The Journal of Healthcare CONTRACTING

Providing Insight, Understanding and Community

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Vol.3 No.2

Lean streets

Healthcare consumers and payers seem to want less of everything.

Providers and suppliers need to adjust to this new world.

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The customer imperative

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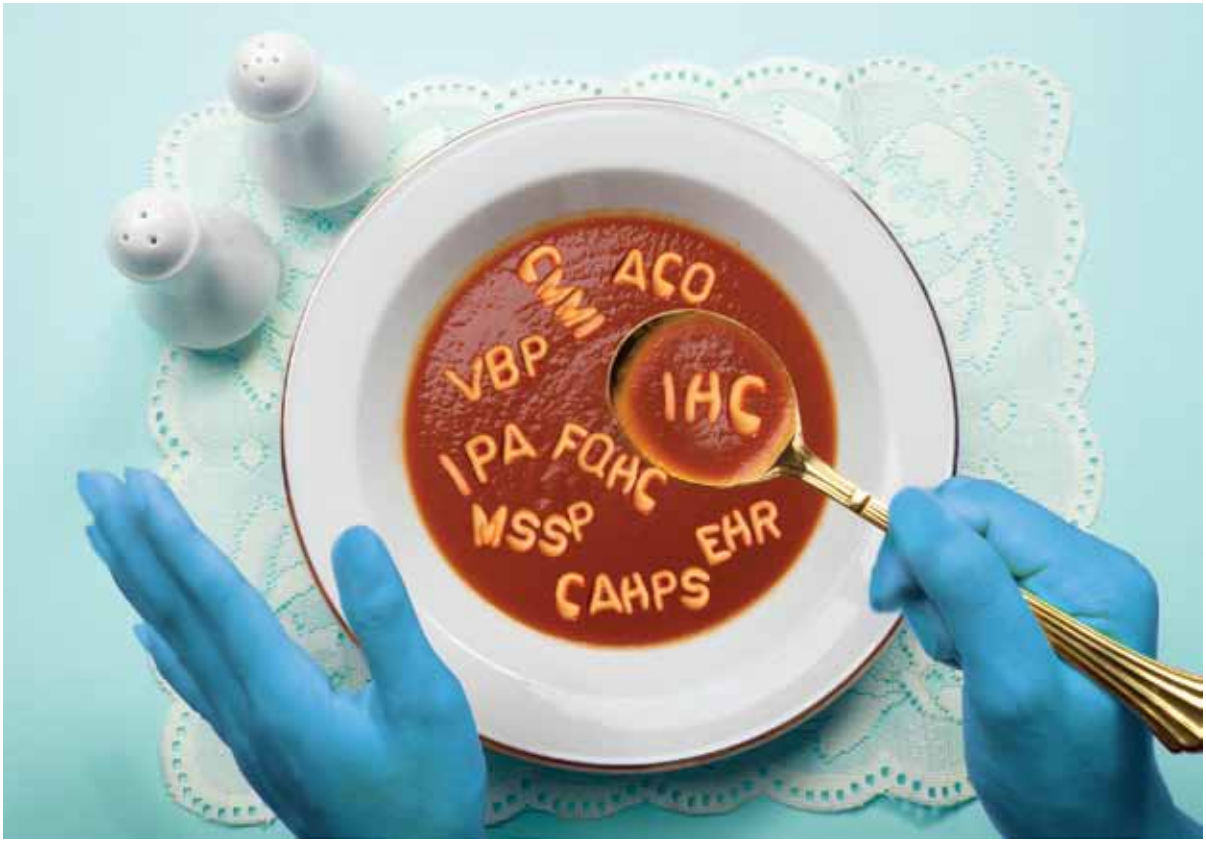

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"One way of being inefficient is doing things 30 different ways, which magnifies product costs, labor costs – all of which providers get reimbursed for."

– James Orlikoff, a Chicago-based consultant

Land of opportunity

Ted Almon knows all about the mother of invention. It was out of sheer necessity that his company, Claflin Co., and Women and Infant's Hospital formed their industry-setting stockless arrangement 25 years ago.

Editor's note: Ten years ago, the *Journal of Healthcare Contracting*'s sister publication, *Repertoire*, launched the Medical Distribution Hall of Fame. It was intended to recognize individuals who have had a significant impact on the medical supply chain. (To visit the Hall of Fame, go to www.repertoiremag.com/halloffame.shtml.) Here is the story of one of this year's inductees – Ted Almon, president and CEO, Claflin Co., Warwick, R.I.

Twenty-eight-year-old Ted Almon acquired a failing, $2 million regional distributor in 1976 named Claflin Co. and has grown it into a successful regional acute-care distributor, one of the last independents still standing in that market. He did it by hard work, courage, conviction and intelligence. And, he would add, luck.

The point, says Almon, is that hospitals will continue to face challenges to contain their costs.

Ted Almon

"Every successful person I have ever met in my career, and there have been many now, was at some point 'in the right place at the right time,' in other words, just plain lucky," he says. "This would certainly include me."

Almon was born in 1947 at the Providence Lying-In Hospital, which, ironically, became Women and Infants Hospital, with which he launched one of the country's first stockless programs in the country almost 40 years later.

He went into the Army in 1969 as an ROTC First lieutenant and was discharged in 1970 as a Second Lieutenant. During that period, Almon was assigned to Fort Bliss Texas, for training as a missile systems officer in anticipation that the enemy in Vietnam would eventually gain

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air capability. At Fort Bliss, he was selected to lead the first platoon of a new weapon system, the self-propelled Hawk, the first mobile medium-range guided anti-aircraft missile deployed by the U.S. Army. For his work, he was awarded an Army Commendation Medal, unusual for non-combat duty. As it turns out, he was never deployed to Vietnam.

His decision to get into medical sales was not really a decision at all. "In reality, I was just looking for a job," he says. Military officers were in high demand at the time, and he found an agency that specialized in their placement. He interviewed with Herb Wise, a discharged Air Force officer, at Baxter, and got a job. "Ironically, at the time, Baxter was a smaller company than Claflin is today," he says. Just six years later, Almon acquired Claflin Co., a small, almost insignificant distributor of Baxter products.

Almon's uncle, who was a sales manager for Davol, knew the principals at Claflin and arranged for the discussions that led to the acquisition. Though the company was small, it had a solid reputation as well as access to all the necessary lines. "The owners jumped at the opportunity to see the company and their remaining handful of employees continue," he says. The president agreed to stay on a year as president emeritus. "It was a perfect platform for an aggressive young salesman to build upon."

Devil in the details

In the mid-1980s, Almon capitalized on what he characterizes as another lucky break – and a watershed event in the history of Claflin Co. At the time, Dudley Sisak – who today is Claflin's vice president of operations – was director of materials management at Women and Infants.

"The distribution model then was, you had your local GPOs and lots of regional distributors," recalls Sisak. The General Medical rep would come in to pick up his 15 or 20 lines, as would the Foster rep, the American rep, the Claflin rep, the Pilgrim rep, etc. "This would happen week after week after week," says Sisak, who had begun his work at the hospital in the finance department. "There was no real vetting" of the sales reps or their companies.

The hospital – which was the birthing and neonatology center for Rhode Island – was facing a dilemma. It was in the process of affiliating with Rhode Island Hospital.

The hospital – which was the birthing and neonatology center for Rhode Island – was facing a dilemma. It was in the process of affiliating with Rhode Island Hospital. That would mean relocating Women and Infants to a new facility on the Rhode Island campus. The reason was simple: "If baby and mother were compromised, the mother went to Rhode Island and the infant to Women and Infants," says Sisak. Relocating to one campus would eliminate that problem.

But there emerged a major shortcoming in the impending affiliation, particularly for those in the supply chain. "All the necessary planning, regulatory approvals, and certifications had been completed

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and construction was in fact underway when negotiations between the two hospitals over a contract to provide certain support services broke down," recalls Almon.

It had been the intent of planners that Rhode Island Hospital would provide all the supply functions to the new Women and Infants through a tunnel between the facilities. "As is often the case, this theoretical idea had many little devils in the details of its implementation, not the least of which was the current inadequacy of the host's facilities to support even their own growing demand, and a rather gross misunderstanding of how different the product requirements of the two facilities would be," recalls Almon. "There wasn't even a receiving dock planned for the new Women and Infants, and there was no place to add one."

Having read about a pioneering stockless program in Omaha, Neb., Sisak called the distributor, Koley's Medical Supply (now Owens & Minor), to inquire about it. Then he approached his distributors – with mixed results.

"I asked my distributors, 'If I bought everything from you, would you deliver to me five days a week?'" says Sisak. Several gave him a simple answer: "Absolutely not." Not Almon, though.

Meanwhile, Women and Infants had created a task force to address the impending supply chain problem. Almon was invited to participate. "We agreed that the inventory management technique then heralded as behind the ascent of the Japanese auto industry, called just-in-time, could be adapted for use in a hospital," he says. Claflin and Women and Infants struck a deal for a stockless program.

"I asked my distributors, 'If I bought everything from you, would you deliver to me five days a week?'" says Sisak. Several gave him a simple answer: "Absolutely not." Not Almon, though.

"All of it was driven by necessity," says Sisak. "We had no options. But Ted really ran with it. He has that kind of vision. He was always convinced it was the way of the future. And [stockless] has grown faster than even he thought it would."

Today, many hospitals and hospital systems tend to look at JIT/stockless as a given, but it certainly wasn't always that way, says Almon. "When the trend began, it was mostly a cost shift from the hospital to the vendor, with the advantage to the vendor only that he became the sole or 'prime' supplier to the facility, and there was a big incentive on the hospital's side to put as much as possible through the new channel to maximize efficiency.

"Once the vendor had several hospital accounts on the program, though, it became feasible to automate some processes that were performed manually, first in hospital storerooms and next in distributors' warehouses. As throughput increased, productivity gains became possible, as warehouse shelving was replaced by automated carousels or flow racks, and conveyors moved end user orders swiftly along computer generated tracks."

EHCR

As he was developing his supply chain expertise, Almon became heavily involved with the Health

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Industry Distributors Association, serving on its Executive Committee, Hospital Market Group and Educational Foundation, and, in 1992, as its chairman. (He was awarded HIDA's Industry Award of Distinction in 1997.)

As chairman, he and HIDA President Jim Stover initiated a critical look at the healthcare supply chain, which they called the Paradigm Project. "[Stover] and I had both been where the rubber met the road, and we knew – or thought we did – where the industry was missing the boat from an efficiency standpoint," he says. "We were warning people that staying the course with some of the processes in our channel – most notably, rebate processing, but there were many others – could be a road to disintermediation.

Just as he threw himself into identifying shortcomings and potential solutions to healthcare supply chain shortcomings, so too has Almon thrown himself into the topic of healthcare reform.

Their efforts, as well as that of late HIDA Vice President Chris Pancratz, resulted in the conversion of the Department of Defense and Veterans Affairs depot systems to commercial distribution.

The Paradigm Project was the precursor of a larger industry effort, the Efficient Healthcare Consumer Response, which in 1996 resulted in a report identifying more than $11 billion of waste in the healthcare supply chain.

EHCR became a call to action, says Almon. But the call wasn't always heeded. "Some of us were hoping for things like more pricing transparency and an end to clearly wasteful practices, but most of those produced small pockets of profit for some stakeholders and proved rather resistant to reform.

"What the EHCR fueled, for the most part, was the healthcare version of the dot com phenomenon. Spouting the data from the study, a vigorous stream of startups claimed to have the solution through technology for the industry's ills. Of course, we know now that virtually all of these enterprises, even those with the most fertile funding sources, eventually succumbed to the need to find a profitable business model."

One survivor from the period is the Global Healthcare Exchange, or GHX, which Almon refers to as a public utility, albeit an unregulated one. "It provides many of the features heralded 15 years ago for such facilities, but quantifying the benefit to the supply chain is as yet unclear and even uncertain.

Healthcare reform

Just as he threw himself into identifying shortcomings and potential solutions to healthcare supply chain shortcomings, so too has Almon thrown himself into the topic of healthcare reform.

He is a frequent contributor on the topic to the Providence Business News, and is an appointee to Rhode Island Governor Lincoln Chafee's Healthcare Reform Commission. He has served on a variety of task forces dealing with health reform, and is a member of the Legislative Affairs and Public Policy Committee of the Rhode Island Business Group on Health.

"Healthcare reform isn't normal cocktail party talk," says Sisak. "But it is to Ted."

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One aspect of the current healthcare system Almon finds distressing is what he refers to as the "perverse" fee-for-service system of reimbursement.

"The incentive created by our form of fee-for-service reimbursement is purely to provide more service," he says. "There is no price competition, because these rates, once negotiated on the private side, and always on the public side, are fixed. Quality or effectiveness of the service is unaccounted for, and indeed, poor performance can often lead to the necessity for further service and more reimbursement. Talk about perverse.

"Where we are trying to get, of course, is some sort of global budgeting for healthcare, and there are a variety of proposals, such as bundled payments and pay-for-performance, which might move us in that direction. Conservative thinking is that the power of the free market must somehow be unleashed in medicine to contain costs. I like free markets as much as the next guy, but with the government already paying well over half of all healthcare costs, I don't see how vibrant consumerism can ever be established."

The point, says Almon, is that hospitals will continue to face challenges to contain their costs. "As they struggle with this transition, the very nature of their enterprise will change. Most hospitals already receive the preponderance of their revenue from outpatient activities. As for distributors and manufacturers, the spoils in this game will likely go to the nimble."

Future for independents

Clafin is, and will remain, a family business. "We have a succession plan and we are working it methodically," says Almon. "There are not specific replacements for the key managers and executives so much as a class, or new generation, of potential leaders who will, through their performance and our assessment of their strengths, sort themselves into the various slots.

"We hold 'succession classes' for the group where the senior managers are the faculty, and all topics we can think of that future managers might need to know are covered. We have separated our medical equipment business functionally and physically as much as possible, and have initiated separate strategic plans for each unit. We expect each business to grow, albeit most likely in different and separate ways."

"There are not specific replacements for the key managers and executives so much as a class, or new generation, of potential leaders who will, through their performance and our assessment of their strengths, sort themselves into the various slots."

– Ted Almon

Though the hospital distribution industry has consolidated, Almon believes there will always be independent distributors. "They exist in virtually every segment of industry, but they are always challenged by consolidation of the customer base, which can create buying entities beyond their geographic or financial capabilities.

"We think technology and collaboration among independent firms will allow for new enterprises, which coordinate the efforts of separate fulfillment agents in a uniform manner, creating 'virtual' enterprises of much greater scope." **JHC**

Dr. Gregory Hickman's goal is to avoid narcotic-based pain control and its potential consequences whenever possible. He succeeds by practicing Regional Anesthesia, "which also gets patients quickly and more comfortably out of the surgery center, opens up beds and makes nurses available to take care of more patients."

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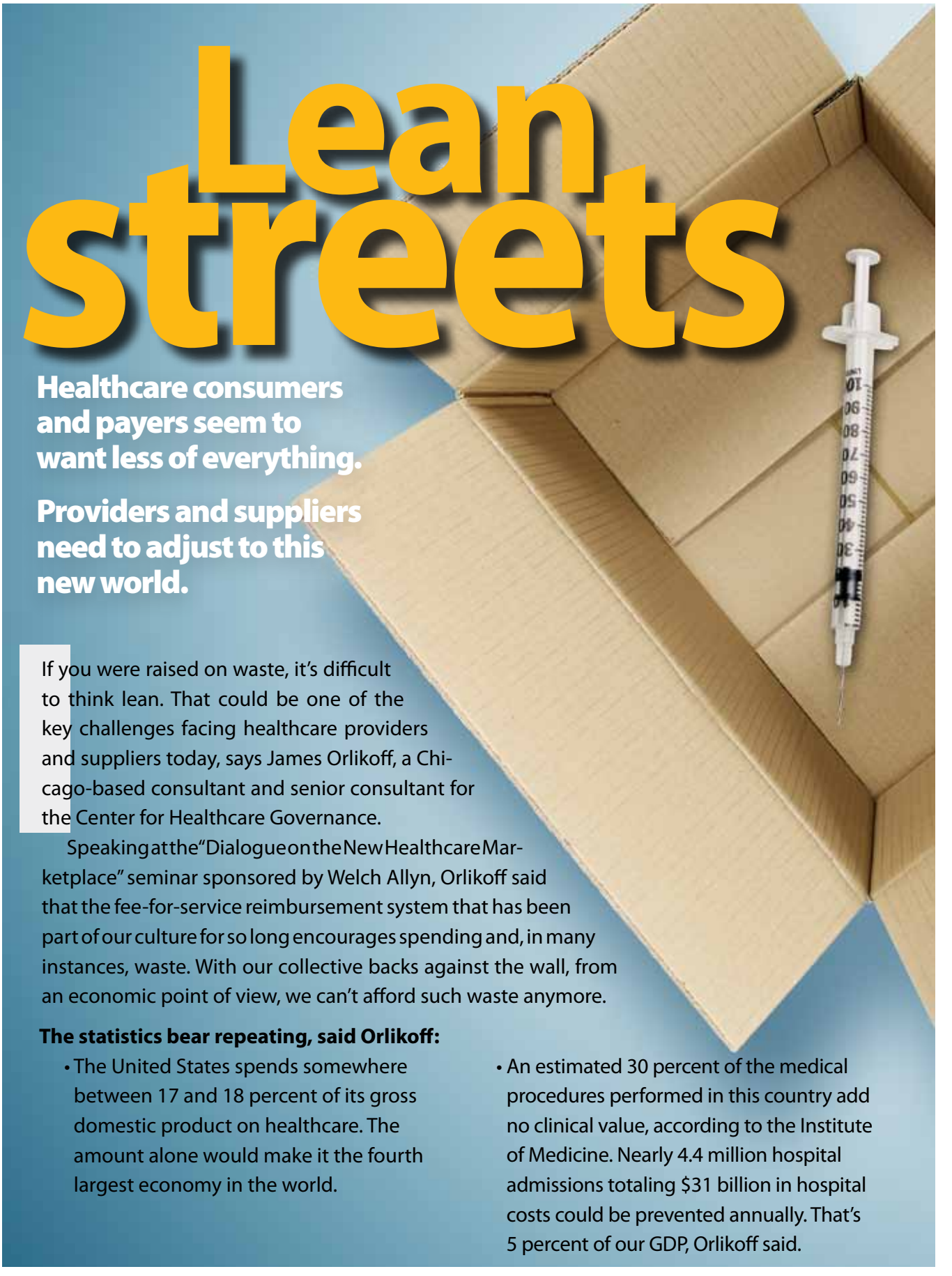


Healthcare consumers and payers seem to want less of everything.

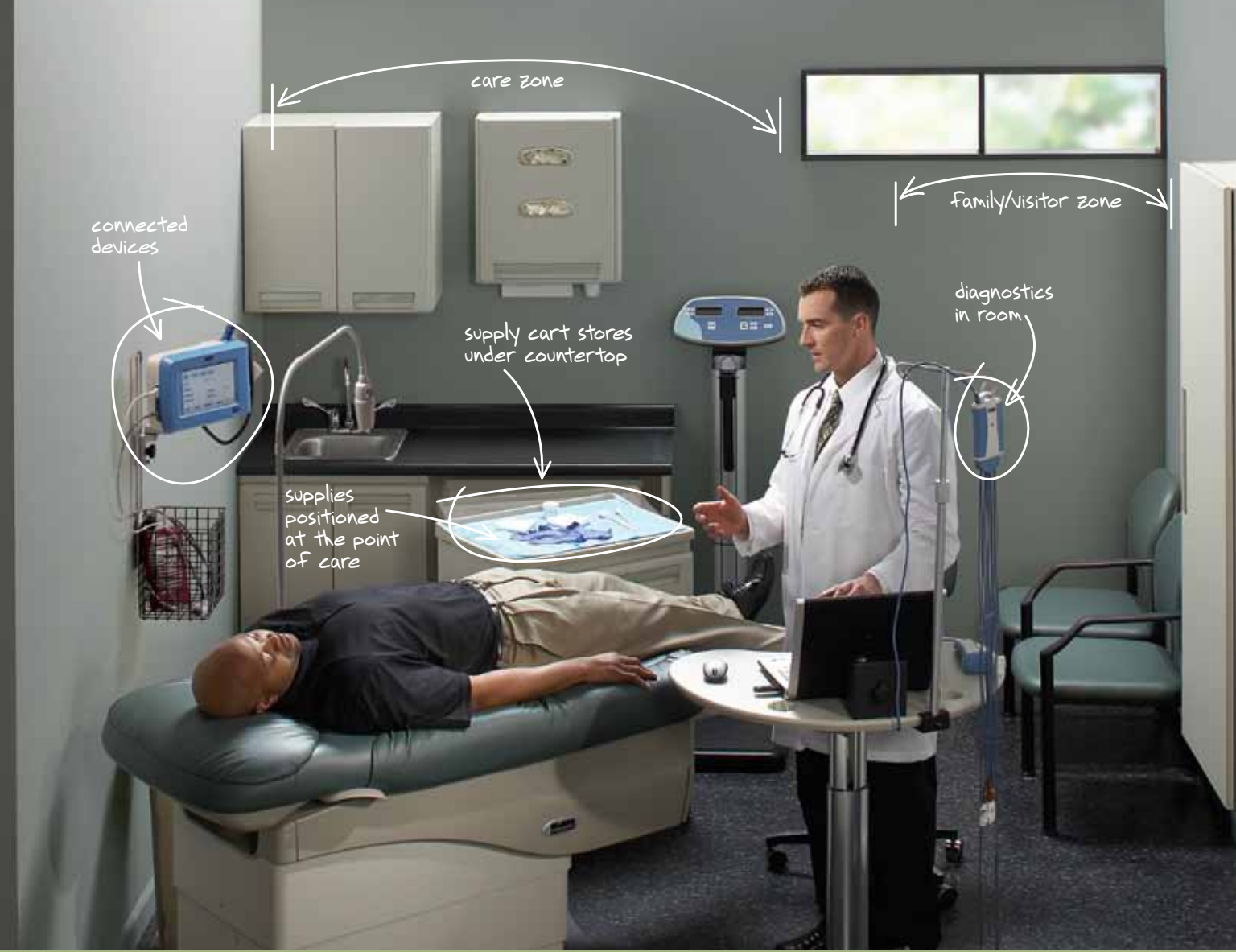
Providers and suppliers need to adjust to this new world.

If you were raised on waste, it's difficult to think lean. That could be one of the key challenges facing healthcare providers and suppliers today, says James Orlikoff, a Chicago-based consultant and senior consultant for the Center for Healthcare Governance.

Speaking at the "Dialogue on the New Healthcare Marketplace" seminar sponsored by Welch Allyn, Orlikoff said that the fee-for-service reimbursement system that has been part of our culture for so long encourages spending and, in many instances, waste. With our collective backs against the wall, from an economic point of view, we can't afford such waste anymore.

The statistics bear repeating, said Orlikoff:

- The United States spends somewhere between 17 and 18 percent of its gross domestic product on healthcare. The amount alone would make it the fourth largest economy in the world.
- An estimated 30 percent of the medical procedures performed in this country add no clinical value, according to the Institute of Medicine. Nearly 4.4 million hospital admissions totaling $31 billion in hospital costs could be prevented annually. That's 5 percent of our GDP, Orlikoff said.



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"We've been rewarded for being wasteful," he said. And it won't be easy to turn the ship. "As George Orwell said, 'It's difficult to get someone to understand something if their salary depends on them not understanding it.'"

In many ways, it is the economy, not federal legislation, that is driving healthcare reform, Orlikoff said. The influx of baby boomers into the healthcare system alone would have destabilized just about any healthcare system. Add to that the current recession, unemployment levels and the downside of globalization.

There's another factor driving fundamental change in the U.S. healthcare system – our massive debt. "We're talking about actual debt, not just unfunded liabilities, such as those associated with Medicare," Orlikoff said. Countries that face crushing debt levels have three choices, none of them desirable, he said: 1) default, which is all but unthinkable; 2) hyperinflation, whose adverse consequences are only slightly less than those of default; or 3) massive belt-tightening, that is, spending less, raising taxes, cutting pensions and benefits, scaling back standards of living, and slowly digging one's way out of deep dark hole we're in. "We're in the early stages of doing that now," said Orlikoff, referring to Option No. 3.

The United States does indeed offer the best high-tech, high-acuity interventional care in the world. If you get hit by a truck, there's no better place to be than the United States.

Turning the ship

Orlikoff believes a fresh, critical look at our healthcare system is sorely needed. When someone says, "We have the most expensive healthcare system in the world," a typical rejoinder is, "Yes, but it's the best," he said. But when asked, "How do you know that?" the answer often is, "Because it's the most expensive."

The United States does indeed offer the best high-tech, high-acuity interventional care in the world, he pointed out. If you get hit by a truck, there's no better place to be than the United States. But in the 1990s, when President Clinton tried – but failed – to implement healthcare reform, data showed that the U.S. did not provide the best healthcare, when measured by such indicators as chronic disease management, infant mortality, etc. What's more, hospitals are the fourth leading cause of death in the United States, said Orlikoff, due to infections and errors.

The United States healthcare system is proof positive that throwing money at healthcare doesn't always produce the most favorable outcomes, he said. In fact, data has shown that the best hospitals – that is, those with the best outcomes and lowest mortality rates – usually consumer fewer products, equipment and pharmaceuticals than others, he said.

Supply creates demand

But for years, providers have been financially rewarded for providing more care. "The way your customers make money is by doing more things – ordering more tests, doing more procedures," Orlikoff told the audience, primarily manufacturers.

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 *Calculations based on these sources; sample calculations available upon request. 1. Computers, Informatics, Nursing: September/October 2009, Volume 27, Issue 5, pages 318-323, Connected Care: Reducing Errors Through Automated Vital Signs Data Upload, Smith, Laura B. MSN, RN; et al. 2. Automated Vital Sign Documentation for Medical Surgical Units: Saving Time and Increasing Accuracy: Fact or Fairytale?, Meg Meccariello, RN MS; Jennifer Johnstone, RN MS, Presented at The Nursing Management Congress 2008 Las Vegas, NV. 3. Vital signs measurement frequency estimates from "Lippincott's Textbook for Nursing Assistants: A Humanistic Approach to Caregiving," Pamela J. Carter, 2007, page 292. 4. Hospital beds (most recent) by country estimates from NationMaster.com, www.nationmaster.com/graph/hea_hos_bed-health-hospital-beds. 5. Population, Source: U.S. Census Bureau, Population Division.

That system has been good for vendors, because they sold more tests, more equipment, more consumables, more everything.

The problem is, supply tends to create its own demand, he said. The No. 1 predictor of how many surgeries are performed in a region, or the number of MRI scans performed, are the number of surgeons nearby, or the number of MRI machines. The most effective way to eliminate cost is to eliminate supply. But that's a tough pill to swallow for providers and suppliers alike.

The stark reality today is that nobody can afford those systems any more, he said. After years of tinkering – think managed care, DRGs, etc. – costs are being shifted back to healthcare consumers themselves, in the form of higher deductibles or no employer-covered insurance at all. And they are responding accordingly.

"For years, we thought people would get healthcare regardless of the cost," said Orlikoff. But it turns out they're first paying their mortgages, feeding their kids and taking care of other obligations before going to the doctor. "As grandma used to say, 'If the blood ain't flowin' and the bone ain't showin', we ain't goin'," said Orlikoff. Grandma's attitude was an attempt to control costs, a form of self-rationing of care. And that's where we are today.

From volume to value

And that's why as a country, we have to reorganize the system, he said. There must be a movement away from a volume-based system to a value-based system, that is, one that focuses on outcomes rather than procedures.

The government has proposed potential solutions, including accountable care organizations and bundled payment programs. And some physicians, seeing the writing on the wall, are joining hospitals in an attempt to align their efforts and reduce some of the "silos" that have characterized the U.S. healthcare system. The movement to transparency in health care – that is, making information about hospitals' and doctors' outcomes and costs publicly available – is intended to guide people to seek out the most efficient providers of care.

"One way of being inefficient is doing things 30 different ways, which magnifies product costs, labor costs – all of which providers get reimbursed for."

– James Orlikoff, a Chicago-based consultant

Providers are responding as well. Many are attempting to wring costs out of the system by standardizing care. Developing protocols for such things as heart attack has been shown to lead to better outcomes. Standardization of care protocols often leads to standardization of pharmaceuticals and medical supplies too. "One way of being inefficient is doing things 30 different ways, which magnifies product costs, labor costs – all of which providers get reimbursed for," said Orlikoff.

In response, suppliers will have to pursue new business and sales models, he said. If a supplier made money on a product in the fee-for-service environment, and now that supplier is touting that same product's ability to help the hospital eliminate waste, expect some pushback, he said. **JHC**

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The customer imperative

Distributors adjust their business and selling models to respond to customers' needs

The macro forces changing healthcare today – e.g., physician/hospital alignment, value-based purchasing, reimbursement cuts, etc. – are affecting medical products distributors in a macro way. And those changes are reflected in how individual sales reps are approaching their customers. Speaking at the Welch Allyn "Dialogue on the New Healthcare Marketplace," a panel of distribution executives explained.

Looking at the changing healthcare landscape, Jacksonville, Fla.-based Physician Sales and Service sees IDNs as an emerging opportunity, said John Sasen, executive vice president and chief marketing officer. In fact, the company has dedicated a number of reps to IDN customers.

"Having a new customer call point, usually in the hospital setting, has been a little bit of a mystery to us," he said. But after a closer look, the mystery is disappearing. "They're all looking for ways to increase productivity." PSS feels it can help IDNs do that by continuing to serve their affiliated physicians.

"For us to differentiate ourselves with our customers, we need more than product," Sasen said. "We have to deliver products quickly, we have to have a great deal of knowledge about how they use those products. So there's a lot of education going on." The distributor's relationship with its manufacturers will continue to shift from transactional to strategic.

"We have to deliver products quickly, we have to have a great deal of knowledge about how they use those products. So there's a lot of education going on."

– John Sasen, executive vice president and chief marketing officer

PSS has made a commitment to strive to improve the financial well-being of its customers by 20 percent. "That's our goal in life – to care for the caregivers; because if we don't, we won't have a business," said Sasen. The challenge for PSS is to help customers meet that goal even though supplies only consume roughly 2 percent of the average physician practice's spending.

Rather than conducting simple sales calls, PSS reps strive to conduct regular business meetings with their customers, in which they jointly review P&L statements, examine revenues and look at potential efficiencies. "We're starting to measure our people by the number of business meetings they have with their customers," said Sasen. Naturally, clinical products and services remain important.

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But increasingly, financial and IT products and services are key.

"In the past, our task was to bring [manufacturers'] products to the customer and make the sale," he said. "We still do that, but now, it's in the context of how they're caring for the patient. We're moving as quickly as we can from product demonstration to application. It's important we understand the specialty's need and application of the product. We have to sell products responsibly and help our customers get healthier."

Hospital supplier perspective

Hospital supplier Owens & Minor is approaching successful, aggressive IDNs with a variety of targeted offerings, such as integrated service centers, said Gavin Jeffs, operating vice president, international strategic sourcing. Like physician distributors, Owens & Minor is examining its ability to help its customers address SG&A costs. And regarding physician employment by hospital systems, "If the customer wants us to assist them in these models, we will. We want to follow the IDN." And the IDN is following the patient, wherever he or she goes, including the outpatient setting. "Where the IDN has a holistic view of the patient," Owens & Minor will try to accommodate it, said Jeffs.

Looking ahead, Owens & Minor foresees more consolidation among providers. Solo hospitals and systems will join larger systems, and physician groups will continue to seek employment and/or partnership with IDNs. As they do so, they will look to reduce the number of suppliers they deal with.

Trusted advisors

Physician supplier Henry Schein Medical is focused on the "C"s of the industry, starting with the C-suite, said President Dave McKinley. But there's also the Centers for Medicare & Medicaid Services, chronic care prevention and wellness, clinical outcomes, comparative effectiveness, consolidation, etc. Two of the weightier C words are "change" and "customers."

"Our customers are changing," said McKinley. The decision-makers in physician practices are becoming more business-oriented, forcing distributors to approach them in a new way. "We have to follow our customers," he said. Those customers are leading the distributor to new places, such as larger group practices, community health centers and IDNs. At the same time, patients are receiving more care at home. Henry Schein – and society at large – has to figure out how to address

Like physician distributors, Owens & Minor is examining its ability to help its customers address SG&A costs. And regarding physician employment by hospital systems, "If the customer wants us to assist them in these models, we will. We want to follow the IDN."

the chronic diseases and conditions that affect a large portion of the population.

All of these big-picture trends are affecting sales reps, said McKinley. Today, Schein's customers are making more strategic buying decisions, he said. "We're looking for a long-term institutional relationship."

Look for Henry Schein to continue to practice a "customer-centric" rather than "product-centric" approach to the market, particularly as physician practices become more business-oriented, said McKinley. "We think we can help our customers run better practices if they allow us to get closer to them. We want to bring more to our customers to allow them to find ways to increase revenues and lower costs. How can we help them communicate with their customer base as well as other physicians?"

Henry Schein is specializing its sales force in order to address different segments of the market. The specialty sales force continues to focus on those segments that probably will remain independent of hospitals for the foreseeable future, such as dermatology, ENT and sports medicine. As a result of all these changes, selling has become much more of a team effort, McKinley said. That reflects what's happening among its customers, he pointed out.

And, like its customers and society at large, Henry Schein takes prevention and wellness very seriously, said McKinley. For example, its "Health Home®: Solutions for Coordinating Prevention and Wellness" program combines the company's medical and oral health offerings to community health care centers, including supplies and equipment, electronic health care records software, health center design and planning; and 340B drug pricing, diagnostic, and influenza vaccine programs.

"We're repositioning our company to be a network of trusted advisors. We can bring a lot of expertise to our customers." **JHC**

Henry Schein is specializing its sales force in order to address different segments of the market. The specialty sales force continues to focus on those segments that probably will remain independent of hospitals for the foreseeable future, such as dermatology, ENT and sports medicine.

By Robert T. Yokl

Supplier Relationship Management Should be a Healthcare Best Practice too!

We don't hear a lot of supply chain professionals talking about "supplier relationship management" as an emerging best practice in healthcare, but it is a best practice in every other industry. So, what's up with that?

Industry has found early on that price is only one component of the "best value" equation with their suppliers. It is equally important to industrial supply chain managers that:

1. They become their supplier's customer of choice, ensure product availability, cost monitoring, technology access, innovation and risk reduction.
2. They promote emphasis on "value" versus price so that they can bend the curve on their supply expenses from acquisition to disposition on their products, services and technologies.
3. They leverage supply network capabilities to assist in the redesign of their current products, services and technologies to enable them to be more cost effective, reliable and defect free.
4. They capture supplier value early in new product, service and technology development to improve the speed, efficiency, quality and pricing of the end product.

This is a whole new way of thinking about your suppliers that requires new strategies, tactics and techniques to ensure that your suppliers are true (not just in word, but in fact) partners in your supply chain success. It means developing close, effective and significant working relationships with your suppliers that go beyond price to bring about value-added partnerships to your healthcare organization.

For example, one of our clients is working closely with his suppliers to re-specify and then reinvent his I.V. catheters' functional specifications that are now extremely feature rich, and then getting their input along the way. Instead of telling his suppliers what he wants he is getting their input, which hasn't been the traditional way of doing business in healthcare.

Is this really an emerging healthcare best practice? Our bet is that it is, since suppliers know where to save money, trim fat and eliminate waste in your healthcare organization if you would just create a healthy relationship with them. You need a relationship where they become real partners, and not kept at arm's length. Keep them close, active and productive in all of your supply chain initiatives to sustain your supply chain savings.

Think of it this way – most of our best healthcare supply chain ideas have come from industry, so don't ignore this opportunity to be a trailblazer with your own "supplier relationship management" program that can provide substantial dividends to your healthcare organization now and in the future. **JHC**

Robert T. Yokl is president and chief value strategist of Strategic Value Analysis® In Healthcare, which is the acknowledged healthcare authority in value analysis and utilization management. Yokl has nearly 38 years of experience as a healthcare materials manager and supply chain consultant, and also is the co-creator of the new Utilizer® Dashboard that moves beyond price for even deeper and broader utilization savings. For more information, visit www.strategicva.com. For questions or comments, e-mail Yokl at bobpres@strategicva.com.

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By John Sammut

Get Real

Interest rates below the rate of inflation have important investment implications

Interest rates continue to hover at generational lows. Not only are conservative investors earning next to nothing on cash deposits, they are actually losing purchasing power after inflation and taxes. A key result of the ultra expansionary monetary and fiscal policies of the last 10 years is this phenomenon of *negative real interest rates*.

Real interest rates are simply a calculation of the rate of return that can be earned on short-term cash deposits minus the rate of inflation. As an example, if short-term interest rates are 5 percent and the inflation rate as measured by the consumer price index is 4 percent, then the real interest rate would be +1 percent (5% - 4% = +1%).

In 2004, the real interest rate went decisively negative after the Federal Reserve slashed the overnight lending rate to 1 percent following the collapse of the NASDAQ stock market and subsequent economic recession. The current real interest rate is -3.31 percent (as of Nov. 1, 2011). The last time the United States experienced negative real interest rates for such an extended period was in the mid and late 1970s.

The last time the United States experienced negative real interest rates for such an extended period was in the mid and late 1970s.

Ramifications of negative real interest rates

1. **Negative real interest rates encourage excessive leverage (debt) and discourage private investor savings.**

2. **Generally speaking, negative real interest rates are bullish for Gold prices.** It takes massive expansion of money and credit to keep interest rates at artificially low levels, and massive money creation deflates the value of paper currencies to the benefit of "hard money" like precious metals. From August 1971 through January 1980, the price of gold increased from $35 per oz. to $850 per oz. Much of this parabolic rise in the 1970s can be attributed to the fact that interest rates were negative relative to the

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rate of inflation. It wasn't until Federal Reserve Chairman Paul Volker dramatically raised short-term interest rates in the early 1980s that the price of gold peaked and subsequently fell.

3. **Negative real interest rates encourage investors to speculate in search of higher rates of return, which in turn causes vicious market volatility.** Private investors, insurance companies, hedge funds, and banks can't earn enough on their cash, so they are forced to take higher risks to achieve higher returns. They buy Greek and Italian bonds in search of higher yield … they buy stocks … they buy commodities. This leads to intermittent distortions in asset prices (both up and down), extraordinary financial market volatility (both up and down), and reckless decisions backed with extraordinary leverage.

While cash provides reassuring stability during periods of market disruption, to invest for safety might prove to be the most dangerous strategy over the long haul.

In an effort to stimulate the economy, Federal Reserve Chairman Ben Bernanke has pledged to keep the Fed Funds rate at today's level through at least mid-2013. As long as interest rates continue to be pushed below the rate of inflation, investors should expect volatility to be the norm. It's also important to remember that volatility works in both directions – up and down, and enduring volatile markets in the short-run is necessary if one seeks to achieve higher rates of return in the long run. While cash provides reassuring stability during periods of market disruption, to invest for safety might prove to be the most dangerous strategy over the long haul. **JHC**

John Sammut, a Financial Advisor with RBC Wealth Management, helps individual investors, families and corporations organize their affairs so they can make better decisions, improve results, and enjoy a peaceful state of mind. You can reach Sammut by telephone at (315)-423-1425, or visit him at www.johnmsammut.com


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Health Reform Update

The following update by the Health Industry Distributors Association (HIDA) is designed to keep healthcare stakeholders current on the latest government-affairs related topics.

Providers collect $2.53 billion in EHR incentives

Healthcare providers participating in the Medicare and Medicaid electronic health record (EHR) incentive program received over $2.53 billion in Medicare and Medicaid incentive payments in 2011. Over 176,000 healthcare providers have registered for the program, which links incentive payments for the meaningful use of EHR. Approximately 123,921 eligible professionals (primarily physicians) are participating in the Medicare program, and 49,051 eligible professionals are participating in the Medicaid program. Over 3,000 hospitals are registered for the EHR incentive program. More information is on HIDA's health reform website.

Health sector job growth totals 314,700 in 2011

The U.S. Bureau of Labor Statistics has reported that healthcare providers added 314,700 new jobs in 2011, more than any other industry. In the past year, physician offices added 67,600 jobs, hospitals added 89,100, and nursing care facilities added 4,100. Many experts cite the shortage of primary care professionals as the reason for increased hiring in the physician market, and that many providers are increasing staff in order to prepare for health reform's various payment changes and expansion of insurance coverage.

Medicare and Medicaid Innovation Center launches 16 health reform initiatives

In January 2012, the Center for Medicare and Medicaid Innovation (CMMI) released a report detailing health reform initiatives including a patient safety program for hospitals and the Pioneer accountable care organization (ACO) program. The health reform center has launched 16 projects that will involve more than 50,000 providers over the next five years. CMMI will have over $1.7 billion in funding for projects such as reducing hospital-acquired conditions ($500 million) and launching ACO pilot programs like Pioneer ACOs ($254 million).

Health reform's comparative effectiveness research board releases proposed focus areas

The Patient-Centered Outcomes Research Institute (PCORI) has released its proposed national priorities and agenda for comparative effectiveness research. PCORI, which will have an estimated $3 billion over the next decade to sponsor research, proposed five central priorities: 1) comparing prevention, diagnosis and treatment options; 2) improving healthcare systems and services; 3) communicating and disseminating information for patients; 4) addressing disparities in health outcomes; and 5) accelerating patient-centered and methodological research. PCORI did not single out any specific diseases, treatments, or procedures to study. **JHC**

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By Lisa Earle McLeod

A Person of Influence

Identifying what makes top performers so persuasive

You know who they are, they're the people who can walk into a meeting and charm the socks off everyone in the room. They inevitably wind up with bigger budgets, more support for their ideas and more promotions than their less persuasive peers.

Knowledge is not enough, being the boss is not enough, if you want to succeed you have to be able to persuade and influence. Three significant changes in the workplace have made the ability to influence and persuade absolutely critical:

1. **Ambivalent Workforce –** Employees still show up for work with their bodies, but many of them are leaving their brains at home. Gallup research confirms that only 29 percent of employees are actively engaged. If you want to get anything done, you have to win the hearts and minds of your employees, peers, and boss.

2. **More Complexity and Change –** Companies are reorganizing at a furious pace. With cross-functional teams and blurred reporting lines, the days of command and deploy leadership are over. Getting results depends on garnering support from outside your department and being able to persuade others to buy into your ideas.

3. **ADD Culture –** Facebook, Twitter, iPhone. Lots of bright shiny objects are competing for your customers' and co-workers' time and attention. Your topic might be important to you, and your company, but if it's less interesting than what's on the Facebook feed, no one is going to give it any incremental effort.

The guy who rambles on about his great new system isn't nearly as persuasive as the person who connects their ideas to the goals of every person and department in the room.

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It doesn't matter how smart and skilled you are, if you don't know how to persuade and influence others, you won't get results, and you will eventually become irrelevant.

Scared yet?

Don't be.

I've spent over 10,000 hours studying the interactions of top performers to identify what makes them more persuasive than everyone else.

You don't have to be a master manipulator to be more persuasive. Here are three techniques of top performers that you can use in your own workplace interactions to be more persuasive and influential by Monday morning:

Lose your attachments

We tend to think of great persuaders as silver-tongued devils who manipulate others. But my research revealed that the most effective influencers are actually quite flexible in their interactions. They have goals and plans, but they're not overly-attached to everything playing out in a certain way. You'll increase your influence if people perceive that you're open to changing circumstances and hearing their perspectives.

Ask questions about other people's goals

When you ignore other people's agendas, the result is resistance and lack of engagement. One of the things that differentiates top performing influencers is that they always make a point to understand where the other person is coming from. They ask about the person's goals early in the conversation and they do it often.

Validate their goals out loud

It's not enough to hear people, they need to know that you understood them. When you repeat their point of view out loud, they know that you "get it." They're then more likely to listen to what you have to say.

The guy who rambles on about his great new system isn't nearly as persuasive as the person who connects their ideas to the goals of every person and department in the room.

Persuasive and influential people don't focus on their own goals; they understand everyone's goals. The fastest way to get people excited about YOU is to start being excited about THEM. **JHC**

Business strategist Lisa Earle McLeod specializes in sales force and leadership development. A sought after speaker, she is author of The Triangle of Truth, a Washington Post Top 5 Business Book. Visit www.TriangleofTruth.com for more.

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Quick Bytes

Editor's Note: *Technology is playing an increasing role in day-to-day business. The following profiles the latest developments in software and gadgets that supply chain execs can use for work and play.*

TV on your iPad

Touchtv announced the availability of its Touchtv App for iPad™, which lets viewers watch their favorite programs on their iPad. Users launch Touchtv and "touch" any channel to start watching. From the home screen, viewers can add more channels and personalize their TV. The app updates automatically and seamlessly delivers the latest programs from the exact channels viewers want, according to the company.

Medical records online

Kaiser Permanente announced that its 9 million patients now can access their medical information on mobile devices through a mobile-optimized website. The Oakland, Calif.-based healthcare system has released a new app for Android devices. Users of other mobile devices, including the iPhone, can also get full access to that information from the Kaiser Permanente health record system with the mobile-optimized version of kp.org. An additional app for iPhone was scheduled to be released in coming months, but iPhone users can download a shortcut icon onto their home screens that will take them directly to the mobile-friendly kp.org. Kaiser Permanente patients will have 24/7 access to lab results, diagnostic information, direct and secure e-mail access to their doctors, and will also be able to order prescription refills.

Office applications for Android

Xform Computing Inc., Santa Barbara, Calif., announced that its AlwaysOnPC mobile app for Android is available in the Amazon Apps Store, with editions for Kindle Fire and other Android tablets. The AlwaysOnPC Virtual Desktop is said to offer productivity apps and features, such as editing Microsoft Word documents, PowerPoint presentations or Excel spreadsheets; viewing and editing PDFs, including annotations and forms; retouching photos and images; creating and editing graphics and drawings; and browsing/using productivity or game websites that require PC-class browser technology, such as Java. Users can host a web conference and share their screen (and show presentations or documents to participants) using the Zoho Meeting feature from their AlwaysOnPC virtual Desktop.

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— Geoff Brenner, president and chief executive officer, Texas Purchasing Coalition

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Quick Bytes

Stick, clamp or wrap your iPad 2

UZBL of Newport Coast, Calif., says it has developed a kit that allows iPad 2 owners to accessorize the tablet device to make it more easily usable in any setting. The "FLEX for iPad 2" kit includes a snap-on hand strap to hold the device, a shoulder strap to carry it, and a snap-on rotating pivot with a ¼-inch tripod thread that can be screwed onto any camera mount or accessory. The FLEX is said to be compatible with a range of accessories and allows the iPad 2 user to stick, clamp, wrap, hang, or prop the iPad 2 almost anyplace imaginable, according to the company. A silicone protects the iPad 2 if dropped.

At a glance

Operating your laptop with your eyes? The technology is already available, at huge cost, to the military and disabled people. But several companies – including Sweden-based Tobii – are set to offer it to makers of laptops and other everyday consumer devices, according to the *New York Times*. The Tobii system works this way: The system finds and learns where your eyes are by using a 10-second calibration procedure, in which you look at an orange dot as it jumps to four positions around the screen. In a "test drive," *New York Times* Technology Editor David Pogue found the system automatically focused and zoomed in on whatever he was looking at during a Google Maps session; "clicked" toolbar buttons; and automatically scrolled down a web page and Word document while he was reading. "The system knows where your eyes are and how fast you are going, so it keeps your place centered on the screen, scrolling automatically as you go, even if you jump back to reread something," reported Pogue.

Working with Office on the iPad

Although Apple's iPad tablet has replaced laptops for many tasks, it isn't a big hit with folks who'd like to use it to create or edit long Microsoft Office documents, reports the *Wall Street Journal*. But Palo Alto, Calif-based OnLive Inc. recently released a free app that brings the full Windows versions of key Office productivity apps – Word, Excel and PowerPoint – to the iPad. The programs are said to look and work just like they do on a real Windows PC, reports the paper. They let the user create or edit genuine Word documents, Excel spreadsheets and PowerPoint presentations. OnLive Desktop is a cloud-based app. That means it doesn't actually install Office on your iPad. Instead, it acts as a gateway to a remote server where Windows 7, and the three Office apps, are actually running. **JHC**

UZBL of Newport Coast, Calif., says it has developed a kit that allows iPad 2 owners to accessorize the tablet device to make it more easily usable in any setting.

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1. López-Huertas HL, Polcari AJ, Acosta-Miranda A, et al. Metallic ureteral stents: a cost-effective method of managing benign upper tract obstruction. *J Endourol.* 2010;24(3):483-485.

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Bradley named president of Sutter Health

Effective February 27, 2012, David Bradley will be promoted to president of Sutter Health (Sacramento, CA), and his current position as CEO of Alta Bates Summit Medical Center (Berkeley, CA) and its three hospital campuses will be filled by Chuck Prosper, who is currently COO. In addition, Ed Berdick, currently East Bay regional president, will become SVP for shared services at Sutter. Patrick Fry continues as CEO of Sutter.

Leonard J. Chabert Medical Center announces layoffs and service cuts

Leonard J. Chabert Medical Center (Houma, LA) plans to lay off 80 of its 950 employees to absorb $2.9 million in mid-year budget cuts. In addition, the hospital announced plans to cut critical services, including its labor and delivery, nursery and neonatal-care services for premature babies, along with its number of available inpatient beds. The layoffs and service cuts are scheduled to take effect on March 5, 2012.

UHC expands Clinical Data Base/Resource Manager

UHC (Chicago, IL) expanded and refined the risk-adjusted models in its Clinical Data Base/Resource Manager™ (CDB/RM) to include 20 pediatric-specific risk models. It also added enhanced variables for secondary oncology diagnosis models. UHC data from more than 400,000 pediatric patient discharges are now modeled separately from the adult discharges. The enhanced oncology variables provide better insight into how specific types of cancer affect other disease conditions or how they impact mortality, length of stay, and costs. The three general cancer variables previously available have been expanded to more than 25 specific variable candidates. The new risk model changes will be applied to all cases starting with patients discharged from Q4 2008 forward, and UHC will continue to support the old risk models through Q4 2012 to allow completion of population trending studies. Expected values for the old models will be discontinued after Q3 2012 discharges are loaded. Risk models are free to CDB/RM subscribers under Measure Performance at www.uhc.edu.

VA ready to consolidate EHR data centers

The U.S. Department of Veterans Affairs (VA) (Washington, DC) will begin transitioning the data centers that support its Veterans Health Information Systems and Technology Articulation (VistA) EHR into data centers run by the Defense Information Systems Agency (DISA) beginning in March 2012. The move will help support the development of a joint EHR system, making it the largest in the world, covering 15.7 million people. It is expected to take one year to complete. The consolidation is meant to reduce costs, improve efficiencies and maximize sustainability, and also free up space in at least 80 VA medical center computer rooms for repurposing, resulting in a greatly reduced operational IT footprint.

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FDA approves leg lengthening system developed by orthopedic surgeons

The FDA (Silver Spring, MD) approved a new leg lengthening system co-developed by Sinai Hospital of Baltimore (Baltimore, MD) orthopedic surgeons and the International Center for Limb Lengthening (Baltimore, MD), called the PRECICE™ Limb Lengthening System, which offers a major advancement in limb lengthening surgery. The system, used to lengthen limbs that are short as a result of birth defects or trauma, consists of a telescopic titanium rod which is surgically implanted into either the femur or tibia. A miniature magnetic motor and gear box within the rod create the force needed to lengthen the rod. The power to drive the motor is provided by an external magnetic field generator that is held on the skin next to the leg several times a day for a few minutes. Bone and soft tissue regenerate when they are slowly pulled apart at a rate of approximately one mm per day. The new device can make the bone lengthening process more comfortable and predictable for patients.

Healthcare system leaders select winners of 2012 IDN Summit Supply Chain of Excellence Awards

Healthcare executives voted to select four category winners for the 2012 IDN Summit Supply Chain of Excellence Awards competition. The awards recognize best practices and innovative ideas from healthcare systems that have achieved critical supply chain efficiencies. The winners, one in each of three size categories as well as the new regional purchasing cooperative category, will be recognized at the 2012 Spring IDN Summit and Reverse Expo scheduled for April 23-25 in Orlando, Florida, where they will go on to compete for the opportunity to be named overall National Award Winner. This year's category winners are St. Anthony's Medical Center (St. Louis, MO), Johns Hopkins Health System (Baltimore, MD), Banner Health (Phoenix, AZ), and Upper Midwest Consolidated Services Center (Minneapolis, MN). To learn more, visit idnsummit.com/media%20releases/nr_awards_finalists_2012.pdf.

Joint Commission unveils tool that targets wrong-site surgery

The Joint Commission (Oakbrook Terrace, IL) introduced a new tool that helps hospitals prevent the occurrence of wrong-site surgery in all phases of the surgery process. Developed by the Joint Commission's quality-improvement segment, the Center for Transforming Healthcare, the Targeted Solutions Tool features several applications that help users identify safety risks, determine causes and develop strategies to address them. Working with hospitals and surgery centers, the center identified 29 potential causes of wrong-site surgery. Pilot sites that used the tool reduced their "number of surgical cases with risks" by 51 percent in the OR and by 46 percent in scheduling. The Targeted Solutions Tool is available to all Joint Commission-accredited hospitals. The next set of solutions, which will address hand-off communications, are expected launch in summer 2012.






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