Formula for successful cost control includes hard data plus surgeon champion

With decreasing Medicare reimbursements and increasing pressure to reduce costs, OR leaders everywhere are looking for creative solutions to balance their budgets. At Thomas Jefferson University Hospital (TJUH) in Philadelphia, standardizing surgical mesh looked like a way to save a bundle, and indeed a $1.5 million savings over a 3-year period was achieved. But as with any new initiative, an investment of time, resources, and collaboration was needed to make it happen.

Identifying the culprit
Monica Young, MBA, RN, DNP, CNOR, vice president, perioperative services, and Michael Profeta, BA, RN, nurse manager of the operating room at TJUH, determined that the OR was spending more money than necessary on surgical mesh. The hospital was using multiple vendors, and a lot of money was being spent on porcine or human tissue mesh even though surgeons weren’t using much of it. In addition, there was no evidence that 1 supplier’s mesh produced better outcomes than the other products.

The possibility of standardizing mesh had been a topic of discussion for years, but it didn’t become a focused project until the fall of 2012. “This was one product where we had multiple suppliers and variation on the shelf,” Young says. “It was a massive undertaking, and in the past we didn’t have the time or resources to devote to a project of this magnitude.”

But with ever greater budget pressures, the perioperative and supply chain leaders at TJUH decided they were ready to try. “We brainstormed for cost savings, and we brought mesh back up again and thought we would take it on,” she says.

Young and Profeta partnered with members of the hospital’s supply chain, Susan Miller, MN, RN, CMRP, director, value analysis, and Kelli McRory Thomas, senior contract manager. This newly formed mesh team dedicated up to 2 hours per week for more than 8 months to this new initiative.

Ultimately, the team was able to negotiate an agreement that would result in approximately $1.5 million of savings over the next 3 years. This led to reinforcement of a policy requiring all new OR supplies to be both cost-effective and evidence-based. But the change did not come easily, according to Young and Profeta. The initiative required the right analytics, accurate data, and staff who were committed to the cause.

Getting surgeon buy-in
Perioperative leaders agree that the time is right for hospitals to improve planning, purchasing, and monitoring of OR inventory and supplies. There are numerous approaches that can be taken, whether choosing gel foam without thrombin, reducing the number of high-end orthopedic implants purchased, or going after the “Holy Grail” of preference cards (sidebar, p 15).

However, no initiative will succeed without the support of the majority of surgeons who use those surgical supplies and instruments. Surgeons are more attuned to costs than they have been in the past 10 to 15 years, perioperative leaders say, but
they still have the power to derail cost-saving initiatives. Accurate medical evidence and data are essential to convince them that changing to different instruments or materials will yield the same outcomes and still save significant amounts of money.

The Cleveland Clinic is 1 facility engaged in trimming OR supply costs. “Three years ago, we challenged ourselves to save $100 million by focusing on how and what we buy to stock the hospital with needed equipment and supplies,” says Chief Executive Officer Toby Cosgrove, a national healthcare expert. “The key was to meaningfully engage doctors.”

But even with Cosgrove’s leadership, “there definitely still is push back from surgeons,” says Jake Runion, BSN, RN, CNOR, assistant director of Cleveland Clinic’s main OR. “It’s no small task.”

It is indeed a difficult process, but it can lead to success, says Patricia A. Farrell, MSN/MBA, RN, NEA-BC, associate vice president of surgical and interventional services for Rush University Medical Center in Chicago. “There are a lot of competing points of view, and you are trying to meet everybody’s needs,” she says. “You don’t want to put physicians in a situation where they can’t do their best, but you’ve got to find a way to get costs under control.”

Surgeons respond well to hard data, not unsubstantiated inferences. “Saying to surgeons that we can save a lot of money using a particular instrument or supply doesn’t mean anything to them. But if you can say, ‘we can save a million dollars,’ that’s a show-stopper,” Young says.

Doing your homework
To gain the support of their surgeons, TJUH staff spent a month researching everything there was to know about mesh, Profeta says—the various types, clinical applications, and each mesh vendor’s product portfolio.

David E. Young, MD, medical director of presurgical testing at Advocate Lutheran General Hospital in Park Ridge, Illinois, recommends that perioperative leaders use a value analysis committee made up of materials management, service line leaders, and surgeon champions to sort out the true supply costs of an OR. “Even before you start gathering benchmark data, it’s important to understand what you are buying and what you are trying to compare to the benchmarks,” he says. Dr Young is also a managing partner with Surgical Directions, a perioperative and anesthesiology consulting company.

Early in the process of any OR supply cost containment initiative, perioperative leaders should decide how they will define success, Dr Young says. “If your costs are 30% above benchmark, what do you consider a success? Will you try to go all the way, or is 15% above benchmark satisfactory? There may be some surgeons who aren’t willing to change,” he says. “Do not set unrealistic goals because if you don’t meet those goals, the project may be considered a failure when it really isn’t.”

After gathering the necessary data, the mesh team at TJUH decided that the hospital could save money by reducing the number of mesh vendors from 8 to 3 or possibly even 2. They reviewed each surgeon’s usage of mesh and discovered that for total dollars spent on mesh, the least amount was spent on the majority of units purchased and the most was spent on the low usage mesh.

Before reducing its number of mesh vendors, the mesh team knew it needed to find a surgeon champion who believed that standardizing mesh could be accomplished without hurting patient care and who was willing to convince his or her peers. Often, the surgeon champion is the major user of the supply item the hospital is trying to reduce.

When administrators approach surgeons about changing supplies, surgeons can quickly shoot holes through the proposals, Young says. But when a peer approaches
them, it has a different impact, especially when that peer has accurate data and can explain the clinical relevancy.

At the Cleveland Clinic, each service line manager has the support of either the chairman or another surgical champion to help move cost-saving efforts along, Runion says. By doing so, they have started to achieve small wins, such as convincing some surgeons to use gel foam without thrombin, which they say is just as effective as and less expensive than other types of gel foam, Runion says.

Demonstrating the evidence
These and larger cost savings are being realized through an ongoing cost visibility campaign, Runion says. Supply chain staff help clinical leaders to develop posters that identify high-volume products and the costs associated with them. The posters are then placed in ORs and high-traffic areas. “Many of our surgeons don’t know what supplies cost,” Runion says. The most recent posters focused on hemostatic products, detailing the costs of each product, such as the gel foam with thrombin.

When Profeta and the team approached a general surgeon to be their champion, they presented him with different options based on bids that vendors had submitted. Not all vendors had equivalent versions of existing mesh in the inventory, so some vendors were not considered. Three tiers of cost savings were presented. The one with the steepest reductions included the fewest vendors and converted the highest cost mesh to a different vendor.

TJUH worked with the Advisory Board Company, a global research, technology, and consulting firm in Washington, DC, to help gather and analyze data, such as a breakdown of how surgeons were using mesh. Information like this can also
be found through group purchasing organizations such as Premier Inc, Dr Young says.

Once data have been collected and analyzed, perioperative leaders are ready to approach the surgeons (sidebar at left). At that point, it is important for them to be confident in their findings and present the information clearly, quickly, and concisely, says Birchie Seiffert of the Advisory Board Company, who worked with TJUH.

**Overcoming resistance**

Dr Young has found that such supply initiatives can quickly fall apart. “We’ve had surgeons say ‘I won’t be a part of this; I can only work with these materials, and I’ll take my cases and go elsewhere.’” OR leaders then need to sort out the profit margin per case, breaking down labor, material, and other associated costs. It may be necessary to explain to the surgeon that the hospital is losing money on his or her cases. “But you’ll need to have your information lined up with reliable data before you have these conversations,” he says.

However, most surgeons are competitive by nature. If a neurosurgeon whose craniotomies are costing $15,000 learns another neurosurgeon is achieving equivalent outcomes for $10,000, there will likely be a desire to find out why costs are higher, say experts.

Profeta’s advice for dealing with surgeons who are opposed to these initiatives is to objectively listen to their points of view, then take that perspective back to the committee to see if it is valid or just a surgeon’s personal preference. “You are always going to have someone who doesn’t want to do it,” Profeta says. “Sometimes because of the opposition we felt like we were taking 1 step forward and 2 steps back.”

Don’t take objections personally, be persistent, and don’t give up, Profeta advises. He brought in representatives and scientists from the developers of the mesh products they had selected to explain the products to the surgeons and answer questions.

Dr Young advises paying as much attention to the initiative’s rollout as to gathering the data, evaluating costs, and selecting vendors. “It’s really important to plan for this day. Don’t let it just stumble forward to failure.”

Based on the success of the TJUH mesh project, Profeta and the mesh team plan to use the same process to standardize advanced energy devices and endomechanical staplers—other items with high costs, high usage, and multiple vendors.

**Jefferson University offers strategies for gaining physicians’ support**

- Spend time up front researching, gathering, and analyzing data related to your initiative; it is time well spent.
- Ensure your data is evidence-based and accurate before approaching a possible surgeon champion—inaccuracies will quickly derail your initiative.
- Choose a surgeon champion who is 100% committed to the cause—he/she will be needed to get peers onboard.
- Be prepared for resistance from others—overcome opposition by leveraging support from physician leadership and departmental alliances.
- Make costs of supplies transparent, such as adding supply costs to preference cards.
- Educate surgeons about costs and reimbursement—some surgeons may not be aware that hospitals aren’t fully reimbursed for case expenses regardless of cost.
- Remain steadfast and focused on the goal.

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**Reference**