THE HEALTHCARE LEADERSHIP EXPERIENCE with LISA MILLER

EPISODE 14

Hospital Supply Chain Series: Re-Thinking Your GPO Strategy with John Reese

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Speaker 1 (00:06):

Welcome to the Healthcare Leadership Experience, a place where healthcare leaders will share proven strategies and innovative approaches to leading the clinical and business side of healthcare. This show is sponsored VIE Healthcare Consulting, who's proudly helped hospitals save over $700 million in non-labor costs since 1999. Here's your host, Lisa Miller, founder and CEO of VIE Healthcare.

Lisa Miller (00:32):

Welcome to the Healthcare Leadership Experience Podcast. I have a new series on the healthcare supply chain where Rich Dormer and I will be discussing with industry experts on ways these leaders are improving, innovating, and planning for the future healthcare supply chain. Join us over the next several weeks where we are focusing on having deep and thoughtful conversations on the healthcare supply chain. This is Lisa Miller, and I'm the host of the Healthcare Leadership Experience.

As we continue our special series on the healthcare supply chain, today, I'm really excited as we have a great discussion with John Reese. John Reese is the Senior Director of health solutions at FTI Consulting, a global consulting firm. John has a wide range of experience. Most of his focus has been in supply chain and expense reduction initiatives, including pharmaceuticals, IT and other purchased services. His experience spans workforce optimization, including productivity improvements and KPI standardization, as well as other

EBITDA improvements. And he has managed third party RFPs and all kinds of expense reduction initiatives. John is truly an expert in helping hospitals reduce costs.

Prior to joining FTI, John worked as a business intelligence manager at Vanderbilt University medical system, and we are very excited to have him and we have a very interesting and thought-provoking show ahead of us. If you'd like to learn more about VIE Healthcare, please go to our website at www.viehealthcare.com and schedule a call with me to learn how we can support and accelerate your purchased services and cost savings goals. Now let's get started.

John Reese (02:19):

55% of the respondents said they wanted better pricing. Now, I get that, that's kind of like, why did you leave your job for more money? That, that exit interview question, it could be similar. Everybody wants better pricing and always, but to have 55% say that the GPO wasn't performing there is very interesting takeaway. 33% said better services. And two other interesting components that came out of the question really around strategy, what are you going to do differently in the post pandemic world, in this GPO environment, in 2021/2022?

Lisa Miller (03:00):

I am excited to have John Reese from FTI on our podcast. So we are frenemies. I say that to him and giggle because we have become friends, yet we are competitors. I have a ton of respect for John's work — and we have similar missions and advocacies. We love supporting our hospitals and getting them through cheap cost-savings. It's a mission for us, and so we've become friends, although we do compete, but we have aligned thinking and aligned mission. So welcome John Reese from FTI, really appreciate you coming on to the Healthcare Leadership Experience.

John Reese (03:37):

Yeah, thanks. Like you said, we do compete, but we do share a common goal. We're just trying to help maximize value to clients and usually that results in saving money and increasing efficiency.

Lisa Miller (03:49):

Yeah. I think it's going to be a great conversation. I came to know you because you started a survey last year, and this year you've recently just completed the survey. So reaching out to hospitals and those in operations and executives to get their ideas and thinking about GPOs and their supply chain, and I'd like to lead with that. If you can just talk to us a little bit about the survey last year, and then — I know this year is not out yet — but maybe you can give us a preview.

John Reese (04:22):

Sure. So the genesis behind the survey was really trying to validate some of the things that we were hearing from our clients. And it came out right as COVID was ramping up in the first wave. So the timing, when we were talking about PPE, we were talking about shortages in GPOs and distributors not being able to help our clients. So we wanted to validate and take a pulse of the market from a CFO, COO and VP of supply chain perspective. What is being done? What are your perspectives on GPOs? How are they helping?

This year, we did change it up a little bit. We changed the bend, we changed a little bit about the survey, which could have led to what we're seeing. And we did, I don't know if we're gaining momentum, we did, there's a lot of reasons why, but we did double our response rate in this go round and the survey just closed about a week ago. Overall GPO sentiment, the big takeaway, the big question, question one is, how do you feel about your GPO? How are they performing just overall? To a scale of one to five, most of these questions are one to five. One is not performing, five is very well. Three is neutral.

John Reese (05:33):

So in the second year of the survey, that answer, how's your GPO doing? It was up to a 3.8 from a 3.4. So, we're still in the process of trying to make sense of what the data is telling us. Obviously, that's positive for GPOs. It could be a lot of reasons. There's been a lot of movement in the marketplace, in the GPO world lately. Aside from that question, though, there's a bunch of other interesting data points that came out. So, 55% of the respondents said they wanted better pricing.

Now, I get that, that's kind of like, why did you leave your job for more money? That exit interview question, it could be similar. Everybody wants better pricing and always, but to have 55% say that the GPO wasn't performing there is very interesting takeaway. 33% said better services. So, that's another one that I'm sure we'll talk about GPO services. Two other interesting components that came out of the question really around strategy, what are you going to do differently in the post pandemic world? In this GPO environment in 2021/2022?

13% said they were going to bid out their GPOs, so looking at changing. 13%, they're going to move to more local contracting. And then we also had 15% actually say that they were looking to start their own thing. So, I think we're going to, if I had to prognosticate and think through what we'll see in next year survey, I think that's going to gain momentum and probably continue. So, that's an interesting takeaway.

John Reese (07:19):

And just anecdotally, we left one question, speak your mind. There's a free text field where you can just fill in. And two really interesting notes came from that. So one respondent said, "Focus on your core, I'm not sure you know who you are anymore." And the other one that was really interesting was, "Make sure you read the fine print." And then went on to expand on the reasons why, and the different things you should look for, but a tip, make sure you read your fine print in your GPO contract, and we can talk about that as well. Those are some of the overall highlights.

Lisa Miller (07:52):

So I have a number of discussion points that I wanted to talk with you about. I did not know what you would be bringing forth in the new survey, so I'm just as shocked to hear what you'd said. And I do feel like I want to start with the open text because I think that's so true. Both points are really powerful. Know who you are.

GPOs are meant to provide favorable agreements. That's the whole purpose of a GPO, that's how it started, favorable agreements that hospitals could access. And for that, they would be paid a percentage, admin fees, and protection to safe harbor. That's the course. If somebody wrote in there something that I believe in, at the core, they should actually know who they are. And I think

that throughout these last 20+ years, a lot of that's been co-mingled and gotten a little confused in the mix of it.

So, I, whoever wrote that, I agree. You know. They're meant to produce great favorable contracts — and if not, hospitals should be free to direct contract, you and I agree on that. Direct contracting is a critical strategy, GPOs are one tool in the toolkit, but not the only one. So I think I'm gonna kind of ask you what you think about direct contracting and mixing this contracting med-surg supplies, you know, bedpans, gauze, those things. They probably do really fantastic at complex services, PPIs, things that hospitals have tremendous leverage and ability to get their own best pricing. So what are your thoughts, John?

John Reese (09:30):

Yeah, I share a lot of the same sentiments. I think there is a place for GPOs, there's really, they're a wheelhouse. And like you said, a lot of the commodity supplies think of it from a provider perspective. When they have a contract landscaping, the landscape will have high dollar contracts and then you'll have thousands of hundred thousand, $10,000 annual spend contracts. And that becomes extremely cumbersome for any provider organization to manage. And that's where GPOs come in. And that's where they lend a lot of value. They lend the horsepower, all of the resources related to analytics negotiation. No one provider organization will ever have the bandwidth to manage those contracts.

However, when you get to the higher dollar annual spend items, some of your core vendors, core manufacturers, core device providers and PPI and purchased services, that's where you really enter a different sphere. You can't have that same attitude all the time. And when I say “you”, I'm always going to be referring to provider organizations.

In the response in the survey this year, the sentiment towards PPI pricing, Physician Preference Item pricing, is 2.9, which is below neutral. It's up from 2.8 last year, for what that's worth. Purchased services was also a 2.9 and up from 2.6 last year. So I think we could probably have a podcast episode dedicated to PPI and a podcast episode dedicated to purchased services. But just briefly, I think I should talk about PPI and there's, there's...

Lisa Miller (11:19):

I think you should, and, and I want you to talk about both of them because I think that's a wonderful use of our time for our audience, below 3%, to 8 to 6 to 9. I hear it too. It's underperforming and you know, hospitals need cost-savings, end of story. They just do. So I'd love for you to talk more about that, please, John.

John Reese (11:42):

Okay. So Physician Preference Items is one that if you're not tackling it, it's probably because you're afraid of the docs or you're not willing to have those difficult conversations for trying to convert them, or you don't have the data. Those are some of the reasons why you wouldn't tackle PPI and go after your own local pricing.

In order to do that however, and cross that bridge, you'll have your GPO price. If you reject that that's a good price, you really need a third-party source telling you what you can get. So that can come in the form of a consultant like us, that can come in the form of third-party benchmarking solution, a software solution to give you market pricing — just really give you a pulse check on what you can go out and get from a price perspective.

There's a bunch of different ways that you can tackle PPI. The easiest is pick up the phone and call and say, “hey can you beat this price?”. And often our clients don't even take that entry step just to tiptoe into the world, but that's at a very base level. You should at least do that. I think the second component is really education of your providers, your surgeons, your docs, and really getting them to back you because some of the reasons why a PPI negotiation could fail, it could be clinical reasoning.

There's another episode about value analysis and new product entry into the provider space. There could be honestly just boils down to relationships with vendors. I've always used as some comfortable with these people, these products, even if it's clinically equivalent. So a lot of conversations need to be had to socialize, and then really once you get all the docs behind you, then you approach that vendor and, and come out with a better outcome.

So then we often hear the argument, “But why would we go through all of that?”. We're getting these rebates and that's the discussion that really, we

need to help educate folks on the rebates versus better pricing. So if I can save 10% off of any given item, a percentage of the contract admin fee share back is never going to equate to that 10%. So the way that people think about it should be, "I should maximize my price benefit before I think about my rebate." So that's moving off of GPO contracting, negotiating locally, and capturing that value for your organization and not sharing with your GPO organization.

Lisa Miller (14:25):

Yeah. So I just want to sit and talk about Physician Preference Items and those higher-cost clinical items, because hospitals — I often talk about this — they have so much leverage negotiation power, it's specific to them. And like you said, they need to put together even a 4- or 5-page deck to provide to their doctors. This is the data in the marketplace. This is where we're priced. This is where we think we can be. We just need your support. And if the vendors come to you, come back to us and we'll handle it, but they have to trust the data.

The hospitals really need to be providing that cost information to physicians because they're scientists, you know. One of the ways that we talk with our hospitals about Physician Preference Items is that all-play model, right? Is it physician's choice? If you want to standardize at the second phase, you can standardize at the second phase. The first phase, all the vendors need to pay the same price for a tibial plateau, or a screw, or like a spine implant or a mesh or whatever, you know. You've got to standardize these pricing and be competitive.

It's very difficult to put in a model to tell a hospital, our GPO agreement says we have to do this. Hospitals have negotiation leverage. They have market power because of the physicians, so a lot of things that they have, that they don't leverage and use and direct contracting is such an important aspect to, you know, reducing costs. So I appreciate you leading us into this Physician Preference Item world. Have you anything else to say on that Rich?

Rich Dormer (16:04):

Yeah. It's just interesting, you know, you're processing into, you know, obviously the three layers you talked about, which is, you know, just kind of the benchmarking and then understanding the clinical and the approach to

the negotiations, but how do you find the post-negotiation analysis of PPIs and how to, to maintain the cost savings that you've achieved?

Because I, I think we see this a lot in purchased services, and you also see it in your PPIs as well — because the representatives that are in the cases with the physicians, they're incentivized by the more volume they could bring in, the more revenue they're going to get paid more. So we find that a lot of times you cut off a couple of different areas and you get good pricing, but they find other ways to increase those revenues through different types of new approaches, new types of technology or types of biologics that they're adding. So I'm just curious what your thoughts are on that. We think the fourth layer, which is that management of the purchased services or the management of the PPIs.

John Reese (17:05):

Yeah. I think that's part of what Lisa said, a 5-page deck to present to your providers that really opens the conversation, and that conversation should not be transactional. So that part of the delivery you're opening that conversation. You are going to come back and revisit with data consistently to — if anything pops up, make sure you — you keep the costs down.

So it's a two-way conversation. You get the other perspective. Well, I need this new biologic for these reasons. And then that gives you some directive to go back to the vendor and, and make sure that that's included in your new pricing. You talked Lisa, a little bit about all-play. And I think that is one way, cause, and the GPOs really try to limit this too. And that the perspective from the client is, we can't do the all-play because we have to be X percent compliant with XYZ vendor. And so that's that GPO mentality. But when you break away from that, that's when the world opens up. That's when you now can get the pricing and you basically, you have carte blanche to do whatever you'd like.

Lisa Miller (18:20):

Yeah. And can you hold there because I like what you just said, and I think that's where the alignments are misaligned because the GPOs want to do that because it benefits them. They secure the admin fees versus opening up a new world, a new way to think — allowing hospitals to have at least all-play model to begin with. We're not saying that — you said it earlier — value analysis could

open up another world of standardizing, maybe 9 vendors to 6. But I love how you just said that it, it opens up the world when you don't have to confine to the way the GPO wants you to do things.

Sometimes if you want to move some product, that's your choice. When you're forced to do it, it only shows that you're the hospital, the provider's cost savings has to be secondary to the admin fees. And, I'm going to tell everybody who's listening, if you are looking at a PPI engagement an all-play model is the way you should go, where the vendors are all required to pay a specific price. And that could be benchmark.

Like John said, there were a number of different companies, you know. We're not the only ones, there's others out there, but that strategy works. We do it every day. I know John, you do it. It's very successful. And you know what, physicians love it. It makes for a high satisfaction engagement with the physicians. And so you're working in the constructs of what is good for your physicians, your hospital cost savings, all those wonderful goals. And sometimes you have to step out of, like you said, John, that kind of group think where we only have to listen to our GPO.

John Reese (20:01):

I think one thing — so there's the breaking free, but when you do break free, the GPO is going to say, "Oh, well, we would like you to put that on our paper rather than on your own contract paper." And I think that's where we go back, let's talk a little bit about the alignment of incentives here. And that's potentially why you couldn't get an all-play type process from a GPO because they are aligned with vendors. They're getting paid by these vendors.

If you were to do the whole process and at the very end, put it on GPO paper, you could know that at least the contract admin costs from the vendor to the GPO could be subtracted from the price that you got because they're making that admin fee into their pricing model. And if they know that you are going to put this on your local contract paper, no GPO involved where you can recoup all of that admin fee, that the GPO is no longer a part of.

So when we think about admin fees and think about how they are taking those admin fees to really fund the rest of the organization, fund growth, fund their servicers, fund their analytics and all their other product offerings that

could all be used for your organization to improve quality, to improve patient satisfaction, all the things that we value within healthcare that could go directly to you rather than to this GPO middleman.

John Reese (21:04):

And so when we talk about that admin fee, I automatically go to, well, these admin fees really have separated the core mission and values from where they need to be. So now the GPO and the GPO representatives, the GPO onsite collaborators that often report to the provider facility every day. Now have an incentive to push that GPO paper. We want more spend to go through our paper than your paper so that we can collect more admin fees.

You may not get the best price. If there's two vendors with similar pricing and one's a GPO vendor, and one is not. The natural inclination for the GPO will be, well, they're both the same, why wouldn't you go with the one that we have on our paper? And so, I'll let the listener judge for themselves —shouldn't there be the ability of freedom of choice as a buyer or as a service recipient?

Rich Dormer (22:35):

No, John that's a great point, and I just wanted to bring up, there was a client that we had worked with uh, on a RFP for food and nutrition services and about two and a half million dollars spend, and the vendors came in with, and included in their GPO administrative fees within their proposal. But when we started to break down the different cost buckets, you know, we asked that they remove those, you know, when we brought it to administration and just to understand the dollar amount, it was about $95,000 a year in administrative fees that the vendors would be paying.

Now what the communication was, well, you're going to get some of that back. So as a client, you're going to get your admin share back. In this case, our client was like 50%. So out of the $95,000, they were going to get $47,500 back. But over a three-year contract, that's almost $150,000 that they're paying for and that's going directly to the GPO that they're not coming back.

And I think a lot of people don't understand that — and they weren't even involved, the GPO wasn't even involved at any step of the process. Yet they're looking to — on a three-year contract — take that 150 and use it elsewhere. And it was really specific in the contract language because that was the chosen,

the vendor was picked. And in the language, they specifically said no GPO fees, but they did have a note that says, GPO fees, the parties agree that a services provider is required to pay new GPO or Group Purchasing Organization fees or increased GPO fees. There will be a corresponding increase in the services to the providers. So basically, if you ask us to put this on GPO paper, we're going to raise our pricing.

Lisa Miller (24:13):

Which just shows you that again, we're saying that GPOs have a place, and they should be in the marketplace. There's a lot of areas where they're good at. However, this is a case where they are costing hospitals, more money, and that's the conversation we're trying to elevate and to show, our job is to save money. And I would hope that no matter what area, no matter what it means to a GPO, that GPO feel the same way.

This is an example that the vendors are just, you know, they're kind of in the middle sometimes, and this is a direct contract that they had to make sure that later on GPO wasn't going to tack on that 3%. They weren't going to get some kind of renegotiation in their agreement that requires them to give them admin fee dollars. In fact, the GPO did not put together a favorable contract, it was the hospital and whatever other sources they decided to use.

John Reese (25:08):

I applaud that vendor for being transparent like that. But I would say that that clause is unwritten in every GPO contract or non-GPO contract. Because if it's not, if that clause were not in there, they would find a way to increase their total revenue by the amount, because a lot of these vendors are publicly-traded companies, and they have Wall Street expectations on margin. If there's a 3% margin hit because of a GPO contract and these admin fees, they have to make it back somewhere. Whether that's pushing additional volume, increasing pricing, ancillary service additions, all of those things will play into the total cost that's paid by the provider.

Lisa Miller (25:54):

So I have a question for you, which I find really fascinating, is that if anyone here listening, you and I or Rich, have a health concern, and we get an opinion. I think the common practice is second opinion. Sometimes even third opinion, is common practice. You, your body, you wanna know everything about it.

Maybe someone has a unique perspective. Maybe somebody is doing something so innovative.

In fact, that happened to my daughter. She has seizures and we ended up getting a second opinion. We were going to a wonderful doctor, he's amazing. We still think he's amazing. I went to another physician, and he actually had a new approach, a new medication, and it, it's working. And not that I didn't love the first doctor, the second one, we were kind of like, let's just get a second opinion. We shouldn't feel bad because we like them.

Um. We did and we have a totally different outcome. It's changed her life, it has changed our lives. And I'm just fascinated, why are hospitals — particularly GPOs — they don't want a second opinion on pricing. They don't want hospitals to utilize another outsourced benchmarking or an outsourced advisory? They get very sensitive, you know. I hear all the time. Well, GPO really doesn't... They said, let us all do that, you don't need to, to go to VIE, you don't need another source. And it's so fascinating, why GPOs are restricting a second opinion, restricting competitiveness, restricting the ability for others to get some other insights.

Why would they do that, if they really care about cost savings and maybe they don't have all the answers? I mean, isn't that a possibility?

John Reese (27:29):

Yeah. I think the other thing we see is that it's acceptable for a VP of supply chain to use whatever their GPOs analytics is. And the analytics would say things like, at your current spend with your current commitment rate, you've got great pricing, you know. You've got relative to the other members and that's the key when they are using those tools, they're still in the sandbox.

They're not looking at national pricing, local contracts, other GPOs, they're looking at within the sandbox of, let's say, Premier, let's say Visian, I've got a good price for this particular item and that's acceptable to them. So they move forward with the contract and then all the other things, admin fees that we talked about. Whereas if they were to truly get an independent second opinion, they might discover new strategies, new items, competing items, clinically equivalent items, and much better pricing with less commitment, less restrictions.

Lisa Miller (28:32):

Yeah. Two interesting, quick stories, I'll tell you talking to two different CFOs. One CFO had said to me, you know, Lisa, it's important to me is that I really pull apart my GPO agreement because the fact that we're buying so many tools and subscriptions and all these services aside from utilizing the GPO, we never really get to see the innovation in the marketplace, and it's important for me... I'm paraphrasing what the CFO said. It's important for me to go to the marketplace. There might be better analytics tools, better innovations, other things out there. And it's important to me that we look at it. And I think as an industry — is so wisely said, the CFO is having this conversation. In contrast, I had actually a COO said to me, "Lisa my GPO says that we're in the top 5% of costs in the GPO."

And I think he's great, um, we've had the opportunity to have many conversations, but I often say, well, what if your best pricing is outside your GPO? You're the top within yours, two thirds plus because there's health systems that don't use a GPO or they, you know, they do other strategies. So you're only seeing this world and that world may be greater and you're missing out on opportunity.

So, and I'm always having these conversations because we really got to get out of this thinking that everything resides within our GPO. They're important, but you need second, third opinions. You need to know the tools and the other innovations, there's some amazing analytics tools that reside outside in the marketplace. So I don't know what your thoughts are John.

John Reese (30:10):

Have you ever left a car dealer, and they say, wow, I just can't believe you got that price? Man, you really drive a hard bargain. We've never done this price before. Boy, you really set the precedent. That's what my mind goes to. And I think now there's different tools out there that are addressing that problem, but we don't have that same type of mentality in healthcare. It's not as easily comparable in healthcare as it is in other markets, and I think that is going to change.

Lisa Miller (30:39):

I did. I, I was talking to a friend of mine. His name is Alan Weiss. I've talked to him a lot about different things. And I was mentioning, trying to explain to him GPOs, and I think it's, it's really hard to explain to people outside of healthcare. And again, there's value. We're not saying there isn't, it's just that they're part of the tool, but not the only tool. They're not the only source of truth. They're part of it.

And so I was explaining to him, and he said, just so shocking that they'd be so threatened, and he almost speaks to, "Maybe that there's some insecurity or some issues that they really do push back on getting others to give insights and advice. It's telling to them not saying, absolutely we want what's best for your hospitals and oh, we're so guaranteed, you know, that we're doing what's great you, you shouldn't do that, you should get a second opinion." But I, I thought that was an interesting perspective from Alan.

I want to jump onto another subject and talk a little bit about what your survey found that there's probably, you know, hospitals are taking a second look at their GPOs and what maybe are the best-practices for them to do that. You know, by, we don't do that work, I think FTI does that work, so we're in good frenemies space, but I do feel like if I was giving advice to a CFO or if I was coming in as a VP of supply chain, I would take my GPO agreement and take it into two parts.

I would have access to the contracts. Their contract is one agreement and anything I would want to buy separate. I would not co-join, co-mingle any analytics, subscriptions, consulting — I would, I would have them separate. I would also perform a very thorough audit of the agreement, use your largest outsourced agreement. We audit everything, you know, in the hospitals, make sure you're getting everything you're promised, you're using everything. I would say first check to see if you're using things, just because your admin fees are paying for it doesn't mean you're not paying for it. But that being the case, that's how I would look at it. John, what would your recommendation, because you're the expert here?

John Reese (32:42):

We turned this GPO optimization — and I think optimization just personally is an overused word, but GPO optimization, what that means is designing that strategy, recognizing that a GPO will have a place in your organization, but where is that place and how do you manage it? A GPO is probably the biggest or one of the biggest vendors that you have as a part of your organization and they need to be managed and just that way.

So when we talk about GPO optimization, it's really designing exactly what you said, where are they going to be permitted to play and where are they going to be carved out. Are there analytics tools within supply chain, within supply spend that are advantageous? Do they have market-competitive other tools, clinical quality tools? They really offer a lot of tools that need to be evaluated just like any other vendor tool would. Are they going to have a place in consulting? What is that going to be?

And then making sure that you stay aligned with that strategy — don't let the creep come in. Oh, okay. It's okay. Just for this one PPI item that we're going to negotiate on a GPO, make sure that you, it's almost like putting up a wall or a fence around them and letting them do their best within that fence, and then you do your best. And work together in partnership to make sure that you're optimizing that spend. So it's really defining the relationship and monitoring closely.

Lisa Miller (34:14):

Right. And so I just want to just sit there for a minute again, if anyone's listening and I will provide some contact information for John, they're doing great work in this area, helping and giving hospitals that strategy. And if you could reach out to John to get more information about how they're reviewing and analyzing, if you're looking to evaluate the marketplace to reach out to John's group.

What I want to talk about again, is that again, putting those walls, have a GPO agreement, GPOs are meant to have favorable agreements. That's one agreement, anything outside should be competitively looked at in the marketplace. So of course, you're going to give the GPO an opportunity to bid on, let's say an analytics tool or a purchased services offering. It should not be

expected that they get it automatically. It shouldn't be put into an agreement and co-mingled with other fees and, you know, that gets things very complicated and messy. It should be separated.

And for lots of reasons, because if you have to untangle them or if your hospital is still at a negative operating margin, and you've done everything that the GPO wants you to do, well, what, what do you have left? You've got to go to the marketplace to look at other options or opportunities, right? And now it's very difficult to kind of unwind — but I want to ask you about a minute, John you have anything else you have to say about those agreements. I wanna jump to that purchased services, but do you have anything else you haven't reached about the agreements? Go ahead John.

John Reese (35:45):

I think I can tie that GPO optimization concept into purchased services because they're really... I, I can't think of a perfect sweet spot for a reason why GPOs would be involved in purchased services. They have really taken a lot of steps to get to the point where they offer a lot of purchased services contracts, but we know that most of those purchased service agreements are pricing independent. Essentially, they're a cover letter that you add pricing to on your own.

So you do all the work. It goes through their GPO admin fee process and spend, but you still hold the onus of negotiating that contract, negotiating the service levels and all the associated negotiations with that vendor. And that's true for a lot of purchased services. So I think when you're designing that GPO strategy, you really need to consider where does purchased services play in that? And the answer likely isn't, they get all of the purchased services spend as well to go back to the rebate.

That rebate is not going to cover your savings. And we've seen Premiere come up with conductive, there's HPG buying Valify. Those are their attempt to close that gap. And when we talk about GPO gaps, that's still a remaining gap. They can advise you on a per patient day type rate. There's all these tools associated with purchased services now — but at the core of it, you're still going to have to own that negotiation and really educate yourself or hire an expert to educate you on what's a favorable purchased service rate for any given category and because of the volume of purchased service categories,

that becomes cumbersome for an individual provider.

Rich Dormer (37:33):

No, that's great points. And we were talking earlier, I see three different layers and we've kind of touched upon it earlier of costs of types of products and services and, and negotiations. And really the first is the med-surge. We talked about like the transactional, this is the bedpans and the gauze, which are pretty simple, but, you know, this is where the GPO shine from a pricing standpoint, and then you have like the second layer, which is the PPIs and the implants, which obviously we talked about it earlier, you know.

It's a lot more challenging while the GPOs do have contracts and some of them will help, you know. There's just so much complexity and there's so many other things that go along with it that there's so many different challenges and gaps — but that third layer, the most challenging, the most important one is the purchased services, even physician agreements would fall into here.

And I liked how you say it, the ability to pricing independently, you know, and to really analyze and to go through these contracts it's not easy. So when you look at a contract and we were working one services agreement where one GPO has their contract, you know, at $3.50 cents, all the services, there's a 7% fuel charge. Where there's another vendor in this RFP that's not under the GPO, which once it gets over $3.50 cents, they're charging 0.5% fuel charges.

So that's a significant difference. And, and the difference really is paying for the administrative fees, because if you can take them off the GPO contract, then you can negotiate that fuel charge. And we see these national contracts, I think a lot of people get, you know, a false sense of security from the GPO agreements, because like you said, it's just really these, you know, kind of over structured agreements where it really talks about payment terms, liability, like you said, fuel charges and then obviously the administrative fees.

So what really purchased services needs to happen is to really understand from a hospital-specific, service-specific, what's going on for each individual type of contract needs, individual type of relationship, that analysis needs to take place. And you're not doing that, you're missing something.

Lisa Miller (39:39):

Yeah, absolutely. I'm going to jump in for a minute. It's again, I'm going to go back to the language around why Congress allowed for GPOs to be protected by the Safe Harbor and the favorable agreement. So when you get into purchased services, particular, they are really not favorable agreements in many times. And so it really begs the question of what's going on with them, even getting those admin fees, if it's not a favorable agreement, that was the whole point of it, and, and also the intention was never to have a one source of truth, you know.

Particularly healthcare, we thrive on innovation. There should be supply chain innovation, pricing innovation. We should not be not innovative. And certainly, competition is invaluable. When we start restricting competition, we're going to have problems when GPOs don't want advisory insight. There are companies like ours, or... That's a problem. We all are working together for a common good, which is the U.S. healthcare system to reduce costs.

So, you know, purchased services, we're very passionate about. John, you have a lot of expertise in purchased services. You can use some technology, you can use some benchmarking, all these things, but it comes down to deep thorough reviews, historical analysis of spend and expertise. You want the best pricing. It cannot be in a tool, it's just not possible.

John Reese (41:08):

Yeah. The, the example that Rich gave was a great one and multiply that times all of your thousands of purchased services contracts. You need really individual expertise on that elevator maintenance agreement that's coming up and the constantly renewing the contracting cycle for purchased services is never ending. So, to have someone say, oh, we already tackled purchased services is not a true statement. If you tackled it with the GPO, you didn't, haven't scratched the surface. If you tackled it on your own, you've got more tackling to do because you, you've got a portion of the agreements coming up next year, and the following year. There's always something to look at in this space. There's always new contract clauses that vendors are trying to add that you need to tamp down. There's a constant evaluation in this world.

Lisa Miller (41:57):

Absolutely. And even if you feel like you've tackled a lot internally, you put an audit on what you have because the data's on the invoices, you can't run a detailed report. And this whole what goes on in the middle is key to tackling, just auditing contract performance. Am I getting the right price? Are there off contract spend?

I just want to have a conversation quickly with you about ratio benchmarking. I'm gonna stay here for a minute. This is what I think drives me the most crazy when I hear, oh yeah, we're getting our purchased services benchmarked and a tool. And I'm like, okay, so you're benchmarking based on comparison of bed size and revenue? And nobody's looking at the line-item details, they're only looking at a little bit, or the contract you're benchmarking is based on bed size.

So that, I just want to talk about because I am very passionate about that being very, very misleading because there's reasons why a hospital's dialysis spend same bed size, same revenue, might be different in two different organizations. That means how they choose to outsource who they choose, where they're located. How could you possibly benchmark a dialysis service based on a ratio of bed size or revenue? John, doesn't that drive you crazy?

John Reese (43:14):

Yeah, when, when this first started happening, I remember just thinking, this makes no sense. You really have to incorporate operations in every discussion. So, that dialysis example is a good one. Let's think about clinical operations. What is impacting that spend? What services are offered? You can't compare, there's no light to like, when you're talking about bed size. Another good one that always comes up is engineering and facilities spend.

If I have a robust in-sourced team of electricians, plumbers, painters, and you name it. And then I hire out 1% of my remaining jobs for that world, I'm going to look great on the benchmark. However, if I have one facilities manager that is essentially, uh, a purchasing agent that goes out and finds a third-party service for all of those specific trades, I'm gonna benchmark horrible.

Now, then we talk about what's the appropriate model and how do we get into the right mix of skilled labor and non-skilled labor and third-party

purchased services. That's a different discussion. You can't just put a numerator and denominator and call that a benchmark.

Lisa Miller (44:29):

Right. Thank you. So, as we wrap up, I can't believe this time went so quickly. So I am inviting you back. We're going to do it soon because we didn't cover like 80% of the other things I wanted to cover. So you're coming back soon.

John Reese (44:42):

Well, I told you this had to be at least three hours or else (laughs).

Lisa Miller (44:51):

You did. So, is there anything that you want to say, before, final words that you think is important as hospitals thinking about their supply chain and cost strategy, or, you know, how they're looking for cost savings or anything that you'd like to say, John?

John Reese (45:02):

Well, I think in the 2021 world, you're going to continuously be asked to save more money, and through traditional methods, it has gotten us to this point. So I think we need to think differently. Not say that we've already tackled it, try to tackle it again with a different mindset, a different angle, a different vision, and come at it again with an open mind, rather than really just thinking through the language that your GPO is telling you, or taking the easy road.

The easy savings come with, almost like apathy that we don't want to creep in. The way to really get the benefit is to do the hard work, roll up your sleeves, investigate, compare with third-party benchmarking and other expertise to make lasting impact.

Lisa Miller (45:53):

Yeah, I agree. And I would gladly, as competitive as I am, glad we lose to you John, any day, because I know that you're going to deliver cost savings to a hospital. I welcome hospitals to have more engagement from experts like you. That makes me feel like, okay, they're going to get a deeper level of savings when they get different thinking. When they get insights, people who have

deep expertise that want what's best, it doesn't have possibly an additional incentive of a admin fee as their directive. We don't have that as a directive. Our directive is to save hospitals money.

So I welcome everyone to reach out to John Reese. I'm going to share his contact information. John does great work, him and his team at FTI. He's got a new survey coming out. His first survey was fantastic, it was very, very well done. And you could reach out to him for the second survey, John. Thank you.

John Reese (46:49):

Yeah. Thank you. This was fun. Stay tuned for the full write-up. We're going to put a white paper together on the findings of the survey. Always a pleasure to talk to you both and thanks for having me.

Leah Miller (47:00):

Hi, this is Leah. You were listening to my mom's podcast, the Healthcare Leadership Experience.

Fernando Miller (47:07):

Hi, this is Fernando, would you like to speak with my mom? Just email her.

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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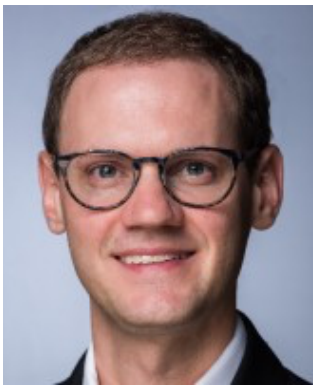
MEET JOHN REESE



John Reese is a Healthcare Performance Improvement Expert, Workforce and Purchased Services and FTI Consulting, a global consulting firm.. Most of his focus has been in supply chain and expense reduction initiatives, including pharmaceuticals, IT and other purchased services.

John's experience spans workforce optimization, including productivity improvements and KPI standardization, as well as other EBITDA improvements. He has managed third-party RFPs and all kinds of expense-reduction initiatives. John is truly an expert in helping hospitals reduce costs.

Prior to joining FTI, John worked as a business intelligence manager at Vanderbilt University medical system,