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INSIDE THE CURRENT ISSUE

Having My Say

Bridging 3 supply chain disconnects

Using clinical resource management can optimize the value in the GPO relationship

by Timothy K. Glennon, R.N., MSN, MBA, CMRP

Effective supply management, particularly of clinical preference products, can make the difference between red and black ink for the many U.S. hospitals struggling with razor-thin operating margins.

With supplies and implants representing more than 30 percent of a hospital's total cost per case, and with clinical preference products accounting for more than 60 percent of the hospital's total supply expense, hospitals must derive maximum value from their supply chain relationships in general and their group purchasing organization (GPO) relationship in particular.¹

A tri-fold case for action that I call "the three disconnects" can make that maximum value a reality.

Disconnect No. 1: Suppliers and their customer hospitals are not partners; their interests are not aligned. As hospitals seek to reduce their losses while pursuing their core mission of providing the highest quality care, hospital equipment manufacturers pursue the goal of maximizing their profits. Medical device manufacturers are seeing record demand and reaping record profits for an ever-expanding list of technological breakthrough products, while hospitals continue to struggle with inadequate reimbursement, lack of access to capital, and break-even (at best) profit margins.

Disconnect No. 2: Supply chain and finance are not focused on the same things as the clinicians. Every year, hospital supply chain executives are charged with the increasingly difficult challenge of cutting costs and delivering savings from an ever-growing list of clinical products they have no control over. Chief financial officers are looking to balance the budget, and clinicians who may not even know the CFO's name are struggling with their own patient care issues – likely including staffing shortages – and rarely is supply chain expense reduction their first priority.

GPOs have been around a long time, and despite claims to the contrary, their value to hospitals in reducing costs has been objectively validated.² In fact, the largest hospital supply chain database has consistently demonstrated that the greater a hospital's GPO penetration, the lower its supply costs are as a percentage of net patient revenue. Thus, the more the supply chain team focus

on implementing its portfolio of GPO contracts, the lower the hospital's supply costs.

Still, many well-meaning supply chain executives are still transactionally oriented, considering every GPO contract offering as a place to start their own negotiation. They regard a GPO contract as a means of leveraging a better deal from the contracted supplier on a "one off" basis, often delaying – sometimes for months – the realization of immediate savings in the hopes of obtaining even larger savings later on. As a result, a significant, often never quantified "opportunity cost" accrues related to the time value of money on those savings delayed or never captured as soon as identified.

Disconnect No. 3: Focusing on the "art of the deal" rather than on the art of optimizing GPO value. The hours spent trying to leverage a few high-profile contracts is time not being spent on deriving value from the vast majority of available contracts (in Premier's case, more than 1,300) that are continually being negotiated and validated by clinicians and supply chain executives. Many of these contract opportunities fly under the radar screen completely, they are never "switched on," and the savings and other built-in contract benefits that have been comprehensively negotiated on members' behalf are never optimally realized. Thus, the potential value in the many is sacrificed to the pursuit of additional value in the few.

At GNYHA Services, the Clinical Resource Management function, in support of the client service executive team, helps our 200-plus member hospitals address each of these disconnects, and to optimize the value of the GPO relationship (in this case, GNYHA Services/Premier) – particularly with respect to the clinical preference category.

Reconnecting disconnects

Disconnect No. 1: For the past three years, GNYHA Services has offered its "Clinical Updates" series of monthly educational seminars. Key suppliers are invited to provide purely educational clinical content on a wide array of topics of current import and interest. These seminars are offered as a free educational service to all members of the Greater New York Hospital Association, whether or not they utilize the GNYHA Services/Premier GPO program. For those who can't attend the Manhattan seminars, the content is Web-streamed live and archived on the GNYHA Services Web site. The seminars help facilitate communication between hospitals, suppliers, supply chain executives, and clinicians, enabling all participants to better appreciate their respective roles and the part each plays in promoting quality patient care and reducing hospital supply chain costs.

Disconnect No. 2: The Clinical Resource Management role is first and foremost one of knowledge-brokering for our members. Particularly when dealing with clinical preference products, it's important that supply chain executives feel comfortable having an intelligent dialogue with the clinician-users about the products being considered in the value analysis process. We've developed a number of resources to help keep our supply chain executives clinically informed and up-to-date relative to the volatile clinical marketplace.

- To facilitate supply chain-related dialogue between supply chain executives and clinicians, we've developed the "APIE – VA" Value Analysis Process – a systematic method for clinical preference product review based on the Assess/Plan/Implement/Evaluate nursing process at the core of clinical nursing practice.

- To be most effective in clinical preference supply chain management, you need enough knowledge and basic familiarity with the topic to have a productive, collaborative dialogue with clinicians regarding their products and utilization patterns. To foster this understanding of the clinical, technological and contractual issues relating to complex clinical preference products, we've created "Clinical Field Guides" to provide timely and relevant information on particularly challenging clinical contract categories.
- Keeping on top of what's important in the clinical supply chain is a major challenge for the busy healthcare executive. Our weekly clinical e-bulletins summarize the latest clinical information in the lay and trade press, plus announcements of upcoming clinical seminars and updates on clinical contracts in the GNYHA/Premier GPO portfolio.

Clinical quality benchmarks, national patient safety goals, and the CMS "pay-for-performance" program are examples of topics not specifically related to the healthcare supply chain but definitely influenced by the supply chain's efficiency and service level. New in 2007, we distributed a Clinical Quality Hospital Profile for each of our members from publicly available information provided by CMS, The Joint Commission and others to help patients become more discriminating consumers of their own healthcare.

By raising the supply chain executive's awareness level regarding the various quality measures and the hospital's individual scorecard reported on various Web sites, we are helping the supply chain team improve quality care in their facilities and become more intelligent healthcare consumers themselves.

Disconnect No. 3: Being a skilled and savvy negotiator has long been a key role for supply chain executives. Historically, an organization's evaluation of the effectiveness of its supply chain executives was determined by how well they demonstrated their ability to "get the best deal." Many defined their roles and the value they personally derived from their work as a function of how well they personally negotiated with their hospital suppliers.

The sheer volume and complexity of clinical products required by today's hospitals make such deal-making possible for only a relative few of the thousands of items used throughout the year. Through skilled and savvy use of the significant resources already invested by the GPO on behalf of its members, the supply chain executive can bring added value through locally or regionally negotiated enhancements to the core contract when warranted, and can focus on putting systems in place to insure that the proven value of maximum GPO penetration can be realized.

A few clinical resource management hints and tools we routinely provide to assist in this process:

- Clinical "Crib Sheet" – a weekly newsletter formatted as a checklist, focusing on major changes in the clinical product catalogue that deserve special attention. In this age of information overload, the goal is to make it easier for supply chain executives to "laser beam" their attention each week on the most relevant topics.
- Key point: statistics prove³ that you will do better overall by focusing on maximizing GPO penetration rather than on individual contracts (similar to the stock market: you generally do better in professionally managed mutual funds than you do buying and selling individual stocks). If you build your internal systems to coincide with the published GPO contracting calendar, you guarantee that you'll be touching all the major product categories purchased by your

hospital at least once every three years. Keep in mind that even if your current pricing is at or better than the contract pricing offered, which does happen, you will likely be able to "grandfather" your current price in a locally negotiated agreement within your GPO relationship, thereby laying claim to the price protection and other benefits beyond the price embedded in the contract.

- What about capital equipment and technology? If your GPO has a group buy schedule posted in advance, consider tying your capital budget schedule to that calendar whenever possible. By publicizing the calendar in advance, perhaps as part of your capital budget communications package, hospital departments will be able to plan and schedule their requests to coincide with the capital purchasing activities of many other facilities — and to reap the benefits accordingly.

Bottom line: Our effectiveness in the increasingly challenging realm of clinical preference supply chain management may be at least partially related to our ability to distinguish between what is merely interesting and what is truly important. In endeavoring to bridge the gaps between the "disconnects," GNYHA Services Clinical Resource Management is focused on making the truly important easy to find, easier to understand, and interesting enough to motivate meaningful action and ultimately optimal outcomes. [HPN](#)

Timothy K. Glennon, R.N., MSN, MBA, CMRP, is vice president of [GNYHA Services Inc.](#) and the recipient of Healthcare Purchasing News' 1997 Materials Management Leadership Award.

References:

1. Montgomery, K, Schneller, E. Hospitals' Strategies for Orchestrating Selection of Physician Preference Items. *Milbank Quarterly*, Vol 85, No 2, 2007, pp 307-335.
2. Muse and Associates, "The Value of Group Purchasing Organizations in the US Health Care System," 2005.
3. According to Supply FOCUS, Premier's health care database comprised of over 700 facilities, not exclusively Premier, there is greater than 4% difference in total supply expense as a percentage of net patient revenue between the hospitals at the median using their GPO with less than 20% penetration, compared to hospitals at the median with greater than 60% GPO penetration. Even when comparing top performing (as opposed to median hospitals), the difference in supply chain expenses between least and most penetrated is still significant at 2.1%.

