

Taking stock of docs

How do you motivate physicians to save money as earnestly as they save lives?

by Rick Dana Barlow

Physicians and materials managers have something to prove...to each other and to themselves.

Despite all of their clinical, medical and surgical prowess, many physicians struggle to connect the dots between the products they want and the budgets that pay for them. At the same time, many materials managers struggle to draw those lines for doctors and make convincing business cases for fiscal responsibility as an underlying engine for the Hippocratic Oath.

Of the Bureau of Labor Statistics-estimated more than 600,000 physicians and surgeons in the United States a small but growing number of them certainly possess some business acumen. Witness the growth in ambulatory surgery centers and physician-owned hospitals, as well as younger doctors earning business degrees. They face declining reimbursement, increasing malpractice insurance coverage and heightened regulatory scrutiny, all of which threaten their generous income.

Yet hospitals fight similar battles on their own fronts with familiar outcomes. Based on that notion alone, conceivably doctors and hospitals should work together, particularly in the area of responsible and efficient supply chain management. Some do. Not most.

So how does materials management cross the line without crossing the line?

Money talks



Nick Sears, M.D.

Numbers represent a good start. But not just any numbers. Materials managers should steer clear of discussing costs, at least initially, according to Nick Sears, M.D., chief medical officer, MedAssets Inc., and co-author of *Healthcare Purchasing News'* "Clinical Business Strategies" monthly column, and focus first and foremost on outcomes data.

"Never approach a physician with the idea that you want to decrease cost as your primary focus," Sears said. "In the equa-

tion of variables cost should take a back seat to quality and performance data and should only be considered when all the other variables have been considered and found to be equal. Therefore, one needs to know both short- and long-term outcomes for patients within the specific service line that you are dealing with." Materials managers should supply these data in aggregate and by physician, highlighting quality first and then cost, he added.

Cost should come second simply because materials managers need to demonstrate "an accurate understanding of the costs involved with the service line" first, Sears continued. "Physicians typically are skeptical and therefore need to understand how data is derived. Cost-to-charges ratios have no impact on a physician since this is derived information," he noted. "Providing actual invoices and accruing those invoices into a succinct cost picture is the truest adjudication of the issue. You must also be able to provide accurate reimbursement data to help construct the framework of the service line."

But Sears warned that hospitals must be aware of and comply with vendor confidentiality agreements, which may hamper the materials managers' credibility and dampen their impact. "Physicians may doubt the accuracy of the information unless complete transparency can be realized," he added.

"The number one obstacle and mistake that materials managers make is not having effective data that can be translated into information," said Dee Donatelli, vice president of supply chain services, VHA Inc., and a former hospital materials manager. "Physicians are above all scientists and they want to see the business case. Second, they are clinicians who want to understand the clinical impact. So if a materials manager approaches a physician and simply says they have a new contract to save money on physician preference items, the doctor typically will not give them the time of day.



Dee Donatelli

"If, however, a materials manager approaches a physician on a collaborative level asking to work on quality outcomes and the products necessary to drive these, a physician will become more engaged," she continued. "Once he or she is interested in the topic, a materials manager must be prepared with a solid business case. Understanding what the physician population is currently using, the variance in the products they are using and the lack of variable outcomes drives discussion. This scientific data will lend itself to driving or suggesting the possibility for change."

To influence physician behavior and gain their support, materials managers need to understand reimbursement trends, how reimbursements link to costs associated with them and benchmarking performance with similar regional facilities, according to Karen Barrow, senior vice president of Amerinet Inc. "By understanding reimbursement trends, material managers will know how cost effective procedures are to their facility," she said. "It also provides a foundation to determine what a facility's capabilities are to offer incentives for potential savings achieved."

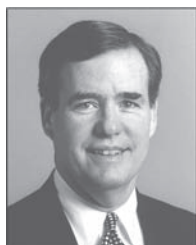
Barrow stressed that materials managers fundamentally must focus on evidence-based information, including internal and external key performance indicators, both current and historical for trending, to build physician relations. "[Such data] illustrates to the physicians who is using what implant, why they are using it and what it costs. It provides the common ground needed to begin a conversation around standardization," she noted. "Material managers armed with evidenced-based information will increase the chances of standardizing products and establishing protocols with surgeons."

Collect all the data you can provide, including usage by physician, by product and by vendor, but make sure all of it is



Karen Barrow

accurate, urged John Gaida, vice president, supply chain, Texas Health Resources. Back in 2005, Gaida spearheaded an Implant Resource Guide, which his department developed and publishes for internal administrative use. The Resource Guide tracks the Texas health system's data on generator implants (pacemakers, ICDs and heart failure devices), coronary stents and hip and knee implants, including costs by expense category, cost center, facility, DRG, ICD-9 Code, procedure and vendor, as well as dollars spent, units purchased and vendor market share.



John Gaida

Necessity motivated Gaida's group to create and manage this project. "Many times Supply Chain was being asked to run this report or that report showing usage, volumes, etc., between hospitals," he noted. "We decided to develop a routine report that had all the info about the major implants across all of the hospitals. The data needed to put this together came from multiple sources across the system. We found there was no one place where it could all be gotten."

Although Gaida's group has only shown individual reports or sections relevant to make any particular case and not the entire book, the publication has been successful, justifying the homework and legwork needed to create it. "Docs always react well to accurate data so this has helped make the case for change," Gaida indicated.

"You typically have one shot, so be prepared," Donatelli advised. "Lure them with clinical information and snag them with business-driven and rich clinical data to drive decisions."

Voice over IT

Pulling accurate and reliable data from an information system may be the lynchpin that motivates physicians to play ball in the game to cut costs and improve supply chain efficiency but it doesn't generally earn materials managers the face time they need - at least not initially without some degree of apprehension.

That's why materials managers need to recruit what some call a physician champion, someone influential enough, whether he or she is a physician executive, chief medical officer or another relevant clinician, to lead the charge and do the heavy lifting when necessary, according to Sears. "It is

preferable to have a champion who is a specialist within a service line who is viewed by his peers as being the de facto expert," he said. "Typically this is either a well-established practitioner within the hospital or someone who was recruited by the medical staff to lead a division or service line."

Hospital administrators shouldn't limit such recruitment to supply chain projects, Barrow argued. "What we have found with hospitals that included physicians in the business strategy and planning of the facility, along with the opportunity to actively take part on key committees such as value analysis and new technology, the physicians were more likely to participate in cost-reduction strategies and implant vendor negotiations," she said.

"From my perspective, after working directly with physicians for more than 25 years, I firmly believe that physicians want what's best for their patients, and want input into the decisions that affect their service lines," she continued. "At the same time, what I have found is that healthcare administrators and materials managers want the same thing - quality outcomes and patient satisfaction with an additional requirement, a reasonable cost structure. We must be good stewards with the resources we are given. However, that doesn't mean patient safety and quality is lessened. It means the opposite. Patient safety and quality are improved when the finances to purchase the latest innovative products, tools and services for the patient are available."

The materials manager may need to tap someone from administration, such as the CEO, COO or a vice president to assist in the process, Gaida indicated. "These folks should have a different relationship than the materials manager, making it easier to get their attention," he said.

Salient sales pitch

Even armed with the right data materials managers must craft their pitches carefully, according to Gaida. "Be able to tell a story about another hospital, preferably in your system or at least market, that has done something similar to what you are suggesting that has been successful," he advised. "Explain the initiative as a partnership between the physician, administration and supply chain to work together for the good of the patient - lowering costs while helping the physician [retain] choice."

First and foremost, however, materials managers need to overcome their hang-ups about doctors.

"Stop thinking of physicians as the enemy, or worst yet, put them in the category

of untouchable," said Joe Colonna, principal, Applesseed Healthcare Resources. "In the end physicians are just as human as the rest of us. Yes, many of them have an ego, which is typically a shield they have put in place. But they're just people. If vendors can build a relationship with them, so can you. I would suggest starting to build a relationship by asking them how you can help them and listening to their comments, questions and complaints. Don't start by asking or demanding they change. Listen to them and take the time to explain how and why things work the way they do and then ask them to help you to help them."



Joe Colonna

But Tom MacVaugh, president, Strategic Initiatives in Healthcare LLC, recognizes the barriers and sensitivities in place that make any contact, let alone conversion, a challenging climb. In fact, MacVaugh believes that older physicians chiseled in their ways may be less receptive to changes than younger physicians who have a basic understanding of healthcare economics and are more entrepreneurially minded.

Physicians, by and large, relegate the financial issues of the hospital as secondary to their own interests, according to MacVaugh. "I do not believe physicians think about, nor care that they may be viewed as a revenue stream to their hospitals," he said. "They want to diagnose and care for patients. The cost and funding mechanisms ... rarely rise to conscious thought levels."

"They care about their revenue stream, but I do not think the vast majority of physicians care about the hospital's unless they have a direct ownership interest in them," he continued. "And even then they don't typically delve into the cash flows, etc. They hire someone to do it for them, which is a prudent decision."

However, that shouldn't prevent doctors from cooperating and collaborating.

"Physicians should already be motivated to do the 'right thing' for their patients, which in my mind includes caring for the patient's fiscal as well as physical well being," MacVaugh said. "Their 'incentive' should be the relief of pain and suffering



Tom MacVaugh

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for their patients, including the relief of fiscal worries and related stress. If a physician is not taking this holistic approach, they are a disgrace to their profession and ought to have their licenses revoked."

MacVaugh contends that administrators have to build consensus and engage physicians in the selection process. Then play hardball. "If they don't comply after the mutual decision has been made, you invoice the physicians for the difference," he advised. "If they want to play the quality of care card, present them with valid clinical data, and/or ask them to produce hard evidence to the contrary."

The bottom line is that it's time to tear down the wall between clinicians and administrators, Colonna noted. "We have to get past this thing where physicians see materials managers as wanting only to buy cheap stuff, and materials managers see doctors as wanting only to get the most expensive stuff," he said. "I've seen doctors willing to work with you if you build relationships with them - not just approach them when you want to change something they're using or doing. If you approach them to work together for the benefit of everyone and not any one special interest you should be fine. Each has vested interest so let's find common ground."

Colonna also advocated learning to play dumb. "Don't be afraid to come to a physician, hat in hand, and ask for their help to solve your problem," he said. "Say, 'I'm getting a lot of pressure from administration and finance to cut costs. Help me understand why this widget, which costs more, is better so I can make a case for administration and finance.' With this tactic you've disarmed the physician."

"If you say it the right way or approach at the right time he or she will more times than not, explain why the product is needed or agree that an alternative may be fine," Colonna continued. "But keep in mind that not every win has to be 100 percent." For example, the materials manager

may have to continue buying the more expensive product - but less of it - even if you switch to something else so the doctor can use that product for those cases he feels requires it. "Sure, that means you're carrying more SKUs, but that's a small price to pay for the relationship and long-term financial success," he said. "And it gives the doctor the option of having their favorite product available if and when they need it."

Back to school

Some observers argue that basic and factual education for both groups represent the ties that bind, cultivating a business perspective among doctors and a clinical understanding among administrators.

"Continuing education is the only effective method," MacVaugh said. "Search each other out in a sincere attempt to understand the other's world without any scheme to overtake them. The key is taking the education to them and work it into their already impossible schedules. Don't expect them to have to travel to get it."

Administrators need to "create a learning environment amidst your operational environment that nurtures and supports the ongoing open exchange of ideas, resolves potential points of conflict and monitors external influencers," MacVaugh noted.

"We're woefully short on understanding each other," Colonna concurred. "But you need to hear from physicians who don't have a vested interest in your organization or can't affect your jobs."

Gaida, however, dismissed this as just another excuse. "[Materials managers] should already be aware of the issues," he stated.

Reinvesting pays dividends

What a hospital does with the initial and ongoing funds derived from mutual cost-reduction projects speaks volumes to physicians.

"Creating a reinvestment plan for the money saved, which goes directly to a physician's specialty is an invaluable way for physicians to feel that the hospital is giving back to them," Sears said.

Barrow agreed that reinvesting in products, equipment and services can be valuable incentives for physicians, suggesting seven ideas that make sense:

1. Invest 50 percent of implant savings back into specialty specific improvements
2. Make available process improvement efforts and work towards resolving practices that are identified by doctors and considered ineffective or inefficient for the service line, e.g., number of elective cases cancelled because of difficulties being cleared through pre-operative assessment
3. Provide additional labor resources in order to free up surgeons' time, such as pre-operative assessment, emergency department coverage, dedicated physician assistants on post-operative orthopedic floors or clinics
4. Make available operating room block scheduling, which is a creative and efficient scheduling methodology
5. Escalate open times for unscheduled ortho surgeries and use block scheduling
6. Grant a percentage of the savings for a service specific capital need, such as upgrading power equipment for orthopedics, adding a new OR table, meeting arthroscopy needs, etc.
7. Offer a dedicated OR service team for all cases

For the best case scenario a simple, straightforward approach should succeed, Barrow concluded. "Material managers need to collect data, understand changes in reimbursements, benchmark expenses, and share information throughout the process to build better understanding to improve physician relations and behavior," she said. [HPN](#)