A small hospital tackles implant costs

When Judy Patterson, RN, BSHA, CNOR, arrived in July 2003 as director of surgical services at 105-bed Hannibal Regional Hospital in Hannibal, Mo, she quickly discovered the hospital had an orthopedic implant purchasing problem.

“We had no IT system, no data, and physicians were unaware of pricing of implants,” Patterson says.

A sensitive issue was that one vendor was a brother and the other a brother-in-law of 2 orthopedic surgeons.

“It was hard to know which direction to take,” she says.

One of the first steps Patterson took was implementing a directive that all implant invoices must come through her before a purchase order is issued.

“This gave me the opportunity to get acquainted with the vendors, implants, and the pricing as well as to collect data for the physicians,” she says.

She began using a data tracking system and collected information from St Louis-area hospitals. She also began sharing information with the physicians for the first time.

“All of these strategies were instrumental in supporting our efforts in cost reduction,” she says.

Setting goals

In her cost review, Patterson found the hospital lost $1,200 on every total hip replacement case. During fiscal 2003, the hospital lost $340,000 on its total hip cases. With fiscal 2004 fast approaching, Patterson’s goals were to reduce implant costs, standardize, and improve inventory management.

Curtis Burton, MD, one of Hannibal’s 3 orthopedic surgeons and brother of one of the vendor reps, said he was surprised when he heard the news.

“I thought I was doing the hospital favors by performing so many surgeries,” he says. “The hospital would have lost less money if I had played golf.”

After going over the cost data with the surgeons, Patterson called a meeting with the representative of the company that supplied the total hip prostheses, who is Dr Burton’s brother.

“We asked the company for 50% off, they offered 20%, and we settled for 35%,” Patterson says. “We thought we did well.”

She says she later learned that although the company was giving the hospital a 35% discount on implants for which it had negotiated a price, vendor representatives were recommending that surgeons use more expensive implants.

“The vendor would come back and add a $650 to $700 up-charge to the implant. It was a way to get their discount back,” she says. “They also charged us for freight, something that was not that unusual a few years ago.”

Joining a collaborative

During the summer of 2004, Patterson was invited by SSM Health Care, a St Louis-based health system, to participate in Premier’s Supply Chain Collaborative Breakthrough Series. Hannibal is an SSM affiliate.

Over about 8 months, teams from some 35 hospitals or hospital systems participated in the fourth annual series, says Gay Wayland, RN, MBA, vice president of Premier’s supply chain knowledge transfer.
Hannibal was the smallest hospital in terms of beds participating in the implant project.

“Smaller hospitals can get just as large discounts as larger hospitals,” Wayland says. “It is a myth that there is a correlation between volume and price. It is how well you can engage physicians and get them involved in the negotiations.”

Wayland coaches hospitals not to start by talking with physicians about product standardization.

“Try to offer to make their life better at the hospital by offering benefits, such as investing in capital equipment if they will help bring the cost per case down,” she suggests.

Like all participants, Patterson’s team, which included the CFO, materials management director, pharmacy director, and orthopedic coordinator, attended the meetings, developed a storyboard of progress, set goals, kept in touch with other participants, and learned OR process improvement techniques.

Patterson says she expected to go to the first breakthrough meeting in September and show what the team had done.

“We were very proud of getting those discounts,” she says. “We learned we didn’t do as well as we thought. We needed to go back and get organized.”

She also learned the hospital needed to use the CFO as the driver of the process and to include the orthopedic coordinator as part of the team.

After the meeting, Patterson talked with the surgeons about standardizing to one vendor to save money, but not surprisingly, they didn’t want to do that.

“Were were on Premier pricing contracts for knees, but that needed to be adjusted,” she says.

Moving to capitated pricing

During the second meeting in December, Patterson learned about capitated pricing—a strategy of setting a flat rate for implants.

“We told the 2 vendors what we would pay for each hip and knee implant, including screws, pins, bits, and trocars,” she says. “We knew what other hospitals were paying based on the breakthrough series.”

Jane Anders, RN, MHA, MBA, SSM’s contract manager of surgical services, says SSM’s 8 participating hospitals saved a total of $1.5 million, mostly in the orthopedic area. “Most of the hospitals have gone to a capitated pricing arrangement and have done well,” she says.

After the second session, Patterson says Hannibal was able to negotiate a 47% discount using capitated contracts that locked in prices for hips and knee implants for 2 years.

“We gave the vendors the contract, and it was revised 5 or 6 times but not on pricing,” she says. “Any new technology has to be approved by me, the staff has to be trained on it, and everything had to be consigned. No freight charges.”

The contracts became effective in January.

“Some hospitals may have lower prices than us, but we locked it in for 2 years,” she says. “Hips and knees went up 8% this year, and probably will go up 8% or more in 2006.”

From September 2004 through March 2005, Hannibal saved $261,781 on hips and reduced costs by more than $1,000 per case, Patterson says. Though there’s further to go, she is pleased with the progress so far.

“We ended up playing one vendor against the other, a common practice in business,” says Dr Burton. “There was a lot of resistance from the vendors. I made it clear the prices were too high.” One vendor was opposed to changing the price. We told them we were going to the other vendor to purchase both types, and the first vendor came around.”

Patterson says that despite the family relationships, the surgeons “never let that be an issue. They became our partners in reducing costs.”

Partnering with physicians is key

Patterson also learned the importance of working with physicians on process improvement in the OR and marketing the hospital to increase referrals.
“We had already started to work with the surgeons on pricing, but improving the process was just beginning,” Patterson says. She also formed a partnership with materials management to educate staff on cost reduction strategies.

She and the staff worked to reduce turnover time for joint replacement surgery from about 45 minutes to about 20 minutes. One strategy is to have patients prepared as much as possible in the holding area before they are taken to the OR. The hospital also has provided the surgeons with another room with laminar flow and bought new instruments and equipment.

She also learned the value of using the surgeons to make outreach visits to the community. “We called on clinics to talk about improvements at the hospital to get more referrals,” she says.

As a result, Hannibal increased orthopedic volume overall by 22% and total joint procedures by 10%.

“I couldn’t be happier,” says Dr Burton, a partner with Midwest Orthopedics Specialists. “I had a busy practice before, but because the hospital OR is more efficient, I can get done by 1 or 2 pm or add another surgery. Before, I was there all day. This is my reward.”

Burton says he often was frustrated when he thought he was helping the OR, but the rewards weren’t coming back to him.

“A well-run organization rewards you for bringing in business by making your life easier or by getting better technology,” he says. “I feel the hospital is doing that now.”

—Jay Greene

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