

**Supply Chain Performance Improvement nets
Avera McKennan potential \$500,000 in savings**

CASE STUDY



**Avera McKennan Hospital
and University Health Center**

ENGAGING ORTHOPEDIC SURGEONS SLASHES IMPLANT COSTS

When Avera McKennan Hospital and University Health Center lost nearly \$2 million last year on total joint replacements (TJR), administrators of the Sioux Falls, S.D., flagship of the region's largest health system knew it was time for action, not talk.

That's when Premier's Region Vice President Rick Salzer and Senior Region Director Kevin Campbell — who have been working with Avera leadership to create a stronger relationship with Premier — stepped in with a suggestion: let Premier's Supply Chain Performance Improvement experts apply their experience and expertise to the challenge.

The results have been far more than expected. First-year savings in total joint replacement costs will be at least \$400,000 and likely more than one-half million dollars. More important than the savings, hospital officials say, is the process that's been put in place to make sure those implant cost savings continue in the years ahead.

"Our CEO said recently that what we're saving this year is just a prelude. It's the savings we will see in the out years that are even more important," said Steve Statz, senior vice president, hospital operations and hospital project team leader. "If we had done it ourselves, I'm convinced we'd have only saved a \$100 or \$200 a case — if we were lucky — and there'd have been no sustainability. The vendors would have just upped the gross charges and we'd have been back where we were — maybe worse."

What Premier gave Avera McKennan, Statz continued, "is sustainable and can withstand pushback from our vendors. Premier helped us put a solid system in place. We implemented beginning the first of July, and every month there are fewer and fewer issues. This is here to stay."

The purpose of the engagement was:

- **to identify cost savings opportunities through a detailed review of existing clinical, supply chain and related data;**
- **to recommend new processes, tools and communication methods to engage physicians in the cost-saving process; and**
- **to prepare the necessary analysis for senior leadership to effectively engage physicians in a productive discussion about quality outcomes and costs.**

Catherine Whitten, a senior clinical associate for orthopedics in Premier's Supply Chain Performance Improvement unit, got the assignment. Based in Detroit, she has more than 20 years of perioperative experience with an emphasis on orthopedic service lines including serving as director of surgical services for a metro-Detroit hospital.

Whitten analyzed three months' data and made a site visit late March 2005 to validate pre-visit data, interview staff and observe total joint cases. But, she emphasized, "This was a tremendous collaborative effort by the Avera McKennan team. They completed a process that usually takes six to nine months in just five months. The team was decisive, timely, moved forward expeditiously and did an excellent job."

Her findings revealed that "Avera is pretty much best practice so its non-implant savings opportunities represented less than \$45,000. Kudos to the staff for such a low target," Whitten said. "The big question was implant costs."

One orthopedic group of 16 surgeons performs most of the surgeries. The payer mix is more than 85 percent Medicare and third party fixed payment. The hospital was losing money on every Medicare joint replacement. The devices in most cases were 43 percent of the reimbursement with some joint cases at more than 75 percent.

In addition, Avera McKennan has stiff competition from a private, physician-owned specialty hospital that handles about 90 percent of the community's orthopedic cases. The specialty surgical hospital began with six orthopedic surgeons and today has 16 as partners.

Whitten's study showed the real opportunity for savings was implant costs. Total hip replacement volume is 250 annually at an average cost of \$5,403. Annual total knee replacement volume is 460 at an average cost of \$3,252. The study data suggested that surgeons employ a patient selection process for implant utilization. She identified potential implants savings opportunities at between \$268,000 and \$446,000 annually.

"To make a difference physicians must be engaged in the process," Whitten said. "To get optimum pricing depends on strong physician relationships and support. You need to make a case for change."

The hospital created a performance improvement challenge for its orthopedic surgeons through open and frank discussions. Administration shared the hospital's target: to improve profitability by significantly reducing implant costs as a percent of the DRG reimbursement.

Said Statz, "The orthopedic surgeons are familiar with this payment scenario. They face the same kind of payment scenario for their own practices — where reimbursement includes pre-surgery consults, surgery, and after surgery visits up to six weeks after surgery. They understood and were sympathetic."

To identify incentives, Statz's team gathered information concerning other issues — the "hassle factors" — surgeons may have. For instance, one said weekend staffing was a problem. As part of the process the hospital set the example and addressed the weekend staffing issues. The hospital also addressed the surgeons' quality concerns by organizing an orthopedic service team and developing quality indicators with clear, objective metrics. They also implemented dashboards to track process improvement and issue resolution.

All of that set the stage for successful negotiations with the orthopedic surgeons on the most important issue, implant costs.



"Discounts from vendors are what you earn," Whitten says. "They do not correlate with volume, market share, region or penetration. Better pricing is related to effort and focus. With some effort, you can get up to 25 percent discount. With focused surgeon engagement come discounts of from 25 to 60 percent."

Hospitals generally lose money on each TJR procedure because they exercise little control over implant purchases. Orthopedic surgeons, usually assisted by an implant manufacturer's sales rep, routinely specify implants independent

of hospital purchasing contracts. It's one of the few situations in which hospitals — instead of following normal purchasing procedures — buy a major piece of equipment without knowing the price beforehand.

"Shifting business relationships is fundamental," Whitten said. "Vendors generally react responsively to the threat of market share shift." But, she added, you also have to monitor the ongoing vendor relationship carefully "to prevent shifts in utilization to compensate for price reductions."

The track Avera McKennan took was to develop "constructs" — to build with their surgeons a product formulary of TJR devices based on a therapeutic interchange model. Each "construct" describes the devices within that therapeutic interchange.

"For instance," Whitten said, "if the device is a cemented hip, the components are described. Once decided, Avera McKennan set pricing for each construct based on its identified reimbursement structure."

Here's how it works in practice. Using a pre-care form, the surgeon decides what device is to be used one week before a surgery. After the case is done, a post case sheet is filled out. The two are compared. There is room for change if for some reason — bone density, for example — a different device is installed. "However," Whitten said, "if changes become routine, if a pattern develops, this is a signal to explore the utilization changes."

Implant costs were a significant component of costs that needed to be controlled, according to Statz. "When Premier helped us put that in front of our major orthopedic group, the light bulb went off. Then they wanted to know how they could help. What could they do? We engaged them. That was the key."

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