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Standardizing to control costs of spinal implants

When Kimberley Murray, MS, RN, CNOR, administrator for the orthopedic and spine service line at St Joseph's Hospital (SJH) in Syracuse, New York, set up a successful system for negotiating with orthopedic vendors on total hip and knee replacement surgery, she knew that spine implants would be the next mountain she needed to climb.

But putting a similar system in place required more than simply transferring an existing process because spine implant options are, as Murray says, "much more complex" than those for joint implants. In addition, both neurosurgery and orthopedic surgeons perform spine surgery, so she knew strategies different from those used with joint implants would be needed.

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The goal was to control spine implant costs through standardization and managed vendor negotiations. Here is how Murray, working with physicians performing this specialty surgery, was able to meet that goal for SJH, where more than 1,500 spine procedures are performed annually. The initiative resulted in a cost reduction of more than $500,000.

A lucky break

Murray struggled initially to introduce the spine implant standardization program. The many spine implants available had created a wide range in surgeon preferences. As expected, each surgeon resisted change. Murray struggled to forge collaboration among surgeons who had strong loyalties to vendors.

Then she got lucky.

In 2011, New York State worker's compensation legislation expired, which meant hospitals no longer received additional payments for expensive implants used in spine fusion.

The expiration "dramatically changed the financial climate of our program," Murray says. SJH was forced to put a hold on implant surgery for worker's compensation patients to stop the loss of thousands of dollars from unreimbursed costs.

"That created a downstream effect for the surgeons," Murray says. They not only had dissatisfied patients waiting a long time for procedures, but the decrease in surgery also took a financial toll.

"It got them to the table and to agree that the only way to continue with a cost-effective program was to rebid implants," she says.

Preparing the RFP

Although a legislative change helped get the process started, Murray still had much work to do. The spine product standardization committee and the "burning platform" created by the legislative change helped ensure surgeon attendance at discussions. The committee consists of surgeons, the service line administrator, service line purchasing associate, spine OR coordinator, and data analyst, and had the final decision-making authority.

As with the hip and knee implant bidding process, the committee put together a request for proposal (RFP) template for vendors. The spine implant RFP was much

St Joseph's hip fracture fixation system bid					
Spinal implant system form					
Components	**Catalog number**	**Qty**	**Comparable catalog #**	**Proposed price (based on annual usage projections)**	**Extended**
COMPANY					
ONE LEVEL - LUMBAR					
SCREW, MULTI-AXIAL		4			
SCREW, SET		4			
ROD		2			
ONE LEVEL - LUMBAR W/GRAFT					
SCREW, MULTI-AXIAL		4			
SCREW, SET		4			
ROD		2			
IMPLANT, CAPSTONE		1			
TWO LEVEL - LUMBAR					
SCREW, MULTI-AXIAL		6			
SCREW, SET		6			
ROD		2			
TWO LEVEL - LUMBAR W/GRAFT					
SCREW, MULTI-AXIAL		6			
SCREW, SET		6			
ROD		2			
IMPLANT, CAPSTONE		2			
ONE LEVEL - CERVICAL					
PLATE		1			
SCREW		4			
ONE LEVEL - CERVICAL W/GRAFT					
PLATE		1			
SCREW		4			
CORTICAL CANCELLOUS RING		1			
TWO LEVEL - CERVICAL					
PLATE		1			
SCREW		6			
TWO LEVEL - CERVICAL W/GRAFT					
PLATE		1			
SCREW		6			
CORTICAL CANCELLOUS RING		2			

more complex than previous ones because each platform had to be defined. For instance, cervical 1 level with and without grafts, lumbar 1 level with and without grafts, and so on.

The RFP went to spinal implant vendors, who were required to provide price quotes only on what was in the RFP. No implant usage numbers were provided, so tiered pricing was not an option.

"We didn't want to muddy the waters," says Murray. "We wanted an apples-to-apples comparison." Rebates were also banned. Vendors "just got one shot" at pricing, she says.

Once bids were received, the spine committee reviewed the RFPs, examining such factors as quality, outcomes, cost, service/vendor support, company reputation, and market share. Costs were benchmarked against The Advisory Board's Surgery Compass program and information from ECRI Institute. The committee decided to invite 5 vendors to the next stage—a product fair.

Product fair and trial

All the invited vendors attended the fair, held once from 4 to 8 pm. Vendors could only bring products that were part of the RFP.

"We had 100% surgeon participation," Murray says. Attendees could eat a light dinner and then visit the vendor stations to examine the equipment. The hands-on opportunity was key, Murray notes, because "instrumentation for spine implants dramatically differs from system to system and is not as homogenous as joint implant instrumentation."

Attendees also confirmed if the company offered support through a local representative, a major consideration.

"It might have been a great product, but if it didn't have a local technical representative to support the surgical team, it wouldn't work for us," Murray says.

Product trials

After the fair, the spine committee decided that 3 vendors would participate in successive product trials. During each trial, surgeons had to commit to using the same product for the same period of time, unless a surgeon felt a patient's complexity required a different implant to avoid placing him or her at risk with an unfamiliar product. Each vendor provided staff and surgeon training before the trial. Murray says the trials took a few months because "we wanted to make sure every physician could use the product on cervical and lumbar cases" and other patients.

Final decision and follow up

After the trials, the spine committee decided on a primary and secondary vendor.

"We notified them, made appropriate arrangements for the transition, and picked a start date [summer 2011]," says Murray. The vendor commitment is for 2 years, and vendors have to agree to honor the same pricing in case of new platforms.

After the program starts, Murray says it's important to have flexibility. For example, a large group of spine surgeons moved to SJH and wanted to continue using the same vendor's products they had previously—not one of the 2 vendors chosen during the bidding process. Because the vendor was able to supply competitive pricing, it was added to the approved vendor list.

Later, the secondary vendor withdrew because the surgeons were not using the company's products consistently though it had a large investment of instrumentation tied up in SJH. Another vendor was added for a current total of 3.

Murray emphasizes that price can't be the only factor in selecting a vendor.

"You can't just say a vendor can meet the price and be an approved vendor," she says. Surgeons and staff must feel comfortable using the product, and the OR must have storage space for the implants and the instrumentation, which is impossible if there are too many systems.

Standing firm

"It's a cliché, but you really have to have the physicians on board to have a successful program," Murray says.

One challenge is vendor communication.

"There is even a closer relationship between surgeon and vendors for spine implants than there is for joint implants," she says.

Murray has asked physicians not to meet with vendors separately. Although not all adhere to this request, there are far fewer meetings before and after the "real meeting" than occurred before the request.

Murray adds that everyone at the hospital who talks with vendors has to stand firm. "You have to make them [vendors] believe you would switch." ❖

—Cynthia Saver, MS, RN

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Reference

Saver C. For implants, balancing choice and cost control. OR Manager. 2012;28(2):10-11,14.

Have a question on the OR revenue cycle?

Keith Siddel will respond to questions in the column. Send your questions to editor@ormanager.com

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