Talking to your clinical staff about resource utilization

Revisiting cost reduction: getting your clinicians’ agreement

The Institute of Medicine estimates the scope of waste in the U.S. health care system at $765 billion per year.¹ The bad news is obvious. The good news is that waste gives executives a target-rich environment for improved margin management. It is critical to engage clinicians in a holistic approach built on these fundamentals:

• Implement evidence-based care processes that improve quality and reduce clinically unnecessary variation in care and outcomes.
• Eliminate overutilization, redundancy and inefficient workflows.
• Flex staffing to accommodate new models of care.
• Enable analytics to create benchmarks, analyze performance against goals and measure market differentiation.
• Align physicians with organizational priorities.

It all sounds so straightforward. However, a 2014 survey of health system financial leaders found that while 88 percent of responding organizations have set cost-reduction targets, 83 percent say they fall short of achieving them.² Why? A number of challenges get in the way of implementing the fundamentals of clinical cost management. The principal barrier is finding a way to bring clinicians into the discussion. Executive teams that are effective at speaking to clinicians find that the best tool for the job is meaningful analytics, used at the right time in a structured process that is directed by clinicians. Within this framework, it’s possible to excel at cost management, resource allocation, regulatory compliance and—most important—patient care.
Demonstrating the rationale for clinical culture change

It starts with the big picture: answering the question “where to go” before asking “how to get there.” When executives effectively communicate how reimbursement and market forces drive the need for total margin management, physicians and other clinicians better understand the need to engage. Using current, credible analytics to define specific opportunities narrows the scope of work to what really matters.

Knowing what matters most to clinicians: patient outcomes

Most physicians care a lot about their patients and less about costs. Clinicians know medicine—and less about finance or information technology. But they completely appreciate the role of meaningful analytics in mapping the route to evidence-based care that benefits their patients and costs less. Conventional wisdom holds that high-quality care costs less. Being able to actually measure this resonates with clinicians.

When health system leaders frame the cost management conversation in terms of improved patient care with less cost or waste, clinicians listen and are willing to engage in the effort. The most effective way to do this is using evidence-based data that tells the story of what needs to be addressed and then measuring progress toward the goal. Quantifying the opportunities that yield the most bang for the buck in terms of time, effort and improvements just makes sense to clinicians. “There is no lack of data in health systems,” said Andrew Mancuso, vice president, Advisory Solutions at Vizient. “It’s synthesized, informative data that’s rare. How do you tease out the noise to reveal what’s really going on, so productive discussions can begin? Some health systems can do this, but not all have the resources to support the data mining and analysis.”

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Vice President, Advisory Solutions
Vizient

Figure 1. Health care executives’ perspectives of physician alignment

What are physicians most concerned about today?

- 60% Their changing financial status
- 14% Lack of influence on health care system strategy
- 12% Their changing role
- 12% Frustration of information technology
- 1% Clinical metric fatigue
- 0% Dramatic increase in what they must know clinically
- 0% Excitement of new discoveries and possibilities

Source: Reference 1.

How do your physicians feel about accepting/sharing risk?

- 46% They are trying to understand
- 32% They have no interest in having risk
- 12% They are ready to embrace
- 11% They are already embracing this opportunity
Measuring the value in innovation: strategies for managing physician preference items

Although some physicians may perceive any movement toward value-based care models as a threat to their autonomy, nothing threatens them more than efforts to manage the cost and utilization of physician preference items (PPI). The choice of these high-cost medical devices by the physicians who use them is at the heart of physician control over their patient care. Orthopedic surgeons, neurosurgeons, cardiothoracic surgeons, interventional radiologists and cardiologists are the principal users of PPI in most hospitals.

An aging population will generate significant growth in orthopedics demand (particularly for total joint replacements) over the next decade, with a shift to outpatient centers (Figure 2).3

It’s long been known that there’s an inherent conflict in managing PPI costs: The physician who chooses the implant has no obligation to pay for it. That’s the hospital’s job. But historically, the hospital has not had the capabilities to assess the added value that new or existing PPI technology brings to patient outcomes. That’s the physician’s job. The result? Purchasing and utilization of PPI have not been managed in an evidence-based way.

In most cases, a third party has seen the opportunity and stepped into this no man’s land between hospital and physician: the PPI supplier representative. Being useful to busy physicians is the representative’s job. Physicians have come to depend on their PPI suppliers for information about new technologies and even for assistance during a procedure in place of hospital staff. In fact, physicians frequently say that they see more of their supplier representative than they see of their hospital’s executive team. In many cases, they aren’t joking, so their trust naturally flows to the representative. Attempts to address this situation may be met with skepticism or even hostility.

Lack of alignment between hospitals and physicians about how best to approach PPI may help explain why the list price of coated hip orthopedic implants increased 154 percent from 2000 to 2014 while hospital Medicare

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**Figure 2. Orthopedics demand**

Inpatient orthopedic and spine discharges  
U.S. market, 2013  
Total volume: 3.4 million

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<table>
<thead>
<tr>
<th>Procedure Type</th>
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<tr>
<td>Primary Hip</td>
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<td>Primary Knee</td>
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<tr>
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Source: Reference 3.
reimbursement rose just 3 to 6 percent. Incidentally, surgeon reimbursement over the same period declined 10 percent.4

Reconfiguring the PPI dynamic to a value-based approach requires a mighty effort and serious administrative will. Above all, it requires a physician-directed process of evaluation that is powered by robust clinical and financial data.

**Member examples**

**Physicians at one academic medical center** decided to undertake the challenge of determining whether new PPI technologies actually bring greater value to patient care. They had observed the explosion of new, more expensive medical devices that had unproven benefits to clinical outcomes. They acknowledged the two major impediments to value-based PPI purchasing: lack of aligned incentives between health systems and their physicians, and physician-industry relationships that influence purchasing and utilization.

To achieve true value-based purchasing of medical devices, they created a process with these critical components:

- Research and third-party information on new technologies
- Comparative market costs for similar devices
- Aligned incentives among key stakeholders
- Development of organizational capability

Their faculty-based technology assessment body, the Medical Economic Outcome Committee, introduced peer oversight for new product adoption. This approach has an evidence-based process to determine what new products will enter the supply chain and how they can be used. Considerations include patient outcomes, marketing differentiation, innovation benefits, research potential and financial impact.

Since its inception, the committee has saved millions, strengthened alignment and reached the next level of peer-to-peer benchmarking and evidence-based product procurement.5

**Based in central Texas**, a large health system with more than 40 hospitals and more than 6,000 affiliated physicians has taken PPI cost management to a new level by leveraging Vizient analytics and consulting expertise to facilitate physician engagement.

Product cost is one consideration for the multidisciplinary teams evaluating PPI, but patient outcomes are front and center as physicians consider new and existing technologies. Granular cost and outcomes data, as well as market price analyses, enable physicians to compare themselves to their peers.

“We get down to product level using outcomes data and peer-to-peer comparative data, which has helped us work with our physicians and ask, ‘What is best for the patient? What are the best outcomes? Is the product you’re using comparable?’ We compare costs, and above all, we look at quality,” said the system’s supply chain leader.

To engage clinicians, it’s vital to use an evidence-based methodology that fully accounts for clinical factors—such as patient age or co-morbidities—as well as device costs. Especially in peer-to-peer discussions, this neutralizes some anecdotal assertions that costlier devices are being used because a physician’s patients are more clinically complex.

“When we use Vizient experts for these discussions, the knowledge they have has allowed us to drive savings that have been leaps and bounds for us. Our physicians have been engaged because when you give physicians good data, you can drive change,” said the system’s supply chain leader.

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**Managing clinical resources to improve patient care and avoid penalties**

The Centers for Medicare & Medicaid Services’ far-reaching drive to reduce costs and improve quality of care at hospitals currently includes the Comprehensive Care for Joint Replacement model, Value-Based Purchasing, the Hospital Readmissions Reduction Program (HRRP), and the Hospital-Acquired Condition Reduction Program. Under the last two programs, hospitals face escalating reductions in payments when they fail to meet performance targets.

In August 2015, Medicare announced that under the HRRP the majority of U.S. hospitals face penalties for higher-than-expected 30-day readmissions in certain patient populations. Penalties begin at 1 percent of reimbursement being withheld and increase to 6 percent if outcomes do not improve over time. Under the new Hospital-Acquired Condition Reduction Program that began in 2015, more than 700 hospitals may face payment penalties. For some
hospitals, this may mean hundreds of millions in lost revenue—not to mention loss in patient confidence and diminished institutional credibility in the community.

**Member example**

**A Texas-based southern hospital system** identified an opportunity to engage clinicians in preventing central line-associated bloodstream infections (CLABSIs). These infections are an important measure for hospital-acquired conditions.

The hospital partnered with Vizient to help reduce CLABSIs, an opportunity with multiple benefits for patients and the organization.

“To tackle this issue, we needed an integrated approach and multiple strategies. Vizient provided the structure to identify the root cause and brought performance improvement and change management solutions,” said the hospital’s director of nursing.

Data and analytics helped narrow the universe of approaches to very specific opportunities that would improve CLABSI rates. Intensive care units (ICUs), cardiovascular ICUs and inpatient departments with high CLABSI rates were evaluated. Vizient data revealed that each CLABSI occurrence cost the system more than $27,000 in care delivery and resulted in nearly 16 avoidable days in the hospital. Most important, CLABSI increased mortality risk by 25 percent.

This evidence galvanized leaders and clinicians to support a multifaceted approach to reducing CLABSI. Nursing, infection control and supply chain staff all played a role. Sharing the initial evaluation data with physicians won their support for new safety protocols and helped them understand the CLABSI-related issues that floor nurses face.

The results? Ninety days after implementation, the hospital experienced zero central line infections and saved $2.9 million in avoided variable costs and more than 1,700 total avoided days. Related mortalities have been prevented: The benefits to patients are clear.

“Our engagement with Vizient gave us the data to manage CLABSI on a daily basis. We could see how efficient practices can evolve on the floor, create change and improve results. Just as important, it encouraged employee buy-in of the initiative by showing in real time how actions help achieve strategic outcomes. And it didn’t take too long and wasn’t too labor intensive,” said the hospital’s director of nursing.

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**Answering physicians who ask, “What’s in it for me?”**

Clinically aligned organizations anticipate the “what’s in it for me” question and are prepared to discuss a range of engagement and alignment possibilities. Vizient helps executives explore a variety of strategies, from gainsharing to co-management agreements to employment and more.

Sometimes, however, the appropriate response is for an organization simply to help physicians become better, quicker and faster so that their time is optimized. When executives really listen to physicians’ legitimate frustrations, they often hear of performance improvement opportunities that will make physicians more productive—which will make the hospital more productive too.

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**Member example**

**Surgeons at a busy program in the Southwest** felt that their time was being squandered by late starts and cancellations in the operating room (OR). (Needless to say, everyone else in the OR also felt stressed when the schedule didn’t run well.) A number of factors compounded the problem, so no one really knew where to start to fix the situation. Vizient brought a Lean approach to diagnosing the problem and creating a fast-track solution.

One key inefficiency was large variation in surgeons’ pre-op ordering. Some preferred to order their pre-op tests the morning of surgery. Others ordered patients to get tests in advance but didn’t communicate to the OR staff which tests they had ordered. Some surgeons sent their patients for pre-anesthesia review, while others insisted on doing the work-up themselves. It was up to the OR staff to scramble to assemble the relevant information from various sources in order to prepare for the case. Case delays and even cancellations were common.
Other processes such as scheduling forms and consents were inefficient too. No one—staff, physicians, patients, their families—was faring well under this system. Surgeons felt the hospital didn’t know how to run an efficient OR. Staff felt that allowing such variety in surgeon practices meant that the hospital really didn’t care about staff efficiency or patient satisfaction. As a result, no one was engaged in finding ways to improve because everyone felt like someone else was to blame.

A data-driven diagnosis of all pre-op functions using Lean techniques provided an objective starting point for solving the problems. A team of surgeons and anesthesia, pre-op, OR, sterile processing and information technology staff was guided on how to redesign the process without pointing fingers. The team members re-engineered the steps for scheduling and consent and standardized pre-op lab orders. Staff now have all the necessary information in advance to prepare the patient and the case for the surgeon. A physician leadership team addressed on-time arrivals by surgeons and anesthesiologists and implemented new rules for on-time starts and block scheduling.

The result? Expectations for everyone are clear and transparent, and real-time measurement keeps everyone accountable. On-time starts are now at 80 percent—which was unprecedented for this OR. The hospital has improved its credibility with physicians, staff and patients. And there’s a track record for clinician-led performance improvement that is straightforward, effective and rapid.

When executives approach physicians for their help with a major initiative such as PPI cost management, it’s not unusual to get the response, “Fix the OR (or cath lab or ICU) and then I’ll help you.” What physicians are really saying is, “I’m frustrated. Help me be more efficient. Protect my time, and I’ll give some of it to your initiative.”

Conclusion

New reimbursement models and initiatives make strange bedfellows. Health care executives must rely on physicians to lead many of the efforts required to be successful. Starting the conversation may be as simple as framing challenges and solutions using meaningful analytics that resonate with everyone.

3 Impact of Change v13.0; NIS; Sg2 Analysis, 2013.
Contributors

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Beth Graefe has 21 years of health care experience in hospital and managed care operations. Prior to her current role, she was director of development at American Healthways (Nashville, Tenn.), specializing in hospital chronic disease management. She has led projects in clinical cost reduction, strategic business planning, product development and vendor/payer contracting. In addition to earning an MHA/MBA from St. Louis University, Graefe has been an adjunct professor in Troy State University’s Executive MBA program and currently serves as an officer in the Colorado Air National Guard.

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Kevin Lieb has more than 20 years of health care experience focusing on quality improvement, market development and cost-reduction initiatives. Prior to his current role, he worked for J.D. Power and Associates and was responsible for the Distinguished Hospital program. He has also worked for several well-known health care companies, including GE Medical Systems, HCIA and LBA in Denver, Colo. He has extensive experience in hospital market-share development for new service lines, consulting management, product development and direct sales. Lieb is certified in Six Sigma and holds a bachelor of science degree in economics from Santa Clara University.

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Andrew Mancuso has more than seven years of health care experience with a focus on clinical nonlabor cost management and value analysis for physician preference items. Prior to his current role, he was managing director for the Clinical Sourcing Group of Medpricer, a strategic sourcing consulting firm focused on sourcing technology and strategy for health care providers. In this capacity, he led strategic sourcing and value analysis engagements at many of the top-rated academic medical centers and health systems in the U.S. in the areas of orthopedics, cardiology and general surgery. Prior to joining the health care industry, Mancuso honed his analytical skills as a commodity derivatives and equities trader for several Wall Street firms. He holds a bachelor’s degree in economics from Harvard University.

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