What comes after value analysis?

You’ve had a value analysis program for a number of years. You think it might have run its course. What’s next? Value analysis, which has been in the forefront of supply chain management for years, is a systematic process for making purchasing decisions and identifying savings opportunities that consider not only price but also clinical efficacy, safety, and the impact on the organization. Value analysis teams can be housewide or focused on a specific department, such as surgical services.

Most ORs are using value analysis. The majority of respondents (53%) to the 2007 OR Manager Salary/Career Survey reported they have a value analysis program for surgery. (See October 2007 OR Manager.)

But after value analysis has been in effect awhile, it may be time for a fresh perspective.

At the University of Washington (UW) Medical Center in Seattle, after 6 years and $107 million in housewide cost savings, revenue enhancement, and cost avoidance, value analysis is morphing into other activities.

“One of the great successes of value analysis is that cost savings and waste reduction became embedded in what we do,” says Bill Anton, RRT, finance manager for surgical services.

What’s beyond value analysis?

“We continue to embrace the philosophy,” Anton stresses, noting that value analysis has become so engrained, it happens almost automatically. He doesn’t advocate moving away from a successful value analysis program. Rather, UW has adopted a new structure and incorporated savings targets into departmental budgets. For the fiscal year ending June 30, surgical services has a savings target of $2 million and was within $180,000 of the goal in February.

Three major areas are targeted:

• supply chain
• purchased services
• patient safety.

Supply chain committee

A multidisciplinary committee is leading an effort to strip $10 million from hospital-wide supply spending. The primary supply cost metric is hospitalwide supply expense as a percentage of total net revenue, the same metric used by the University HealthSystem Consortium (UHC), an alliance of academic medical centers.

The medical center’s supply cost metric is supply expense as a percentage of total net revenue. Supplies include consumables, pharmaceuticals, blood, and implants. The operating plan goal is 19.2%. Through February 2008, UW was at 19%, a little better than the goal for the year.

In addition, the OR monitors the total expense per case, which includes labor, supplies, and purchased services.

A major OR initiative is to analyze surgical supply utilization by surgeon when multiple surgeons are performing the same procedure.

“We are going service by service,” says Anton, focusing currently on general surgery and orthopedics. “We are looking at what each surgeon is using and whether
there is any difference in outcome from using less costly products. At the same time, we are trying to take waste out of our preference lists."

UW has begun using Surgical Compass, a new product from the Advisory Board, which can hone in on expense and profit margin by surgeon and procedure.

**Purchased services committee**

Purchased services is a big budget bucket that takes in most nonlabor expenses except supplies and salaries. Examples are consulting fees, shipping, and contracts for outside services, such as lab tests.

**Freight and handling fees**

The OR is turning a spotlight on freight and handling fees.

“You need to figure out exactly what you’re paying for and if you should be paying for it,” says Anton. “We are catching costs we don’t think we should be paying and negotiating with the companies.” His staff discovered one vendor was charging a $100 handling fee just for switching implants and instruments in orthopedic sets. He instructed the implant room to no longer pay those charges.

**Rental agreements**

One of the OR’s largest rental costs is for the accessory kits patients take home after implantation of a ventricular assist device (VAD). VADs, battery-operated devices that help one or both ventricles of the heart to pump blood, are used temporarily as a bridge to transplant or on a permanent basis.

After a cost-benefit analysis of purchase versus rental, UW elected to purchase some kits after determining they could be used for the next 2 to 3 years.

“In the next month, we will almost eliminate rental, which was running $80,000 to $90,000 a year,” says Anton. Savings are expected to be a minimum of about $55,000 in the first year.

**Patient safety committee**

The third arm of the cost management effort is to eliminate costs associated with patient complications and other hospital-acquired conditions. This is a national priority following Medicare’s announcement that as of Oct 1, 2008, it will no longer pay for certain hospital-acquired complications, such as catheter-associated infections, pressure ulcers, and certain injuries. States and private insurers are following suit.

UW’s targets this fiscal year are medication safety, infection control, and decreasing injuries, such as patient falls.

In the OR, the effort is part of an ongoing initiative to improve processes target-ed by the Surgical Care Improvement Project (SCIP) and other quality improvement programs. Examples are improving glucose control for surgical patients, on-time administration of antibiotics, and appropriate administration of beta blockers.

“You can say this isn’t about the money; it’s about quality and safety. That’s true, and we would not launch patient safety measures just to reduce cost. But I think if these measures were shored up, the cost savings would follow.”

**Practice lean thinking**

The director of UW’s lean thinking program sits on the supply chain committee as an advocate for eliminating waste. Lean thinking, pioneered by Toyota and described in the book *Lean Thinking* by James P. Womack and Daniel T. Jones (www.lean.org), advocates tightening processes and making small, sustained changes that result in significant improvements.

One lean project was to go through all patient units systematically, updating par levels and supply delivery dates.

“This not only reduces cost but is a nurse satisfier because the nurses have the supplies they need,” Anton points out. “It also eliminates hoarding because nurses know they will have supplies available.” (For more on lean thinking in the OR, see the March 2007 *OR Manager.*)

**Don’t neglect the fundamentals**

Being diligent about cost management means a continual focus on fundamentals.
“A lot of this is basic. You just have to have a program to address it and keep at it,” Anton says.

- **Contract review.** Systematic contract review can make a big difference in what your hospital is paying.
  
  “Go through all of your contracts by dollar amount and volume, making sure you are benchmarking pricing, getting the best pricing—and then locking in the price for as long as possible, at least 3 years.” Anton stresses.

- **Benchmark pricing data.** Anton says he’s “somewhat heartened” that Congress is considering a bill to require price transparency of implants. The bill (S 2221), introduced in October 2007 by Senators Charles Grassley and Arlen Specter, would require companies to submit to the government their prices for certain implantable devices. Prospects for passage are unknown, but it’s a sign lawmakers realize the impact of rising devices costs. In the meantime, benchmarking services are the only means hospitals have to find out if they are receiving the best pricing, Anton says.

- **Vendor access controls.** Like many organizations, UW is fine-tuning policies and procedures for sales representatives’ access to the surgical department.
  
  “We want to automate this more,” says Anton, referring to systems with scannable badges reps must use to enter the department. “We want them identified, and we want to know why and when they’re here.”

- **Business planning.** Faced with constant requests to add new products and services, like all ORs, Anton and his team are redoubling efforts to develop business plans and cost-benefit analysis before a new technology or procedure is introduced.
  
  “You need to find out specifically which devices, instruments, and equipment the surgeons will be using,” he says. Then work with the OR business manager or finance department to find out what reimbursement the hospital will receive and whether there will be a margin for the service.

  Recently, Anton worked with the orthopedic surgeons to perform an analysis for hip resurfacing. They determined the procedure would have a positive margin. They also learned it would help to capture patients who might need a total hip replacement if not eligible for resurfacing.

  With health care costs slated to rise to about 20% of the nation’s economy in the next 17 years, OR leaders will be challenged to keep up the relentless pressure on costs. ✦