How do you use your computerized reports on surgical supplies? Of course, you use them to monitor your usage and pricing. But there’s more these reports can do—they can tell you a story that may help you reduce costs and manage inventory more efficiently.

By marrying supply data with physicians’ preference lists, for example, you can spot opportunities to work with the surgeons to manage supply cost per case. “Saving even a few cents or a couple of dollars on a routinely used product can make the difference between being on budget or being over budget,” says Kimberly Alvord, director of materials management for National Surgical Hospitals, Inc (NSH), a management and development company for ambulatory surgery centers (ASCs) and surgical hospitals. She’s been helping NSH facilities learn to use their supply cost data as a resource for managing costs. She presented a session on the use of technology and data to assist in supply chain management at the FASA Inc meeting in April in New Orleans.

Preference list review

One idea is to use supply cost data to compare the supplies surgeons use for the same procedure. Then you can collaborate with the physicians who have more expensive habits to see if they would consider changing to less costly alternatives.

“We have found a periodic preference card review is the best way to educate the staff and physicians about clinically acceptable lower-cost alternatives,” Alvord says.

For example, you might select the top 3 surgeons who perform knee arthroscopy. Pull their preference lists, cost out the lists, and present the results to the surgeons. Once the surgeons with the more costly preferences see how their costs compare with their peers, they might be willing to discuss changing to some less expensive items their colleagues are already using.

Alvord is assisting the NSH facilities in a preference list review for selected procedures, and they are benchmarking the results.

These are steps she suggests for letting your preference lists “tell their story” about costs and supply utilization.

Link preference lists with costs

Ask your ASC’s information system vendor to have your preference lists linked to per-unit supply costs so the staff can view the costs on computers in the OR. Many of the NSH facilities use AdvantX software from Source Medical. The company enabled them to display unit costs on their printed preference lists as well as on the screen in the operating rooms, where they are visible to staff and physicians.

Just linking the costs to the preference lists “enabled us to save” even before reviewing the lists themselves, Alvord says. As soon as the surgical team could see the cost of supplies, there was a positive effect on behavior. For example, when the staff picked up a burr for an arthroscopy case, they might say, “This burr costs $65.” The surgeon might not have been aware of the cost before that. After learning the cost, he might say, “I don’t need that just yet. Let’s go into the knee and see if I need it before we open it.” Previously, the staff would have opened the package automatically.

If linking the lists to costs automatically isn’t possible, you can still review the
preference lists using an Excel spreadsheet or even a hand-created chart. Create a spreadsheet for knee arthroscopy, for instance, and enter the 3 physician’s preference lists side by side. Have your materials manager add the supply cost for each item. Then run a total cost for each list.

**Compare like cases**

Compare the 3 preference lists and note if there are significant differences in supply and pharmaceutical costs. You might find Surgeon A is using tubing that costs $15 more per case than Surgeon B and C, for example. Or perhaps Surgeon C is using the $65 burr, while Surgeon A and B are using a less expensive burr or a burr reprocessed by a third-party company.

**Evaluate the savings**

If Surgeon A switches to the less expensive tubing, the ASC will save $15 for each of Surgeon A’s knee arthroscopy cases. Multiply the $15 by Surgeon A’s annual volume of knee arthroscopies to determine the annual savings.

“If you can save $15 to $100 per case, that is huge if you are doing a high volume of those cases,” she says.

**Create a presentation package**

In preparing to meet with the surgeons, develop a presentation package to support the change you want Surgeon A to consider. The package might include:

- A description of the item.
- The recommended change: A description of the alternative item.
- Procedure: A list of the procedures and/or physicians the change will affect.
- Current (old) cost: Display the current cost of the supply.
- New cost: Show the cost of the alternate product.
- Explain: Explain the current situation, the impact of the change, and the physician’s desired outcome.
- Overview: Give an overview of the program and the results you are attempting to achieve.

If you can create colorful charts to illustrate the costs with the current and proposed supplies, so much the better. Alvord creates graphs for the NSH facilities so they can see the comparison (illustration).

In meeting with the physicians:

- Express the need for the physicians’ involvement and support. “Simply asking for their assistance can go a long way,” says Alvord.
- Present your package. Walk through the savings opportunities to see whether this change can happen without affecting physician satisfaction.
- Report the total annual savings to the facility’s administration.

For surgeons and teams who agree to the changes, be sure to give accolades so they know their support is appreciated.

**Monitor the results**

Assuming the change is made, review the preference lists again periodically to see that the gains are maintained.

**The story of shipping costs**

Alvord has also used supply usage reports to tell a story about ASC shipping costs. Overnight and direct shipping is common for surgical supplies, particularly specialty items, and the cost can run into thousands of dollars a year.

“We looked at how many items we were having shipped in,” says Alvord.
Especially for specialty cases, vendors tend to send supplies for each case. If 3 of the same cases are scheduled on one day, the ASC can end up paying 3 shipping charges.

“There are vendors who will do freight management. But we said, ‘If we can just drill in to the data, we can do our own freight management.’”

Analyzing reports, they were able to see how shipments could be consolidated.

“Our consumption reports showed that most of our shipping occurrences were a result of fees from vendors hand carrying implants and physician preference items into the facility,” she says.

“We implemented a policy that would contain these costs because the vendor was already responsible for being present during the case. Now, we are only willing to pay ‘extraordinary’ freight fees, and the vendor must produce a bill of lading showing the item had to be shipped by a national carrier. We pay only the amount the vendor was charged by the carrier. Our rationale is that the vendor’s margin should come from the product, and freight should not be part of that.

“With these tools, we have found ways to collaborate with our physicians,” Alvord notes. “We have found tools that don’t cost us a fortune, using data from reports we routinely run.

“I can run the report and say, ‘What’s the story this data tells me. How can I use it to enhance the efficiency of our supply chain?’”