

Engaging Physicians for Supply Chain Savings



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From knee and hip implants to surgical sutures, the hospital supply chain is made up of thousands upon thousands of supplies. And that means, some might say, thousands upon thousands of opportunities for supply cost savings—an especially important concept in an era of increased pressures to the bottom line.

For many hospital administrators, this multitude of savings opportunities begins with the chief user of the most expensive supplies—physicians. Physician preference items, such as implants, stents, pacemakers, and other advanced medical devices, can account for as much as 60 percent of a hospital's supply expenditures.¹ What's more, these items often are brought to market at roaring speed and marketed directly to physicians, thereby bypassing many of the checks and balances of a hospital's typical purchasing process.

It should be little wonder then that in a 2008 HFMA survey sponsored by the group purchasing organization (GPO) Amerinet, gaining physician/clinician buy-in represented the greatest opportunity for supply chain improvement among both CFOs and supply chain leaders. Of the 225 survey respondents, 72 percent indicated it was a "high" or "tremendous" opportunity area.²

■ Strategies for Physician Buy-In

Although it's not difficult to recognize the importance of physicians in supply chain cost management, gaining their agreement around such efforts can be altogether different.

It's not that physicians don't want to save money. Quite the contrary, most physicians recognize the inherent value of assisting the organization and may even directly benefit from organizational initiatives that reinvest supply chain savings into equipment or clinical programs. Rather, physicians often are resistant to changes to the supply chain out of concern for altering practice patterns. Physicians typically are comfortable with certain supplies because they've received training on their use and know through experience that they can support good quality outcomes.

Such rationale for status quo may make a lot of sense—and ultimately may indeed be the right option for physician and hospital. However, unexamined reliance on preference also can needlessly lead to lost opportunities for cost savings throughout the supply chain.

The underlying solution therefore involves developing strategies so physicians and the hospital take into account physician preference as well as the financial equation around acquisition of supplies and equipment.

So how exactly is this done? Consider the following real-life strategies several hospitals have relied on to meet physician needs while still achieving supply chain savings.

■ Let Physicians Do the Talking

One of the problems with obtaining buy-in from physicians is trying to find common ground. Physicians and hospital financial executives come from two different worlds. They work in different environments, use different tools, and speak different professional languages. The route to cost savings thus begins with bridging this chasm.

When supply chain costs began escalating at Virginia Mason Medical Center (VMMC), a Seattle-based not-for-profit integrated delivery network that includes a 336-bed hospital, administrators began examining processes to see where there was room for greater efficiencies that would lead to cost savings. Overall, they have come up with a plan involving the use of Lean manufacturing principles coupled with physician input to shave \$1 million off supply chain costs by the end of 2009.

One of the first areas affected has been product review. In the past, a product review team evaluated a physician's request for a new product. That evaluation was sent to a vice president in the department where the request originated, say orthopedics, for a decision to be rendered. The problem: While a majority of requests were approved, the process took way too long—about 46 days from the time of submission to an answer—a time frame that didn't go over too well with the hospital's staff physicians. The team working on retooling the product review process termed it "a speed bump to 'yes,'" says Steve Schaefer, vice president of finance, who oversees the supply chain and revenue cycle for VMMC.

Part of the problem was that the process was disconnected. The product review team didn't have the clinical knowledge to question a request, the requesting physician didn't understand the financials of the request, and the vice president was not part of the review process, but nonetheless made the final decision.

The solution: Let a physician do the talking. The hospital's chief of orthopedics, Paul Benca, MD, was brought in as a part-time physician adviser to the supply chain, with part of his responsibilities including helping out with the product review process when necessary. Although Benca does not make any final decisions, he does help the product review team evaluate a product and explains the financial analysis to the physician who requested it.

Benca, a 25-year veteran of VMMC, sees himself as an aid to efficiency. "It's just a lot easier when you have someone who can walk in both of those worlds and feel comfortable going back and forth between them," he says. "It really expedites the process and breaks logjams."

So far, this physician advisory role has played a significant role in helping VMMC achieve hundreds of thousands of dollars in savings and cost avoidance.

For example, Schaefer describes how financial analysis showed that purchasing a new middle ear laser would add \$15,600 in supply costs, for which a payer wouldn't provide additional reimbursement—turning a profitable service into an unprofitable one. Comparing revenue scenarios for the procedure by CPT code with and without the laser, the organization projected an annual loss of \$102,700 with use of the laser. VMMC's physician adviser, Benca, was able to help review this analysis with the financial staff keeping an eye toward the perceived clinical need. He also was able to explain the projected loss in the context of this value equation with the requesting physician, who then withdrew his request.

In another example, a seemingly benign request to use a new type of suture was denied because of the potential for financial loss. Not only was the cost for a pack of these barbed sutures about 20 times the cost of the sutures the hospital already used, but if too many physicians used the sutures, the hospital risked missing volume targets that were part of the contractual agreement with its regular supplier. Benca went back and forth among the requesting physicians, the cost manager of the operating room, and the product review team to figure out the potential benefits and downsides. The result, although not what the requesting physicians initially had sought, was a quicker answer and one that made sense to all involved.

Where Is Greatest Opportunity for Physician Buy-In?

HFMA's 2008 Supply Chain Survey, which was sponsored by Amerinet, asked 225 supply chain and financial leaders to identify strategies that pose greatest opportunity for garnering physician and clinician buy-in to supply chain savings. The top three ranked as "high" or "tremendous" opportunity were:

- Engaging the physician executive team in the development of a supply chain strategic plan with clear goals and accountabilities (**51 percent**)
- Sharing data with physicians to increase their awareness (**50 percent**)
- Conducting value analysis (**49 percent**)

The new process and its associated faster pace for decisions has garnered much support from physicians. "The interesting thing is we're actually denying things more now than we ever did," says Benca, noting that the goal is to reduce the review process by more than 50 percent, to 14 to 16 days.

The longer-term goal at VMMC is to implement product standardization, so finding an effective way to communicate with the organization's 450 physicians has become a necessity.

"There have been a lot of physician preference items that we've allowed to proliferate over many years," Benca says. "As we move to a product formulary, we're going to need to begin to create standardization, something that has traditionally been met with great resistance."

■ Seek User Feedback Early On

Organizations also can incorporate formal processes for obtaining physician input into cost-saving strategy. "Physicians should be included in the actual decision-making process so they can see for themselves how changing a supply or turning down a physician request would benefit the hospital and, in turn, themselves," notes Vicki Smith-Daniels, a professor of supply chain management at the W. P. Carey School of Business, Arizona State University.

She adds that such discussions play to a physician's strengths, since physicians are trained to do cost-benefit analysis. "That's what they do all day long," Smith-Daniels says. "They diagnose, they probe, they filter, and then they make a decision."

Particularly useful is insight from those with greatest familiarity with an item's use. When Loma Linda University Medical Center (LLUMC), Loma Linda, Calif., wanted to standardize pricing for total knee and hip joint implants, the not-for-profit hospital was sure to seek early input from a surgeon who was very interested in cost containment and performed the most total joint replacement surgeries at the medical center.

LLUMC used its group purchasing organization to research various pricing levels in the market and came up with a pricing recommendation based on the number of surgeries performed at the center each year. The surgeon then reviewed the recommendation and made a few adjustments to the pricing based on implant type and technology.

The resulting pricing plan—which included potential for hundreds of thousands of dollars in cost savings—was then presented to and approved by the total joint surgeons at the medical center. In large part, the medical center was able to gain the physicians' support for the new pricing because it already had been supported by the physician champion, says Sunder Nambiar, RN, executive director of perioperative services for LLUMC.

"Working with him helped get all the other orthopedic total joint team on board," he says, adding that through implementing the pricing plan, the hospital was able to achieve its goal and saved about \$500,000.

Fletcher Allen Health Care (FAHC), a not-for-profit university-affiliated academic medical center based in Burlington, Vt., also ensures user presence in decisions. Part of the center's very detailed, step-by-step process for evaluating a physician's request for a new product or piece of equipment includes a test of the item by one or more peers.

For example, when FAHC recently wanted to switch to a new kind of surgical glove, physicians were given the opportunity to use the gloves first in a test trial. The new glove got an overwhelmingly positive response, with more than three-quarters of the surgeons giving their approval, says Charlie Miceli, vice president of supply

chain for the medical center, which has 771 physicians, 538 of whom are on staff. The hospital went ahead with the change and as result shaved 15 percent off the cost of surgical gloves, Miceli says.

Create Structures for Inclusion at a Strategic Level

Of course, seeking early-adopter champions or providing opportunities for feedback through trials represents only a small opportunity for including physicians in supply chain processes. Many organizations find it particularly useful to engage physicians at a broader strategic level as well, often by including them in a steering committee that guides cost-containment initiatives.

Such an approach was followed this past summer when VMHC formed a supply chain oversight team. In addition to the typical administrative participants, such as the CFO, CIO, director of corporate quality, and director of supply chain, the organization also included the chief medical officer, medical director, and physician adviser.

The team, which meets monthly, is responsible for maximizing the total value of the supply chain by ensuring that all materials are used effectively and processes are cost-efficient. One of the targets of the team's five-year plan is to reduce hospital expenses as a percentage of net revenue from 10.5 percent to 7 percent, the industry average for independent delivery networks, according to VMHC's Schaefer.

Schaefer says including physician presence on the executive team creates a sense of ownership of the supply chain. Rather than being viewed as a separate department dictating policy, the supply chain "gets enterprise commitment and accountability," he says.

Other formal opportunities for physician input at a strategic level are provided at VMHC as well. As part of the organization's Lean strategy, the center is conducting a series of rapid process improvement workshops. The intensive week-long workshops bring together administrative and clinical leaders—everyone who has a piece of a process—to work on such things as reducing costs or improving patient flow around a particular issue. For example, a recent workshop on improving the product review process involved staff

Keys to Working with Physicians for Supply Chain Success

→ **Give options for level of data detail.** Physicians want to see data at the level most useful for decision making—which can vary considerably by individual. When Fletcher Allen Health Care e-mails physicians value-analysis information for a proposed supply change, it makes sure to include a section with the financials in summary. Charlie Miceli, vice president of supply chain for the medical center, says this effort is useful because it minimizes the likelihood for any physicians to feel overwhelmed with too much information.

→ **Show physicians you're committed to learning more about their concerns.** Physicians will be most receptive to hearing a proposal for change when they know there is willingness to fully investigate and address potential effects on delivery of care. To gain an understanding of a surgeon's practices and reasons for work environment preferences, some executives have even found it effective to observe a physician during surgery, notes Vicki Smith-Daniels, a professor of supply chain management at the W. P. Carey School of Business, Arizona State University. "I know that

sounds like a different way to approach the issue, but it's been successful in some situations," she says.

→ **Don't play favorites.** Consistency and transparency of process when approving or denying supply changes breeds faith in decisions. "You really have to follow a process for value analysis and product acquisition," says Miceli. "Following a process allows you to have a more accepting and participative audience."

→ **Anticipate pressures to go against plan.** Loma Linda University Medical Center obtained physician support before presenting its revised pricing plan to vendors. When vendors tried to use the surgeons to get the hospital to reverse course and not standardize pricing, the attempt failed because the surgeons already were in support of the change. "The surgeons said, 'That's the pricing we are going to go with, so you either play along, or I won't use you,'" says Sunder Nambiar, RN, executive director of perioperative services. Other hospitals have found success by coaching physicians on marketing techniques that may be used to encourage them to go outside of purchasing controls.

who administer that process along with several clinical heavyweights, such as the chief of surgery, the chief of orthopaedics, and a general surgeon.

"This level of collaboration is something that I think is fairly unique in health care, where surgeons would carve out a week in their schedule to work out a process," Schaefer says.

Taken together, VMMC's supply savings strategies should go a long way toward reaching, if not surpassing, its goal. "We believe we can get far more than a million dollars in savings through our various efforts in 2009," Schaefer says.

■ Show Them the Numbers

Improving data sharing and reporting efforts is another key area for gaining physician buy-in. Half of CFOs and supply chain executives in *HFMA's 2008 Supply Chain Survey* identified it as a high area of cost-saving opportunity.

As FAHC's Miceli explains: "You're dealing with scientists, people trained as empiricists. If you don't have meaningful informatics, then you can't expect to successfully engage with them in a positive dialogue or effect any type of change or success."

Often physicians will welcome highly detailed information on cost. So, for example, the financial executive should present not only that a particular item costs X, but also why it costs X—whether other items are bundled in with this cost and whether the cost is based on volume purchasing. "Sharing data with physicians tends to work best when physicians understand what drives the cost," says Smith-Daniels. "Often they will even use the data to come up with solutions themselves."

Also, organizations with data-sharing success often go beyond line-item savings in a given supply category and relate supply and other expenses to revenues to help physicians appreciate total cost savings by procedure or service line.

Of course, not only which data are used but also how these data are communicated is important. Because physicians are so busy, it's important to create processes and structures so information is available when needed. In addition to sharing cost information at formal meetings, many organizations provide access through online databases.

In January, FAHC began using a workflow tool that automates the supply value analysis process and serves as a web-based repository of the information used for analysis. Often the organization will send physicians the process review information via e-mail.

In addition, as part of data-sharing processes for existing supplies, physicians at FAHC receive financial and clinical information that comes from both internal and external sources. Internal data may include a hospital's cost per surgical case or an individual surgeon's cost per case. Those data may be benchmarked against aggregate data from the hospital's GPO or other third-party decision support organizations, Miceli says.

Physicians have access to an automated tool that can provide such comparative information on demand. Use of such tools helps the hospital and physician set cost-saving targets and identify other opportunities for savings, says Miceli, noting that helping physicians see where the hospital stands on a cost per case can help them understand why there's room for improvement and provide motivation to reduce supply costs in the area.

As just one example of how such data comparison can be useful for setting goals, consider a situation where a physician might see that the organization is in the top quartile

within its GPO for cost per surgical case, and that simply reducing costs by \$12 per case would move it into the top 10 of GPO members with the lowest surgical case costs. "If you perform 2,000 cases in a month, multiply that by 12, and that shows you what your target savings can be," Miceli says.

Data transparency also is important and can lead to cost savings. If physician A learns that his per case surgical cost is \$5,000 while physician B's is \$3,000, then the competitive nature of physicians might cause physician A to review his practices to get his costs in line with physician B's—something he couldn't do without having seen the data, notes Miceli.

LLUMC's Nambiar notes that it's also important to show physicians the financial detail for one very simple reason: They may mistakenly believe the hospital is making hefty profits on certain procedures. To capture buy-in, providing data with direct and indirect costs, along with reimbursements will help put things in perspective; it helps to show the bottom line. "Physicians are very data driven," he says. "Show them the details. They like to see numbers, and they tend to respond."

Keep the Larger Clinical Picture in Mind

Clearly, using data on supply costs is an effective way to engage physicians in supply chain savings. Yet any one medical supply is just part of a much broader clinical picture, and that's what hospitals need to understand, says Smith-Daniels.

Hospitals can be most effective in gaining buy-in by taking a holistic approach when making supply changes, she says. Such an approach involves going beyond price and patient outcomes to take into account a physician's preferences and surgical practices when evaluating a product change.

Forward-looking hospitals tend to understand that physicians have their own "recipes" for how they perform procedures. So changing vendors for an implant, for instance, may not just mean a different implant, but a difference in how that surgeon performs the procedure, she says.

There are all sorts of reasons why physicians may prefer a certain supply. Surgeons, for example, may have been trained on a procedure using a certain implant. Or perhaps they've grown accustomed to working with the representative of the implant manufacturer, who may sit in on procedures. Also, as



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Tips for Supply Collaboration

Karen Barrow, senior vice president, business development for Amerinet, who oversees Amerinet's Clinical Advantage program, offers the following insights on ways facility-physician collaboration should work in today's challenging economic environment.

Q Physician engagement opportunities to improve quality and reduce cost are of paramount importance for financial and operational sustainability. Given your experience collaborating with physicians, what are some optimal strategies for working with them to cost-effectively manage physician preference items?

A Facilities need to be able to fully customize a program to meet their physicians' specific needs. For example, choosing which devices to target and the appropriate strategy – whether it be quality improvement, standardization, or cost savings through custom contracting.

Having a facilitator, liaison, or project lead also can aid the facility's efforts to work with physicians on supply costs. Physicians and others are best able to support the cost-savings initiative after they already have developed trust in working with internal staff, from the start of collecting and analyzing data through benchmarking, identifying cost-reduction opportunities, and selecting supplies.

Success depends on physicians' full confidence in the integrity of the data presented and having a voice in determining which implant/interventional manufacturers are acceptable.

Also, material managers armed with evidenced-based information will increase the chances of standardizing products and establishing protocols with physicians. Above cost, physicians' primary concerns typically include maintaining quality of care, ease of use, and quality outcomes.

Another key element can be designing programs that apply a portion of savings to initiatives that benefit physicians and their patients. Savings may be applied to needed equipment, personnel additions, educational and research opportunities, marketing, or other programs.

The successes of our members have been significant using these approaches. Savings on physician preference items have averaged 17 percent to 26 percent, with several larger facilities saving more than \$1 million.

Smith-Daniels explains, vendor reps often observe surgeries to help with preoperative preparations, making sure that knee implants are unscrewed and taken out of the package the right way or that instrument trays are set up appropriately. Physicians come to rely on this expertise, she says.

So it's only natural for a physician who has been successful to be resistant to a change in surgical practices. Smith-Daniels says hospitals have to understand this reasoning and the consequences of implementing a change, such as standardization.

Viewing the wider financial picture doesn't necessarily mean that the hospital acquiesces to the physician's resistance. Rather, the hospital should look at all the factors—the physician's practice methods, productivity, revenue-generation potential—to see how making a change will impact the bottom line, she says. It may be that by switching to a certain implant, a physician will not be able to perform a procedure as fast as would be possible using the former implant,

causing the surgeon's productivity to decline—along with the hospital's revenue.

Looking at patient outcomes and supply costs is valuable and necessary, but it's not necessarily going to address all the issues unless the hospital looks at how a change might impact the department and the physician's practices, Smith-Daniels says. "There needs to be an integrated view."

■ Be Ready to Give a Little

Any successful relationship requires a little give and take, and gaining physician buy-in over the long term sometimes requires the hospital to do a little giving.

Physicians should never have to feel like the hospital always turns down their requests for new products or equipment, says LLUMC's Nambiar. "If physicians are always being told, 'You can't use it,' then they can become very anti-administration," he says.

Also, sometimes it's worth it to make accommodations, such as fast-tracking a product request without going through a complete value analysis by a committee. For example, for product requests at LLUMC where the cost is the same or lower than what is in use and patient outcomes are not negatively affected, there is a streamlined process that gives approval authority to a service line specialist. Nambiar says physicians appreciate such efforts at minimizing observance to unnecessarily cumbersome process.

"I'm trying to cut down on all this red tape, and let surgeons know there is a little room for leeway," he says. "I want to help them understand that our goal isn't trying to stop them from using new products."

When a surgeon requests a product where the cost would result in a loss for the hospital, Nambiar and the service line specialist will meet with the physician and explain the cost disadvantage and how it would affect the hospital. The physician often understands, Nambiar says. And when there is great resistance from a physician, Nambiar will sometimes just give in and allow acquisition of the new supply. Nambiar says the hope is that the surgeon will return the favor when the hospital needs his support on another matter.

While physicians can be effective communicators with their peers and sharing data with them allows them to be effective



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decision makers, this give-and-take strategy recognizes the human side of a mutually dependent business relationship.

"Physicians bring patients to the hospital, and they are the point of contact," notes Nambiar. "A high-quality outcome gives satisfaction not only to patients, but also to the surgeon. And if a surgeon is happy with our support for the ability to deliver this outcome, then he or she is going to attract more patients and ultimately improve the hospital's business."

Endnotes

- ¹ Eugene Schneller, professor in the School of Health Management and Policy and director of the Health Sector Supply Chain Research Consortium at the W.P. Carey School of Business, quoted in "Purchasing Physician Preference Items: The Search for a Cure," Knowledge@W.P. Carey, July 18, 2007.
- ² HFMA's 2008 Supply Chain Survey, Healthcare Financial Management Association, May 2008, www.hfma.org/library/accounting/costcontrol/400607.htm.



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