For implants, balancing choice and cost control

Negotiating with orthopedic vendors can be frustrating as OR leaders strive to balance competing agendas among companies, surgeons, and the hospital. Kimberley Murray, MS, RN, CNOR, administrator for the orthopedic and spine service line at St. Joseph’s Hospital (SJH) in Syracuse, New York, reduced frustration by adopting a program that increased surgeon satisfaction and improved the OR’s bottom line. SJH is a 431-bed, nonteaching, not-for-profit hospital with 12 inpatient OR rooms and 2 surgery centers.

“We have been successful by being able to control the process,” says Murray. That process has enabled SJH to maintain or decrease costs despite rising implant costs.

The case for planning
Gaining control over orthopedic expenditures, particularly implants, is an important financial move according to Murray. The American Academy of Orthopedic Surgeons forecasts knee replacement volume will jump by 670% and primary hip replacements by 174% between 2006 and 2030. SJH performed approximately 1,600 joint replacements in 2011—a 20% increase over 2010.

As OR leaders know, orthopedic replacement surgery is expensive. In 2007, medical device expenses totaled $80 billion, with implants accounting for a substantial portion, and costs for implants are expected to rise 9.8% annually to $23 billion by 2012, according to Health Care Management Review.

Unfortunately, “Medicare reimbursement has not kept pace with rises in costs of implants,” says Murray.

Murray says one of the challenges in managing costs is that joint implants “are driven almost exclusively by physician choice.” She had to balance the desire to control costs with the desire to encourage other orthopedic surgeon groups in the area to move to SJH.

“We had to engage physicians in a nontraditional manner,” she says. That included managing the triad of who participates in purchasing orthopedic implants: the hospital, the surgeon, and the vendors.

It takes three
“Vendors are very skilled at what they do,” says Murray. Vendor representatives had developed close alliances with the surgeons over the years and had to understand the new ground rules.

“We have no discussions [about implants] with any vendors unless all 3 entities [vendor, surgeon, hospital representative] are there. That’s a dramatic change,” says Murray, who often serves as the hospital’s representative, particularly when new technology is discussed.

“The hospital and physician have to stand firm,” she says, adding, “We made it clear to the vendor that the hospital and physician are aligned.”

Murray traces surgeon support for the change back to the creation of the orthope-
dic service line in 2008, which put the service line in the hands of her and a medical administrator, Seth Greenky, MD. (See May 2010 OR Manager.)

“We do everything together,” she says. They are members of a governing council that reports directly to the CEO. In practice, they interact with the CEO on a regular basis.

The service line includes a comanagement agreement with the orthopedic groups. Murray advises collaborating with a consultant knowledgeable about governmental regulations to develop the agreement so it meets legal requirements.

“If you work in partnership with physicians to improve quality, to improve implant costs, and to lower the cost of care, it’s completely legal to share some of those financial gains with the physicians you work with,” she says.

SJH sets aside money as “at-risk payment” that is linked to quality improvement and indicators such as those from the Surgical Care Improvement Project, reduction in complications, and patient satisfaction goals. “Physicians are incentivized to help improve quality.”

The bar is set high; in fact, in the 2 1/2 years the agreement has been in place, the total amount has never been issued. But money isn’t the primary motivator for surgeons, says Murray. “It’s more that the feel they are involved and improving quality of patient care, and the hospital appreciates what they are doing.”

Strategies at the heart of SJH’s success in orthopedic vendor negotiations are competitive bidding, primary and secondary vendors, and product fairs.

Competitive bidding

Murray says SJH conducts a competitive bidding process for all implants at least every 2 years, rotating between hips and knees. Even vendors popular with staff and physicians must participate in the process, which has been in place for 8 years.

“It keeps everyone engaged and helps us get the best cost, quality product, and services,” she says.

Vendors receive a request for proposal (RFP) that includes the bidding process and contact information. Vendors must agree that they will only talk to the orthopedic purchasing agent, Murray, or Dr Greenky.

“We send the RFP to targeted vendors so the process is manageable,” says Murray. “We tell them it’s one bid up front. Give us your best price.”

Vendors are also required to provide quotes only on what is in the RFP and instructed not to add items. SJH doesn’t include usage, so there is no tiered pricing. The hospital doesn’t permit volume discounts or rebates because they make it challenging to allocate costs, and any savings goes to the general hospital budget, not the service line.
Murray says it’s important to communicate the goal of the bidding process, which is to lower expenses and ensure that “technologically advanced, high-quality products are used for the delivery of care. We emphasize that quality is first, but right behind that is cost.”

The Orthopedic Standardization Committee (OSC), which consists of all orthopedic surgeons, the orthopedic purchasing agent, the OR specialty coordinators, and Murray, evaluate the RFP based on factors such as cost; warranty; manufacturing technique; support; service response; product tracking capability, and the company’s references, experience, and market share.

“Meeting attendance is high because the surgeons know they have a tremendous influence over decision making,” says Murray. Surgeons who don’t participate forfeit the right to take part in the decision.

Costs are benchmarked against those obtained from The Advisory Board’s Surgery Compass program, which allows the user to enter a price and compare it with national averages. The program takes geography into account. Murray says other options include Orthopedic Network News and ECRI Institute.

Based on the analysis, the committee decides who will be asked to participate in the vendor fair.

At the fair
All the vendors set up in one room, which allows the surgeons, physician assistants, residents, and staff to go from one table to another. “Everyone participates,” says Murray.

After the fair, the OSC reconvenes to choose which vendors will move forward to the product trial.

“All physicians are required to participate in the trial process,” says Murray. “No other products can be introduced. During the month of the trial, we don’t exclusively use the current company’s products.” Implant costs are what the vendor presented in the bid.

After the trial, the OSC chooses the primary and secondary vendors. The hip and knee vendors are usually different. If 2 companies had comparable implants and similar prices, Murray says value-added services such as clinical education and patient education would be used to help make the decision. Murray communicates the outcome to the surgeons and then turns over the process to the orthopedic purchasing agent.

“It may be 4 to 6 weeks until the contract is negotiated,” says Murray, who adds, “We always put language in the contract about new technology. If there is a new generation of an item, the pricing has to be consistent with the current product. If the item is radically different, we do a separate negotiation.”

Murray also notifies the vendors of the decision. “We have relationships with all of them [vendors]. They are people we know, so we typically share with them high level detail as to what made us go with the vendor.”

Be focused and follow up
Murray recommends attacking one area at a time.

“It’s only when we drilled it down and broke out orthopedics as a separate section of vendor negotiations that we were able to make significant differences,” she says. Another key to success is ongoing measurement of financial impact, monthly surgeon volume, and quality indicators.

—Cynthia Saver, MS, RN
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References