Where to look for supply savings

A s one of the hospital’s biggest revenue and cost centers, ORs are a big target for expense reduction in these tough economic times. Supply costs are always a focus, but OR business managers say they’re redoubling efforts.

The biggest opportunities are in physician preference items like orthopedic implants—also the thorniest because of surgeons’ brand loyalty. And the greatest savings potential is in product utilization; in other words, changing physician behavior.

“Utilization, changing behavior to consume less or use alternative products, is where you have the opportunity to save the most. It is also the hardest part because it requires the alignment of all stakeholders,” notes Gary Dowling of Huron Consulting Group’s Wellspring nonlabor practice.

On the plus side, hospitals may find surgeons are more interested in collaborating.

“It’s early, but we are seeing physicians becoming more receptive. They understand the economic conditions because they’re seeing it in their own practices,” adds Hazel Seabrook, RN, MBA, of Huron’s Wellspring practice.

One health system they work with has even named a surgeon as medical director of supply chain management. His time will be split 50-50 between his practice and working with physicians on cost savings.

Here’s a look at supply cost issues and how ORs are tackling them.

New climate of openness

The public airing of the cozy financial arrangements between physicians and device and drug companies is starting to create a new climate of openness.

Under an agreement with the Department of Justice in 2007, the major orthopedic implant companies are now posting consulting arrangements on their websites. The American Academy of Orthopaedic Surgeons and the North American Spine Society have adopted more stringent conflict of interest policies. AdvaMed, the Advanced Medical Technology Association, a trade group, recently strengthened its ethics guidelines.

Seabrook says one of the first questions clients ask is what arrangements their physicians have with industry. “I’m finding more hospitals are seeking advice on how to get proactive physician disclosures so they are aware of relationships physicians have with vendors,” she says.

Keeping data out front

Accurate, complete data is essential to working with physicians on supply costs. That’s still a challenge for most ORs, Seabrook says. A root problem is
incomplete and out-of-date preference cards, which many rely on for reports on cost per case. Cleaning up preference cards is a major step toward better data.

Cost per case is reported monthly to the OR’s clinical managers at St Joseph Hospital in Orange, California. Managers are expected to review the report and share trends with physicians in their service.

“We have always shared cost per case,” explains Terry Wooten, director of business and material resources for surgical services and endoscopy. With a recently upgraded information system, “we can now show the true cost without additional items like the overhead.” Physicians can see exactly what their preferences cost. “Some are shocked,” he says.

**Adaman about value analysis**

Value analysis is a mainstay for supply decisions at St Joseph.

For continuity, the value analysis team meets monthly, even if no items are on the agenda. Staff and physicians requesting new products are told, “Wait for the next value analysis meeting.” Exceptions are allowed only for unusual situations.

The St Louis-based Sisters of Mercy Health System, with 19 hospitals, is taking value analysis to the next level to focus on utilization. A systemwide value analysis committee guides decisions on new products requested at the system’s hospitals.

Cardiac rhythm management is the focus of one utilization initiative, notes Marita Parks, RN, MHA, vice president for performance consulting for the system’s supply chain arm, ROi (Resource Optimization and Innovation).

A physician committee is examining use of high-tech devices such as pacemakers and implantable cardioverter defibrillators (ICDs) and developing algorithms to guide use of the devices. After the algorithm is adopted, the committee plans to monitor use of the algorithm and any related cost reduction. A similar approach is planned for total joint implants.

**The challenge of spine**

If you ask OR directors and business managers about their biggest supply cost challenge, the answer is resounding: “Spine.” The bewildering array of hardware and biologicals make costs tough to manage.

Capitated pricing and/or reducing the number of implant vendors are the most common strategies. In capitation, ceiling prices are set for categories of implant constructs. Which approach is best depends on local market dynamics, Seabrook observes. Hospitals need to balance the need to reduce costs with the risk of losing surgeons if their preferred brand is eliminated.

“Reducing vendors generally is not well received,” she says. Capitation may seem easier, but it’s not a panacea because capped pricing requires close monitoring.

**Capping implant prices**

Mission Hospital in Asheville, North Carolina, has pulled off the feat of capitated pricing for trauma and spinal surgery implants, a program that took almost a year to develop, notes the surgical services business manager, Allen Warren. Capitated pricing has been in place for about 5 years for spine and about 1 year for trauma. The hospital, which has 43 ORs at 3 sites, performed more than 2,400 spinal surgery cases in fiscal 2008.

For trauma, one of the trauma orthopedic surgeons worked with materi-
als management to determine a capitated price for the plates, screws, and other supplies used for an orthopedic trauma case.

Mission presented the capitated pricing to the vendors, and 2 signed on. The previous supplier elected not to participate, which meant the trauma surgeons had to change brands.

**Capping prices for spine**

For spinal surgery, Mission’s 11 orthopedic and neuro spine surgeons agreed to limit implants to 2 vendors that met the capitated pricing. The surgeons recently merged into 1 group. The schedule of 38 constructs was originally based on one developed by Premier that has been modified over time to fit new technology.

The participating vendors must comply with the capped pricing unless the surgeon has a specific reason for using components outside the pricing agreement. The program is enforced by a committee that includes spine surgeons, and they must approve exceptions. Occasionally, a product has to be supplied free if a company circumvents the process.

In a strategy that helped gain physician buy-in, a portion of cost savings from the capitated pricing program is dedicated to Mission’s spine program, including education for staff and purchase of new instruments.

**Managing “new technology”**

The biggest challenge with capitated pricing is managing the loopholes, Warren says. Mission is seeking to address that issue as it negotiates its fourth capitated contract for total joint prostheses. One issue is determining what is “new technology.” A company might say a product is “new technology” and should be paid for outside the capitated agreement. Sometimes a part number is changed, and the change is defined as “new technology.”

The shift of implants toward the high-tech category is a national trend. Orthopedic Network News (ONN) reports that in 2007, 85% of total hip constructs fell in the most expensive category, compared to about 40% in 1999 in its national network of hospitals.

New technology should be addressed as part of the implant contract, Seabrook advises. “You need to put in a solid process for how any new technology is brought in,” she says. She suggests engaging the surgeons in determining whether the product is really new, saying, “It is often easier for the surgeon to put pressure on the vendor than it is for the hospital.”

One way to address “construct creep” is to require a vendor to provide the 510(k) clearance from the Food and Drug Administration to document a new technology, suggests Orthopedic Network News editor, Stan Mendenhall. He says the issue has become more complicated, particularly in spine, as more startup companies enter the market. A single component from different vendors can vary widely in price, and identifying the original manufacturer can be difficult.

One hospital system includes a clause about new technology in its implant contract. The clause states that the company must provide a formal invoice before a new technology is offered for use in its facilities, with documentation that the product is defined as new technology by the FDA and/or third-party experts. The price must be mutually agreed upon in writing before the product is used. The contract states that products invoiced without prior approval for amounts over the capitated price will be paid at the capitated amount.
Potential in gainsharing?

Does gainsharing hold promise as a way to aid savings on physician preference items? Gainsharing is a formal and highly structured collaboration between hospitals and physicians in which the two parties agree to share savings from clinical projects. Gainsharing is subject to scrutiny by the Health and Human Services Office of Inspector General (OIG) because of the risk these projects might create incentives to cherry-pick healthier patients or stint on care. About a dozen such arrangements have passed muster with the OIG, all from one firm, Goodroe Healthcare Solutions, a unit of VHA.

Seabrook says hospitals she’s talked with are cautious about gainsharing, finding it complex and cumbersome. And savings may not be enough to interest physicians. Moreover, because of legal requirements, a new savings objective must be set each year. “A big question hospitals have is, ‘How do you sustain a model like that year after year?’” she says. <>