NEWS

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Docs in a box

Can managing physician preference become a preemptive strike vs. a reactive exercise?

by Rick Dana Barlow

Talk to healthcare materials managers about managing physician preference for products, and those who may be working on an initiative or attempting to start some kind of standardization program will tell you all about the tips they learned through consulting projects, educational seminars, media articles and peer conversations.

They'll relay how you should establish and develop partnerships or working relationships with physicians by having coffee with them, accompanying them on rounds, learning their language and helping them understand yours, researching and showing them data on consumption patterns, encouraging them to spearhead product evaluations based on their chosen vendors.

Such strategies have been emphasized and encouraged for nearly two decades, kicked up quite a few notches when managed care emerged in the early 1990s and a hospital's cost concerns finally arrived at the doctor's doorstep.

Certainly, physician demand for specific high-tech devices and equipment represent a significant expense for hospitals and a key challenge for materials management departments and the supply contracts they've set up with or without the aid of a group purchasing organization.

The common thread in most "physician alignment" or standardization activities to date in this arena is that they typically happen after the fact with doctors who are employed staff members or simply have practicing privileges. Virtually no one questions the importance or value of these efforts because they do impact the expense and revenue streams so they must take place.

But what if a hospital – specifically a materials manager – could launch this process in motion before doctors even arrive at the facility? How could a materials manager participate in the process of hiring or granting privileges to a doctor or at least make the key executive and clinician decision makers aware of the hospital's supply chain management policies and procedures, their contribution to the facility's clinical and fiscal health, and factor that into their discussions and negotiations?

"With physician preference items being such a target … to save the big bucks, it certainly would seem easier to manage this up front than to try and change physician practice after the fact when they hit your organization with their wish list – or, more accurately, their list of items promised during the recruitment process," said David Brabham, director of materials management at Kalispell (MT) Regional Medical Center and HealthCenter Northwest.

Brabham initially broached the subject during a regional group purchasing strategic planning session for VHA. His fellow materials managers naturally thought it was a great idea but the CEOs and CFOs in the room were skeptical, he recalled. There's more to the recruitment practice than supplies, he recalled them saying. "But in six months [after they've brought someone on board] they'll be hounding [the materials manager] to save money through standardization," he deadpanned.

"No physician wants to be told what to do," said Karen Barrow, vice president of Amerinet Inc.'s Clinical Advantage program. "We don't want to take decisions away from doctors. If we don't control our costs then the government will take control of this for us. Physicians don't want this. You can't improve quality and reduce costs without having protocols in place. Variances are going to occur but they have to be the exception and not the standard. Research has shown that the more variances you have the lower the quality you deliver, and those variances can kill. Physicians have to understand that these hospitals can't take losses anymore."

Not surprisingly, materials managers and physicians don't always see eye-to-eye in this area – even during standardization efforts. "If women are from Venus and men are from Mars then materials management professionals are from Neptune and orthopedic surgeons are from Pluto," said Peggy Naas, R.N., M.D., MBA, an orthopedic surgeon who recently joined VHA to lead its Physician Preference Management Program. "Both have completely different world views."

Naas noted that the verbiage materials managers hear in educational sessions and read about in media reports, such as data, cooperate and physician alignment, all mean different things to different people. "To materials managers, physician alignment tends to mean 'if they would just agree to use what I'm giving them.' To doctors, physician alignment tends to mean 'they just want me to use what they want to give me,'" she said. "As a doctor, this jeopardizes one of my core values, which is under assault from all directions – individuality and self-determination."

Unfortunately, in a true Pavlovian response, many materials managers label doctors as one of the key problems and not the solution to a much greater need, according to Naas. "And if you simply tell a group of materials managers to collaborate with [doctors] to get them aligned, well, they don't know how to do any of that. When people make these presentations they tend not to elaborate on a predictable, reproducible process to get people where they want to be successfully. It becomes easy for people to check off why this or that won't work at their facility."

The bottom line is that this simply is hard to do, said Mike Rudomin, founder and principal, Michael Rudomin & Associates, Bolton, MA, and a former hospital materials manager-turned-consultant who is an advocate of physician economic credentialing. "This requires administration to make some very hard decisions," he said. "And they haven't shown so far that they're willing to do it."

Overcoming barriers to success

So that raises the question on how to approach this proactively.

Experts generally agree, and perhaps rightly so, that a draconian method won't fly. Any effort must be as fair as possible to all specialties without singling out any one of them, such as cardiology or orthopedics, Brabham advised. And it probably must be done on a case-by-case basis, rather than a universal application. Maybe it merely involves listing the GPO to which the hospital belongs, as well as the products used in a particular area as part of the hiring criteria for prospective doctors, he noted. At the very least, materials management should be involved in the hiring and recruitment process in some way, he added.

"We have a good working relationship with medical staff office," Brabham admitted. "We do pre-contacts to get preference cards. When someone leaves we get a heads-up for moving products out. That's the extent of our involvement." But he's not convinced that's sufficient.

Neither is Barrow. "Materials managers don't control [physician preference] but they are being held accountable for it," she said.

Setting up product selection as a criterion for a physician being hired or receiving hospital privileges is "a particularly bad idea that I believe many physicians would never participate in," said John McGuire, president and CEO, Surgical Implant Services LLC, a Jacksonville, FL-based physician-oriented GPO.

"No physician should agree to restrict his patients' access to technology or to limit his ability to continuously look for new or improved products that might improve some facet of the clinical outcomes," McGuire noted. "If one were to agree ahead of time to only use certain products, there might also be a professional liability question in the future for the doctor. Also, if one were to agree to this type of arrangement and then find the products inferior or feel the need to use 'off contract' items frequently, what type of incentive or enforcement could the hospital employ?"

Rudomin sees nothing wrong with instilling the recruited doctor with a management perspective in the organization. In fact, it may be the single most critical factor in the hospital's decision to go with the physician, as well as the physician's willingness to come on board, he added. "You should be able to say, 'We set these standards as part of the fabric of our organization so you have to fit our needs,'" he said. "That may mean you can't recruit someone because he's not willing to play. But these management parameters should be spelled out in the employment contract. And it should affect all physicians. It's reasonable to ask physicians to partner on quality and cost but you need to strike a reasonable balance between clinical outcomes and financials. This shouldn't be a strict dollars and cents issue."

Barrow agreed that sometimes playing hardball may be necessary, particularly if a hospital is under financial duress. "It's okay to say, 'We welcome you but here are the protocols we use, the products we use and this is our cost,' but it has to have the blessing of the C-suite, the medical staff and the board," she said.

Compromise may be inevitable, but with limits. "You can say 'We're willing to work with your vendor but they have to play at our costs.' We can't afford to do this otherwise," she noted.

Of course, playing hardball in a two-hospital town may not make much sense if the doctor can approach or pursue the other facility that may give him or her what he or she wants. However, it may work in areas where only a single hospital operates or in metropolitan areas where multiple hospitals may be struggling financially, experts concurred. "We're talking serious financial distress where the pain is palpable, and you have to live with it day-by-day until you get religion and have to deal with significant cuts," Rudomin added.

"Any restriction of privileges becomes a reportable offense to state medical boards and could threaten the physician's ability to make a living, as well as enter a blemish on his public record," McGuire said. "No doctor should agree to this type of unprecedented economic credentialing and, without some enforcement mechanism or incentive, any cost savings from standardization will be transient. The concept of working this type of plan into credentialing,

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licensing or participation with certain managed care organizations would be very poorly received by patients, as well. The public recognizes that physicians are uniquely qualified to evaluate and select implantable devices and would react very unfavorably to the idea of limited access to technology in favor of cost savings."

Naas also frowned on inserting product consumption history and vendor selections as part of the physician accreditation or licensing process but agreed that it could factor into the hiring and privilege granting process. The complications? Physicians with privileges at different hospitals might have to comply with different rules and work with different vendors that make different products, implying needless learning curves.

"Licensing focuses on education, ethics and experience – not the supply chain," Naas noted. "We have an open market here on technology, so you just need to implement open disclosure policies and procedures." Most facilities aren't doing this yet, she admitted.

Licensing and accreditation boards want to ensure clinical appropriate activities, skills and outcomes, Rudomin said, and may not see a role for supply chain in this. "The focus should be on clinical indications and better managing that process," he said. "We're just beginning to tiptoe into this area. When do clinical indications stop and financial conditions come into play? It makes life more difficult for everybody but it's still the right thing to do."

How to make this work

Launching a proactive measure to manage physician preference may be easier said than done but that shouldn't stymie meaningful efforts.

Brabham encouraged identifying an ally in the C-suite or a physician on the board of directors or on the medical board and mentor that person to be the liaison with materials management to ensure supply chain issues are discussed during hiring and privilege granting processes.

He admitted that recruiting and convincing the CEO might be easier because he or she is one person compared to a group of doctors in different specialties and positions, but maybe less effective the peer-to-peer influence that will make more of an impact. "You need board level understanding and support, as well as the CEO and the medical board to include supply chain in hiring and granting privileges," he said. "It has to come from the highest level of influence.

"Philosophically, creating the discussion and awareness is probably 50 percent of the battle at least," Brabham continued. "After that, it's dealing with opinions and strong wills. Our CEO is physician friendly. All of them have to be because a lot of the job revolves around physician relationships. But she discussed with a spine doctor the need to play ball with us because he was costing us money. The last thing doctors think about is supplies and equipment, although we're getting better. It's all about discussion, communication and awareness. Supply chain management philosophies need to be introduced during recruitment, which will bring awareness."

Brabham advocated supply chain issues be included as an element in the normalized standard of care because it strives for the highest quality of care with as much fiscal responsibility as possible. But it has to be structured as a clinical outcome-oriented issue and not a fiscal outcome-oriented issue, he added.

Barrow agreed that protocols and quality controls be established that incorporate defendable fiscal matters, such as product consumption, and that these efforts should be spearheaded by physicians with materials management's assistance. "This is the future," she said. "With transparency issues coming to the forefront, this is going to happen. At least it needs to happen. Hospitals need to have low cost but high quality physicians in practice before their data are disclosed publicly."

But McGuire urged caution.

"Hospitals would have to find some viable incentive to convince physicians to partner with them in addressing preference item costs," he said. "Obviously, sharing data is ineffective in the face of the personal and financial relationships that surgeons have with manufacturers. To try and make this work, a hospital could strike a deal with a potential staff member to reduce per-case costs as part of an inducement package to move his practice to that particular facility.

"Agreeing to use certain product lines or to participate in care pathway development and integration of nursing, anesthesia, PT, etc. could be done, but only the product selection is likely to make a significant difference," he continued. "The other issues should be in place or under way by now, regardless of who the surgeons are, and these efforts do not really require much ongoing input from physicians. Product standardization and price reductions per implant case are where the big savings can be had. In order to get doctors involved, one must find and deliver a sustainable incentive that will be solid enough to overcome manufacturers' efforts on a long-term basis."

MM readiness

Naas argued that doing your homework up front to maximize "materials management readiness" may be all that's needed to proactively manage physician preference. Certainly, vendors have mastered this skill because they know how to reach and service a physician wherever and whenever he or she moves.

For example, when the materials manager learns (hopefully, well in advance) that a new surgeon may be joining the hospital nothing prevents him or her from immediately reaching out and developing a relationship from the start. That may include advising the physician on proper procedures, how the hospital handles product and technology evaluations, what's on contract and being used, how contracts are determined, as well as how to secure block times, request needed supplies and interface with others on the team. "The savvy service line manager will seize the opportunity to do that," Naas said, "and by communicating that the new guy on the block clearly knows how things are done."

If the doctor won't cooperate initially for whatever reason, the materials manager could contact a peer at another hospital where the doctor practices to find out this information, she indicated. Rest assured, this is common practice among the vendor community, she added.

Physician and materials management leaders need to understand clinical and financial accountability issues and be able to communicate and skillfully work with one another, according to Naas. "If materials management has administrative alignment with the [operating room] then when it hears of a new clinician coming in the manager wants to meet them," Naas said. "It's a way to take charge of their part of the process."

But supply chain managers shouldn't take their value for granted in terms of the data they oversee, according to Rudomin.

"Supply chain people are holders and keepers of critical pieces of info in the areas of resource consumption, cost and quantities of supplies consumed," he said. "They develop reports that easily allow clinical people to see and analyze data. But I'm still very chagrined on how few managers do this." Typical excuses range from not having the right system to not knowing how to use it to no one's asking for it. "You don't need a system for that," he noted. "You can do a simple Excel spreadsheet and still be the person who pulls it together from an amalgamation of systems that don't work together. It's materials management's responsibility to send this to senior management." HPN