Cost management

Top strategies for juggling quality, cost of physician preference items

Managing the costs of procedures with implants continues to be a juggling act for OR directors and business managers. Total joint replacements, once profitable, have seen prices climb while Medicare reimbursement slides. Some spinal procedures still have a positive margin because the surgery is more often performed in younger patients with commercial insurance. But financial success depends on an organization’s ability to work with the surgeons to control costs.

ROI (Resource Optimization and Innovation) is the supply chain arm for the 20-hospital Sisters of Mercy Health System based in St Louis. ROI’s mission is to improve the clinical, operational, and financial performance of customers through a clinically integrated supply chain.

“The Sisters of Mercy is all about reduction of variation and improved efficiencies because we believe that drives safety and quality,” says Marita Parks, RN, MHA, ROI’s vice president for performance consulting.

Here are ROI’s top strategies for physician preference items.

Develop a compelling reason for change

For a hospital or health system to enlist physicians’ support for managing sensitive items like orthopedic and spinal implants, there must be a compelling reason for change that goes beyond finances, Parks advises.

“Three critical factors have to be there—clinical, operational, as well as financial. We ask, ‘What are the opportunities that go along with better management of the process?’”

For example, if the number of implant vendors is reduced, will that help to improve operational processes? Fewer vendors could help reduce variation, which should lead to a more streamlined, safer process.

“If you say the reason you want to reduce variation is to improve patient safety and help provide better service to the surgeons—and by the way, we are going to reduce some costs—that is more compelling than just saying, ‘We have to save money,’” she says.

Have senior leaders commit to the process

Sisters of Mercy has a hospital CEO council that meets monthly. Projects with a large impact, such as addressing physician preference items, are presented to the council so the CEOs can discuss opportunities and strategies for involving physicians and other key stakeholders.

“We keep them in the loop as we work through the process,” Parks says. As the project progresses, she and her team work with the CEOs to develop talking points to assist them in discussions with physicians who have questions or concerns.

Develop a strategy to reduce variation

ROI uses 2 approaches for reducing variation in use of physician preference items:

- capitation
- vendor compression.

Both require a great deal of collaboration with physicians.

The most effective strategy, Parks says, has been to reduce the number of vendors, termed “vendor compression.” This strategy accomplishes the twin objectives of reducing variation and reducing cost by driving volume to fewer vendors.

There has been debate about which method is the most effective. Reducing the num-
ber of implant vendors is difficult because surgeons are reluctant to give up a product line they are accustomed to and have a strong loyalty to. On the other hand, with capitation, surgeons continue to use any vendor they choose, and the hospital and vendors agree to ceiling prices for implant classes or constructs. Capitation has less impact on clinical practice and operations than vendor compression.

“Capitation can work,” Parks says. “You need significant buy-in from physicians because if you have vendors who will not participate in the capitated pricing and physicians continue to use those vendors, costs increase and the capitation model does not work. Physicians must agree to align with us by telling vendors that only if they participate will the surgeons use their products.”

In ROI’s experience, after benchmarking among its 20 hospitals and comparing best practices, limiting the number of vendors has been more successful than capitation.

“It is not always the most popular strategy, but it works. It both saves costs and reduces variability,” she says.

With fewer vendors, the staff has fewer types of instrument sets to manage. This is no small matter because a major orthopedic case can take 15 or more trays. With fewer types of trays, the staff can become more proficient at reprocessing and setting up cases, improving service to surgeons.

This strategy is consistent with the Sisters of Mercy’s overall approach of improving quality by using protocols or standardized methods for everything that makes sense in improving patient care.

“That way, care providers have a consistent roadmap for producing predictable outcomes,” Parks says.

In the Sisters of Mercy total joint initiative, the number of orthopedic vendors was reduced from 13 to 5, shifting market share and achieving better pricing from the remaining vendors, she says. The 5 final vendors were market leaders across the system, and the vast majority of surgeons either used one of them or had in the past.

Enlist physician leaders

The secret to vendor compression is enlisting a respected physician leader. Says Parks, “If a physician leads these initiatives, the rate of success is much higher.”

ROI is currently conducting an initiative on bone products used in spinal surgery, where physician leadership is instrumental.

“First, we try to understand the utilization of these products and what the opportunities are,” she explains. “Then we try to find an influential surgeon who can talk with peers” to help reach consensus on the products and vendors that will be used based on criteria the surgeons have identified, such as quality, safety, and costs.

“What we have found in particular with surgeons is that peer-to-peer communication and support are the most successful strategies,” she says.

Ideally, the physician leader will be a practicing surgeon in the same specialty. “Physicians tend to listen to peers who understand their day-to-day challenges,” she says. To be effective, physician leaders also need strong leadership and financial skills.

Align incentives

With physicians under growing financial pressure in their own practices, they may have little time or inclination to help on these projects. Parks says there are incentives hospitals can offer that are within the law and not overly expensive.

“People tend to say, ‘There’s little we can do,’” she says. “But I think there are things you can offer surgeons that are appealing and don’t cost a lot of money. We try to find out what the drivers are with specific physician groups. The key is active engagement of the physicians in the process.”

Orthopedic surgeons, for example, may want another C-arm for the operating room.

“We would need to first validate the need for this equipment. Then we could collaborate with the physicians to develop a target for reducing implant variation and cost,” she explains. The savings could then be earmarked for purchase of the preapproved equipment.

A longer term goal might be to work with the surgeons on improving their quality of work life through OR efficiencies such as on-time starts and shorter turnover times. Another incentive might be an offer to pay a physician leader for administrative time.
to lead the project. Such arrangements must, of course, be based on fair-market value and avoid violating the federal Anti-kickback Statute, which prohibits remuneration in exchange for referrals or for recommending purchase of supplies and services that are reimbursable under government health programs.

**Draw on physician-to-physician comparisons**

Presenting surgeons with data on their individual practice patterns for a particular procedure can be an effective way to focus their attention on implant and supply utilization.

“There are lots of opportunities if you’re willing to dig into the data,” Parks says.

“When we do these physician-to-physician comparisons, they are always blinded. We show them the variability between Drs A, B, C, and D. We say, ‘These are some of the drivers of variability in your practice.’ That’s often an eye opener to them. They will say, ‘Oh, I use this device, and nobody else uses it?’”

**Develop a vendor credentialing program**

Sisters of Mercy is implementing an enterprise-wide vendor access and credentialing system for its 20 hospitals. The systems will require vendors to be registered and meet certain criteria, depending on their level of patient contact.

Parks sees this as a necessary part of providing a safe environment, meeting regulatory requirements, protecting patients’ privacy, and reducing the infection risk.

Senior executives are being educated about the process so they can explain the program to physicians and vendors. Then if a vendor complains to a CEO about “being locked out of the OR,” the CEO can explain, “It’s not that we’re locking you out. But there are criteria that must be followed and qualifications that must be met.

“Again, this is engaging the key stakeholders in the initiatives and partnering with them to accomplish established goals,” Parks comments.

**With technology, strategy shifting to ‘If you prove it, they will come’**

What’s going to bring patients to your facility for spine care? One factor has been whether you offer the latest technology—minimally invasive surgery, computer-guided navigation, the latest CT scanner.

The theme has been, “If you buy it, they will come.” The new theme is, “If you prove it, they will come.”

Demonstrating performance is becoming a way to differentiate your organization from competitors.

“Success will be less about what technology you have and more about how well you use it,” says Steve Miff, PhD, vice president with Sg2, Skokie, Illinois, a consulting firm focused on health care strategy and business development.

Can you demonstrate how your organization is doing on measures like reoperation and readmission rates? Will you be able to show your services yield better outcomes and a faster return to normal activities?

Health care facilities will become more selective in the technology they pick, Miff says. “They will focus more on the impact of that technology—not only on market differentiation but also on how it affects clinical performance, operations, and costs of care.”

That will require more consensus on measurements, more robust data systems, and the ability to collect data across different sites.

Here are some trends Miff sees for orthopedics and spine care.

**More transparency**

At least 1 million patients covered by WellPoint, one of the nation’s largest insurers, can now look up ratings on their physician from Zagat, best known for rating restaurants. They can see how other patients rate their physician on trust, communication, availability, and environment.
Clinical data is also available, though it’s still limited. Patients can check Medicare’s Hospital Compare website to see how hospitals in their area are doing on measures like administering antibiotics before surgery and venous thromboembolism prophylaxis. WebMD, Health Grades, the Leapfrog group, and others also offer reports.

**Patients shopping for services**

Consumers are starting to use this information to make decisions about their care, and they will demand more data, Miff says.

On spine care, for example, patients still want access to the most innovative care. But they also want solid information on treatment options, both surgical and medical care.

“I think we’ll see more patients shopping for services, and I think we will see this play out first in orthopedics and spine,” Miff says. “It’s early, but it is a trend that is going to accelerate.”

Progressive organizations are already collecting data and posting it on their websites so they can communicate directly with patients and physicians.

**Bundled hospital, MD payment**

Medicare is experimenting with a new program called ACE—the Acute Care Episode demonstration project—which gives a single global payment to a hospital and physicians for certain orthopedic and cardiac procedures. The government hopes this will encourage hospitals and physicians to collaborate in improving quality and managing costs. The demo will take place in Texas, Oklahoma, New Mexico, and Colorado.

“This is the way payment is evolving, looking at a bundled payment for a broader continuum of care,” Miff says.

**Need for better data systems**

These efforts will require more and better data. Systems are needed to capture and connect spine care data on spine care across settings, including the hospital, surgery center, surgeons’ offices, diagnostic center, and physical therapy clinic.

These systems are in their infancy, and comparison data are lacking. In cardiovascular services, Miff says, 85% of Sg2’s client hospitals use national benchmarking data. But in orthopedics, only about 30% are using national data, and another 30% are using regional data. The other 40% just use their “best estimates.”

Also needed is consensus on measurements. What kind of data should organizations be collecting?

“Spine programs should be collecting procedure-specific data,” Miff advises. That includes clinical outcomes, operational performance, financials, and staff and physician performance. Data are also needed matching patients’ severity of illness to outcomes. Other measures should include where applicable length of stay, cost of implants as a percentage of reimbursement, discharge disposition, return-to-work time, complications, readmissions, and improvements in functional scores.

“They will be able to review the data and develop processes to address measures they want to improve,” he says. “They will also be able to look back and match certain procedures and implants to patient types and be able to assess what produced superior results.”

Programs that are successful are starting slow and taking small steps. For example, they might start by collecting data for patients having laminectomy or discectomy by a subgroup of surgeons.

But a wider view is needed. Miff says Sg2 is developing metrics for data collection that would enable benchmarking and practice comparisons. Sg2 is working with other organizations, including the National Spine Network (NSN) and Priority Consult, a company that develops software systems for patient management.

NSN, a nonprofit spine registry based in Marietta, Georgia, has gathered spine data for use by physician practices and research centers. To automate data collection, NSN has software called SpineChart that allows patients and physicians to
use touch screens to record information about care. Though the software is currently focused on physician practices, NSN plans to expand it to hospitals. For more information, visit www.nationalspinenetwork.org or phone 404/520-1555.

**How will trends affect ORs?**

What impact will these trends have on technology decisions for surgery?

“I think teams will be more aware of the implications of adding something new,” Miff comments. With performance transparency, more profiling will be done, not only for individual surgeons but also for whole programs and departments.

“If you have a surgeon who is extremely aggressive with new technology and new procedures, but the surgeon’s readmission rates are high, that will affect the whole department because the whole department will be profiled.”

He thinks performance data will become part of the conversation with surgeons about new technology.

“It will make it easier to counsel caution and take a more comprehensive look at the impact of a new procedure or technology before it is adopted,” he says. “There will be a need to understand the impact on staffing and the operation of the facility as well as the broad clinical impact.”

Physicians are data driven, and as data becomes more refined, working with physicians to develop programs and make technology decisions will become more targeted and productive, he predicts.