

By Laura Thill

On the Same Side

Are surgeons starting to align themselves more closely with their hospitals?

Is contracting for products and devices for the operating room all that different from contracting for products for other areas of the hospital? In one sense, no. Supply chain management directors and administrators walk the same thin line in the OR as they do in the rest of the hospital, balancing physician preference with cost. And, as with contracting for all hospital departments, purchasing decisions ideally are tied to patient outcomes.

But, add to this the predominance of physician preference in the OR, where patient outcomes often depend on the availability of the newest technologies, and the surgeon's level of comfort using such devices. Suddenly, surgeons see their relationships with vendors as important educational opportunities.

"We surgeons are always looking at new products and technologies to improve the outcomes of our surgical procedures," says Freddy A. Achecar, Jr., M.D., an orthopedic surgeon affiliated with the Wellstar Health System, a five-hospital system in the Atlanta area. "Surgeons

are accustomed to using different products and techniques according to individual experience in training and practice. As such, each surgeon develops a certain level of comfort in different procedures.”

“This complicates issues pertaining to OR contracting,” he continues. “A successful model for achieving an amicable relationship between the physician and the hospital must preserve the surgeon’s ability to choose products that he or she is comfortable with, while controlling costs for the hospital.”

To a point, Don Millbauer, director of perioperative service at Seattle-based Harborview Medical Center, University of Washington, agrees. “It’s nice to be able to offer your physicians a choice,” he says. “As a teaching hospital, we have to be flexible and provide our surgeons with [a variety of] experiences.” Still, the facility cannot

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do that at the expense of its financial well-being, he adds.

Indeed, the operating room is a resource-intensive department, says Ed Robinson, system VP, supply chain services at OhioHealth (Columbus, Ohio). “The dollars under contract [in the OR] are usually much more significant than most other departments,” he says. “Savings opportunities of several hundred thousand dollars annually are frequently identified and have much higher visibility within the organization.”

“Contracting in the OR is multi-dimensional in the sense that initiatives can be focused on a single specialty, such as orthopedics or urology, or impact every specialty and surgeon, such as a glove or suture,” adds Robinson. “In one regard, a contracting issue that involves the orthopedic surgeons at a hospital might be easier to pursue with the key practicing orthopods vs. getting buy-in for a potential conversion from hundreds of physicians.”

What surgeons want

To understand the nature of OR contracting, supply chain administrators must stay abreast of the latest and greatest – in other words, those devices that capture surgeons’ attention. “Surgeons will continue to want the latest technologies in the OR, especially those that allow the use of less invasive techniques,” says John McGuire, president and CEO of Surgical Implant Services, LLC, a Jacksonville, Fla.-based GPO that establishes local physician-owned companies, which work together to standardize on implant devices, reduce costs and improve patient outcomes.

“Many procedures that previously required large incisions and prolonged recoveries are now being offered through minimal exposure and smaller incisions, or through endoscopic technologies,” he continues. “The [benefits] to patients will continue to drive the adoption of less invasive technologies, and surgeons will want to be on the leading edge of these changes to maintain their skills and their competitive advantage.”

One of the most significant technologies introduced into the operating room at OhioHealth concerns minimally invasive spinal surgery, says Robinson. “Like most minimally invasive procedures, the benefit to the patient in terms of more rapid recovery is significant,” he says. “OhioHealth has experienced a dramatic increase in the number of spinal surgeries and has seen a corresponding increase in the use of more complex implant constructs and synthetic bone products and substitutes that aid in the fusion process.

“To remain leading edge, we have also made investments in robotic systems, surgical navigation systems, video systems and technology platforms that will integrate the operating room with the various clinical information systems used throughout the organization,” he adds.

At Minneapolis-based Allina Hospitals and Clinics, spinal, orthopedic and cardiovascular products are in high demand in the OR. The hospital system is currently implementing a new electronic medical record system (EMR). “It is very important that we tie physician preference information to the software we are using,” explains Cheryl Harelstad, VP of supply chain management.

Harborview Medical Center has been running studies to evaluate new technology for the operating room, according to Millbauer. Cutting-edge products that are highly valued by surgeons include spinal implants and

endovascular stent grafts for thoracic and abdominal aortic surgeries. “We’ve [completed] a lot of studies, especially on spinal implants, which are evolving rapidly,” he says.

More orthopedic surgeries are being performed in community settings, as opposed to academic institutions, Achecar says. “As such, more and more orthopedic surgeons will utilize these newer techniques and products as scientific studies validate them.” In addition to minimally invasive technologies, Achecar has seen advances in computer-assisted surgery and robotics in the orthopedic community.

Tried and true

Of course, products that have withstood the test of time will always appeal to surgeons, since their outcome is reproducible, says Achecar.

Indeed, surgeons are better off using “tried and true” products “when the use of new technology does not provide improved clinical outcomes, does not enhance patient and/or practitioner safety, or does not provide other demonstrated benefits, such as a reduction in surgical procedure time,” says Robinson. “Of course, a hospital must consider other factors, such as the importance of new technology to key physician stakeholders and the potential use of new technology by competitive organizations.”

“The newest products with all the bells and whistles often do not provide a measurable improvement in clinical outcomes,” adds McGuire. Still, it is the surgeon who is best qualified to make that judgment for each patient, he emphasizes.

“New technology is developed to improve patient outcomes and increase the likelihood of long-term surgical success,” Achecar points out. Ultimately, medical costs should decrease as long-term results improve with these emerging technologies and products, he says. “The only con, as I see it, is when technology is rushed too quickly to the market without adequate scientific evidence to validate its use.”

Vendors’ role in new technology

Without the support of their surgeons, no amount of consumer reports and decision support software can help

supply chain administrators assess the value of new technology. “New technology assessment demands physician input, and contracting for the newest products can be a challenge if no history of shared incentives and alignment has been established between the hospital and the medical staff,” says McGuire. “In the absence of such a relationship, the primary driver of new product selection will be the [physician-vendor] relationship. If a culture of aligned incentives and shared benefit from cost containment strategies is in place, surgeons will look at new products and technologies from a new perspective, and will be more likely to weigh the cost/benefit ratio before demanding the newest and most heavily promoted products.”

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Harelstad, too, says that technology assessment must involve a balance of input from supply chain administrators and physicians. “We want to ensure that all aspects of our business are involved,” she says. “We look at new products in terms of quality, compliance, inventory and training.”

“Sometimes physicians say we are overusing a product or not getting the best results,” she

continues. “Sometimes decisions are supplier driven.” Technology changes so rapidly, it takes all perspectives — that of the supply chain professionals, physician and vendor — to make the decision when to purchase new products, she adds.

Vendor input can be helpful in assessing the value of new technology, according to Robinson. At the same time, supply chain administrators must proceed with caution. “While contracting leverage is limited for many new technology requests, especially when no competitive alternatives are available, any positive impact from contracting is more likely to occur prior to the time the product is introduced and the vendor is still anxious to establish a relationship and potential reference site,” he says. “Conversely, some vendors take advantage of a sole source market position by charging hospitals an inflated price for new technologies, which [sometimes can have] an extreme negative impact on the contribution to margin and profitability of the procedure involved.”

OhioHealth employs a “new technology” process in which physicians lead evaluations of the clinical and economic impact of new technology requests, according to Robinson. In addition, an OR value analysis committee — also physician-led — evaluates new technology requests across all surgical specialties. The hospital system relies on a spend analytics tool provided by its GPO, the market expertise of such groups as SG2 and The Health Care Advisory Board, and other available benchmarking services, to assess cost and quality performance of new technology.

When Millbauer assesses how new technology will affect Harborview Medical Center’s bottom line, he considers not only cost and patient outcome, but the competition from other hospitals as well. “Will a new technology attract more



patients?” he asks. “If we don’t provide it, will we lose paying customers to other hospitals down the street?”

While he is quick to point out that the financial assessment of new products and technology often starts with supply chain management, Millbauer is adamant that physicians and surgeons must play a prominent role in the evaluation process. And, given their busy schedules, it can be tricky to get them involved. “Surgeons at a teaching hospital are very busy,” he says. “Harborview Medical Center is a level-one trauma center. Our surgeons don’t just make rounds and schedule two days a week of surgery.” Still, he adds, “we must involve physicians in hands-on evaluations of devices and technology.”

Getting surgeons involved

Few would dispute that the best results — from an economic and patient care standpoint — occur when supply

chain management works closely with surgeons and medical staff. And, even fewer would dispute that this is easier said than done.

“Clinical review committees potentially can be very time consuming, thus decreasing the ability for a busy surgeon to participate,” Achecar points out.

“As physicians [continue to] see dramatic reductions in reimbursements, increased demands on their time and growth in patient and procedure volumes, they must limit their involvement in meetings and other hospital-based activities,” adds McGuire.

Is it beneficial to pay surgeons to join clinical review committees? That depends, note the experts. “Compensation for clinical review committee participation should not lead to problems or ethical conflict for the participating physicians, but it could lead to discontent [among those] physicians not asked to participate,” says Achecar. “Thus, 100 percent participation would be paramount to success.”

McGuire agrees. “Selection of certain physicians and the exclusion of others would likely heighten conflicts and competitive issues among staff members and further reduce compliance,” he says. “Clinical review committees are a solution from the past that fail to recognize the current interests and concerns of physicians.”

Supply chain management, however, has developed another perspective. Paid medical staff and affiliated physicians are, indeed, willing to participate in clinical review committees, Robinson believes. “To sustain participation, the physician must derive value from his or her involvement,” he says. “This includes providing input into product selection decisions as well as the capital justification and acquisition process for the related specialty.

“Any time a physician dedicates [time] to contracting and supply chain initiatives, it is time not spent in clinical practice,” he continues. “I believe physicians should be compensated on a fair market basis for such participation. The arena of physician compensation has come under intense scrutiny and is a hot button for regulatory agencies. It is imperative to have clear physician policies in place, which have been appropriately reviewed and approved by legal counsel. In addition, documentation of the physicians’ involvement, including contractual agreements, meeting minutes, sign-in sheets and payment records must be accurately maintained.”

Depending on the facility or the mix of physicians and supply chain administrators involved, there appears to be more than one path leading to successful contracting for the OR. But, at least one question prevails: Are surgeons and physicians starting to align themselves more closely with their hospitals?

“Surgeons in some communities are becoming more closely aligned with hospitals, especially where the hospital assumes some of the cost of the practice, or adds a financial incentive to the physicians’ utilization of a specific facility,” says McGuire. “These incentives often include joint ventures like surgery centers, devoted operating rooms and staff, administrative services

out. “Still, we must stay on top of [supplier-physician interaction], and coordinate communication,” she says.

“I think vendors would welcome more constructive means to introduce their products,” Harelstad notes. “They are there to assist physicians. From a patient-outcomes perspective, we want our doctors to have access to the best devices.” If that means including vendor input in the product analysis process, so be it.

The value of the relationship between the surgeon and the vendor should not be underestimated, adds Robinson. “The best sales reps are highly responsive, provide educational expertise and always come through with products and instrumentation in a pinch.” On the other

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[and more].” In many cases, however, physicians prefer to maintain their independence and assume greater control over the clinical issues affecting their patients, he adds.

But, surgeons such as Achecar say they ultimately have their hospitals’ best interests at heart. “We surgeons tend to understand the business of running hospitals successfully in our communities,” he says. “We are interested in the success of our hospitals, because it is a reflection of our success.”

Lessons learned

For all of the effort supply chain administrators invest in strengthening the physician-hospital relationship, they can get frustrated by the ease with which vendor-physician relationships evolve. But, supply chain directors and vice presidents have lately been rethinking the role of the vendor.

“Supplier-physician relationships are the nature of the beast,” says Harelstad. However, vendors can be informative and play an educational role, and hospital administrators don’t necessarily want to interfere with this, she points

hand, reps can encourage an unhealthy level of dependency from surgeons, he says.

“At OhioHealth, we want to utilize the expertise of sales reps in an appropriate manner that complements our internal processes and structure, but does not create a critical dependency,” he says. “Most important, we must remain market competitive by ensuring [that we receive] the best pricing for products and services.”

With or without vendor-physician relationships, early involvement and communication with surgeons continue to generate the best contracting results. “Slow down and work together,” notes Harelstad. “Doctors are data-driven. They respond to this. So we [administrators] must get our information out there.”

“Physicians want a place to practice medicine that is safe, efficient, user-friendly and provides a healing environment,” says Robinson. This means providing physicians with a much greater say in how the organization is run, as well as direct input into supply chain management, he points out. “A contracting decision that saves money but decreases physician satisfaction and makes it more difficult for a physician to practice medicine is in clear conflict with our vision.” 