Data on implant costs wins MD support

When 2 of its hospitals came close to shutting down their total joint replacement programs because of rising costs, a Midwestern health care system knew it needed to take a new approach to orthopedic implant purchasing.

The system tried demand matching several years ago, but the project felt flat. In its competitive market, surgeons weren’t receptive to standardizing to just a couple of implant vendors.

Instead, like many others, Milwaukee-based Wheaton Franciscan Healthcare decided to adopt a capitated approach to implant pricing.

After the system’s leaders shared its data about the impact rising implant costs were having on its financial health, surgeons got behind the effort. Some even agreed to withhold their business from vendors who didn’t sign the capitated contract.

Rising implant costs are hitting a lot of organizations hard.

“Only 1 in 10 hospitals is making a profit on orthopedic implants, and I doubt they’re making much of a profit,” says Joseph Volpe, vice president for supply chain management for Wheaton Franciscan, which has 9 hospitals in southern Wisconsin and eastern Iowa.

He estimates physician preference items account for 40% of hospitals’ total average medical supply spending in their area.

The Upper Midwest, Wisconsin in particular, has some of the nation’s highest health care costs, “so our prices were already way above the national averages,” he says.

Because most surgeons in Milwaukee work at multiple hospitals, they can move to another facility if the hospital puts pressure on them to switch implant brands.

Upfront about implant costs

Volpe and Terri Kendrick, system director of purchasing, found most of the surgeons didn’t have a good understanding of the hospitals’ costs and didn’t know if they were making or losing money.

When one site came close to closing its total joint program and a second was seriously considering it, the surgeons started paying attention. They knew that could affect their practice.

Volpe and his team were upfront with the physicians about their financial plight.

The system’s common materials management information system allows them to pull their data on implant costs. For comparison, they used pricing data from the nonprofit ECRI, Plymouth Meeting, Pa.

Once the surgeons saw the data, they were much more accepting of the capitated arrangement, Volpe says. In a capitated approach, the hospital sets prices it will pay for certain implant constructs. Vendors who agree to the price can participate.

Deadline for contracts

“We went for pricing that was much better than what we had but not necessarily the best in the country,” he says. “We met with all the vendors and told them what we were doing. We set a deadline for them to sign the contract, or we would not do business with them for 6 months.” Two signed, but 4 did not, and Wheaton
Franciscan stopped buying their implants for 6 months. By the end of the 6th month, all had signed.

At 2 of the high-volume facilities, the surgeons put muscle behind the plan. They said that if the vendors didn’t sign, they wouldn’t use their products for 6 months. In one hospital, the chair of orthopedics backed the plan. In the other, the president was the champion, working through the medical executive committee and the orthopedic section and even going to the board for approval.

Currently, 7 vendors are participating, all under the capped contract.

**Moving on to cardiac rhythm**

Wheaton Franciscan is taking a similar approach with cardiac rhythm management devices.

“We currently have 2 vendors under contract, and 2 on the outs,” says Volpe, and volume is beginning to move away from the noncontracted vendors. Those vendors will be kept at arm’s length for about 6 months or so to give vendors that did sign a chance to gain market share and consolidate their relationships. At the end of the 6 months, he expects all 4 vendors to be under contract.

Wheaton Franciscan hasn’t tried the capitated approach for spinal surgery because there are so many variations in procedures but is using a percentage discount instead. “We’ve had some success. We’re not done; we’re still working on it,” he says.

**Comparing notes on pricing**

Previously, Wheaton Franciscan accepted the vendors’ assertion that if its hospitals moved more of their implant business to them, it would get better pricing.

But after it consolidated its purchasing system and had the ability to compare data across its facilities, “it became apparent to us that is not the case,” Volpe says. “We had vendors in different areas that had huge market shares, but those hospitals were paying more than the others. They know it’s difficult to get the physicians to switch vendors.”

Now, he says, the approach is to say to the vendors, “Selling your product is not our job. Let’s get a reasonable contract in place, and we’ll do business with you.”

To the physicians, the system’s leaders have said, “We don’t want to tell you how to practice medicine. We don’t think we’re the people to tell you what products to use. But we want you to work with us to get the vendors to charge us what is reasonable so we have a viable business.”

There are 2 keys to making this approach work, he says: “You have to have good data, and you have to build relationships with the physicians and the administration.

“It sounds simple, but it’s not.”