



2011 IMDA Annual Conference

Selling to IDNs...on their terms

Because no two IDNs are alike, it's up to the IMDA member to master the nuances of each one they approach. Here's how.

SAN ANTONIO, TEXAS--At one point during IMDA's recent Annual Conference, a member raised his hand and told the speaker – who was from a large Midwestern integrated delivery network – that he was taking all the fun out of selling. Then he paused and said that was OK; better to know the new rules of the game than to get blindsided somewhere down the line.

It's true that call points are more difficult to identify these days. In the past, specialty distributors called on clinicians, physicians or department heads. Today, that call point can include a materials executive, clinical executive, value analysis expert – or, more likely, some combination thereof. It depends on the IDN.

You've seen one IDN...

In fact, Rule No. 1 for IMDA members is that there are no rules. The expression, "If you've seen one IDN, you've seen one IDN," is true, said Dave Hesson, vice president, Aspen Health Care Metrics, a MedAssets company, and a former IDN executive.

Some IDNs are integrated in name only, he said. Often, the flagship hospital buys a neighboring facility or two, but uses them for referrals only. There is little attempt to integrate clinical or back office operations. This presents a challenge for specialty distributors and the IDN's materials executives as well, because if hospitals in the same IDN practice medicine differently, they will have different product and technology needs.

Other IDNs, on the other hand, are truly integrated, Hesson pointed out. Perhaps they have arrived at some agreed-upon patient care protocols. They might have integrated HR, finance, etc. Integrated IDNs tend to act as one from a purchasing perspective too, he said. They have one value analysis committee, and strive for IDN-wide standardization. Those that have been successful wield tremendous influence over vendors in their geography. "[They] can expect that type of pricing because [they] give you commitment," he said. Suppliers who bypass materials in such IDNs may be penalized.

What drives decisions?

IMDA members won't be surprised to learn that materials executives are focused on "pricing, pricing, pricing," said Hesson. "Every dollar we save goes directly to the bottom line, and administration understands that." Money saved on products and equipment is money that can be redirected to labor, utilities, capital assets, etc.

What's more, IMDA members should get to know a new player on the IDN decision-making team – the risk management executive, said Hesson. Providers are more concerned than ever about patient safety, fall prevention, wound prevention, hospital-acquired infections, etc. Not only are so-called "never events" bad for patient well-being (not to mention public relations), but the federal government is refusing to pay for them. "This changes your sales pitch," Hesson told IMDA members.

IMDA members will do themselves a favor by learning what they can about their customers, said Hesson. Find out what keeps materials executives up at night, he advised, and he offered two answers:

Customer satisfaction. The materials executive has customers of his or her own, namely, doctors, nurses, ancillary department heads, etc. They expect the products they need to be on hand when and where they need them. Distributors who help materials executives meet those expectations will find doors open more easily for them.

Limited resources. In most hospitals and IDNs, when budget cuts are called for, they most frequently occur in ancillary – not clinical -- areas. That includes materials management. Facing manpower cuts within their own departments, materials executives strive for efficiency. That might translate to longer-term contracts with suppliers, or a resistance to take on new products. “It’s a very difficult process to make product decisions in the IDN,” said Hesson. And because there are so many stakeholders, changing products can be a monumental task.

C-suite selling

Selling to the C suite is a good idea, but not always practical or even useful for specialty sales and marketing organizations, Hesson said. Supply chain issues are definitely on executives’ lists, but revenue and reimbursement are higher. What else are administrators thinking about?

- *Healthcare reform.* The 16 percent of the GDP that is currently spent on healthcare is not sustainable, said Hesson. “Something’s gotta give.”
- *Physician alignment.* No one knows how successful or widespread accountable care organizations will be, but the concept of aligning physicians and hospitals to coordinate patient care is a lasting one, said Hesson. And that’s good news for providers. “Ten years ago, doctors had all the power, because they were the admitting agents,” he said. Doctors could choose the products they used on their patients, even if – as in the case of some implantables – the cost of those products actually caused the hospital to lose money on a case. Today, hospitals can ill afford such losses, and administrators are talking to their doctors about it. What’s more, as hospitals and physicians align more closely, then the latter will become more involved in product decisions. “That’s good news for me,” said Hesson. “I’d rather have *them* screen [vendors] than me.”
- *Competition.* Hospitals and IDNs continue to seek other providers with whom they can align and increase their market presence – while steering clear of antitrust laws.
- *The cost of technology.* IDNs use medical technology to enhance their reputation, improve care and increase market share, said Hesson. But it’s expensive. So for administrators, it’s a balancing act.
- *Bond ratings.* Dropping from a double-A to a single-A rating can affect an IDN’s ability to access capital, so administrators watch their ratings carefully.
- *Bottom line, bottom line, bottom line.* Every day, administrators face a simple question: Are we staying afloat?

One IDN’s approach to value analysis

Traditionally, hospital and IDN supply chain teams have focused on procuring items, adding them to the item master, paying for them, etc. The emphasis was on how the supply chain would interact with the product. But that’s changing, as BJC HealthCare in St. Louis is demonstrating. And suppliers need to take note.

BJC comprises 13 hospitals, more than 4,000 physicians, and an annual supply budget of \$828 million.

Much of the transformation surrounding BJC's supply chain is centered on the IDN's value analysis efforts. "Value analysis isn't new," said Garrett Jackson, JD, MHA, BJC HealthCare's value analysis manager. "People have been making judgments on the cost-effectiveness of capital and supplies for years. Now, we're working on centralizing that role."

Providers have little choice but to make such changes, he said. For years, providers have used payments from private insurers to offset shortfalls from Medicare and Medicaid patients. "But that isn't going to continue," said Jackson. "Everything we're doing is with the expectation that if we're not breaking even with Medicare and Medicaid, we're not going to be successful."

Third-party payers

Traditionally, IDNs have acted like third-party payers when it comes to procuring medical devices, equipment and supplies, said Jackson. Clinicians have enjoyed a closer relationship with vendor sales reps – particularly vendors representing clinician-preference products -- than they have with their facilities' supply chain team. "Many times, the first time the purchasing department is aware that a new item has come in is when the bill is submitted," he said.

Vendors of physician-preference items know that if they can get a product through the door of one facility in an IDN, they can count on that item being added to the master list, and they can then bring it into any of the IDN's facilities, said Jackson. He calls it the "fragment and conquer" approach to sales.

The problem is, this approach doesn't serve the IDN's interest, said Jackson. "We lose the ability to track how an item is being utilized or what kind of patient it's being used on." The same is true for free products. "Nurses in the OR might not chart how the [free] product is being used. That's a big problem for utilization management."

The goal: More conscious decisions

"Any time we get introduced to a new product, we want to take a full look at the book of business that the product will compete with, and what it will work in conjunction with," said Jackson. "We want to know, 'How did our physicians work with the old product [that is being replaced]?' With this information, BJC hopes to make "conscious decisions about how we want to move forward."

To facilitate that goal, BJC has centralized much of its value analysis and product-decision-making. "Having centralized resources is a huge change from the past," Jackson said. "If you [that is, a vendor] wanted to sell to the OR in one of our facilities, you just went to that OR; now we're asking you come to the value analysis group first and allow us to facilitate that discussion. We know who needs to know about your product. We want to facilitate [the introduction of] products that we believe we have value."

"Best practice exchange teams" include clinical experts who can evaluate how a new product or technology would be used in the IDN. "We treat every new product introduction as a project," said Jackson.

Adopting this approach has called for a culture change within BJC, he said. "There's a hero mentality in healthcare," in that nurses and other staff members compete to be the first ones to introduce physicians to the latest and greatest technologies. "It's huge to ask them to step back and give us the necessary time to do the due diligence."

IDNs face a myriad of other challenges as they try to systemize product introductions, continued Jackson. Physicians in community facilities, for example, respond to different incentives than those affiliated with academic institutions.

To make it all work, BJC's supply chain team has improved communications with its internal staff as well as those outside supply chain, said Jackson. "It was important for us to get the word out [in BJC] that all this was going on," he said. "There had been very little interaction between supply chain and the functional areas. It was a big change for us -- to be more open and transparent with our processes."

One tool that BJC has used to improve communications is an automated system from a company called MedApproved. It's a web-based service that helps connect all the IDN's stakeholders who are involved in a product evaluation project. Vendors – who pay a small fee to MedApproved – can submit their documentation to MedApproved, and can track online at what stage the product evaluation is.

Advice for vendors

For all this to work, vendors and providers have to strike up a new, more cooperative relationship, said Jackson. But can that happen? Jackson believes it can – and must.

"We want to have much more of a cooperative relationship with vendors," he said. BJC has developed a sophisticated value analysis committee system, "but we haven't taken vendor reps out of the diagram," he said.

Providers rely on vendor reps for product information, inservicing, and guidance on how a new product fits in with the IDN's business and clinical needs, Jackson said. "I tell reps, 'Treat me like you treat the physician.' I want to know everything about the product, so we can be the ones responsible for providing that summary to whoever needs it."

Suppliers should have a clinical sponsor for every product they would like to introduce to BJC, he said. "We give our clinicians as many opportunities as we can to determine what's best for their patients."

Vendors should come to BJC prepared to address the following points about the technologies they want to introduce:

- *Patient safety.* "Any product that affects patient safety will immediately get through the initial step," said Jackson.
- *Clinical efficacy.* "We want to know not only is it effective in terms of outcomes, but how it compares to your competitors' product."
- *Uniqueness.* "Does the product do something that no other product does?" If so, BJC will probably consider it.
- *Cost.* "A hugely variable idea," cost encompasses far more than price, said Jackson. How does the point-of-use cost of the new product compare with that of the incumbent? How many of the new products will the IDN use? If the IDN were to bring in the new product, would usage climb, thus erasing any per-unit price savings? How would implementing the new product affect rebates the IDN may currently be collecting? And even though hospitals aren't reimbursed specifically for the products they use, reimbursement still plays a role in product selection.

Vendors need to be aware that IDNs such as BJC are taking a closer look at the value and rationale for bringing in new products, in an effort to keep costs down while maintaining or improving patient care, said Jackson. “Too often, new products are introduced or adopted to address something that would have been better addressed by process changes or standardization,” he said.

BJC is embracing the Obama administration’s emphasis on comparative effectiveness studies, which are designed to compare the effectiveness of various technologies and procedures. “FDA approvals have emphasized safety, and that has put us in a huge bind in terms of being able to determine whether Product A works better or worse than Product B,” said Jackson. “Very limited studies are available, and if anything is available, it has been funded by the manufacturer.” That fact immediately lowers the study’s credibility, at least in the eyes of the IDN.

What’s more, IDNs are striving to make judgments about new technologies on the basis of more than price. Yes, IDNs must figure out if it makes financial sense to bring in a new product. “We haven’t concentrated on, ‘Does it do [a procedure] as well as what we’re currently doing?’ We want that question answered at the beginning.” And vendors should be prepared.