with two equity sales firms on Wall Street. He applies the same analytical approach he learned on Wall Street to his work at VIE, and has become an expert in finance analytics for healthcare organizations.

Rich is also a skilled negotiator known for his ability to drive down contract costs without sacrificing services or quality. His sharp negotiating skills contribute to his expertise in the difficult areas of physician preference items and clinical preference services.

THE HEALTHCARE LEADERSHIP EXPERIENCE with LISA MILLER

MEET BRYAN COVERT

Healthcare Margin Improvement Expert, Managing Director.

Bryan joined VIE Healthcare Consulting in 2012 and works alongside the top healthcare providers in the country carrying out high-level analytics and cost savings work.

Bryan's strength lies in strong analytics skills which enable him to analyze and organize complicated data sets, identifying trends and true costs of VIE Healthcare Consulting's clients. He is also skilled in working with pricing models to determine strategy and reveal underlying costs. He brings high-level negotiation skills and intelligent negotiating strategies for the benefit of healthcare organizations.

His experience extends across a wide array of contracting areas from IT and purchased services to physician preference items.

While working with VIE Healthcare Consulting, Bryan's success stories include:

- Playing a critical role in driving over a dozen successful Spine implant cost savings initiatives. These included a detailed analysis of reimbursement, side-by-side vendor construct comparisons, and physician utilization/landscapes.
- Working with clients to navigate through very complicated EMR system renewals to drive six figure savings.
- Successfully renegotiating and transitioning a prestigious university and medical center from Coca Cola to Pepsi which generated over $5 million in savings over 10 years, including $700,000 in Year One.
- Helping to lead the transition team to re-design supply chain operations for a 459-bed health system moving from state-owned to private entity.

Prior to joining VIE Healthcare Consulting, Bryan gained entrepreneurial experience as the CFO of two successful start-up companies in the public safety sector. During this time, he helped to lead a start-up public safety company to a $2.5million dollar pre-revenue valuation in 2017.

Bryan graduated Cum Laude From Richard Stockton College achieving special distinction in the business program. He is also a certified NJ Tax Assessor.

THE HEALTHCARE LEADERSHIP EXPERIENCE with LISA MILLER

MEET PANDU MITRE

Healthcare Margin Improvement Expert, Senior Business Analyst.

Pandu Mitre brings a depth of business acumen and analytical expertise to VIE Healthcare®, coupled with an ability to manipulate data to provide actionable information for its clients. He is skilled in creating efficiency in healthcare systems by reducing their reliance on manual processes.

Since joining VIE Healthcare® in August 2016, Pandu has played an integral role in the development of its automated, patented technology, Invoice ROI™. He has helped to deliver significant cost savings to hospital purchased services through this guaranteed margin improvement expertise.

In one instance, invoicing errors extending over two years were identified in a client's diagnostic laboratory services, resulting in thousands of dollars in credits each month.

Pandu is committed to empowering hospitals and healthcare systems to develop strategies to implement these cost savings.

He previously held a number of demanding positions in the financial services sector requiring adaptability and versatility. While working at Fidelity Investments, he was recognized for his work in reconciling millions of dollars in alternative investments through persistent work in Excel.

These transferable skills enable Pandush to obtain invaluable insights into purchased services spend for the clients of VIE Healthcare®.

Pandush graduated with his MBA from Western Governs University and got his undergraduate degree in finance and economics from Monmouth University.

He possesses specific skills in coding language (M) for Power BI Data Modelling and an in-depth knowledge of data manipulation and advanced Excel and Microsoft Office programs.