Beyond price: Hospitals need to revamp their approach to value analysis, and IMDA members can help

Materials managers need to expand their focus beyond price, GPO contracts and product standardization in order to achieve big savings in their hospitals or IDNs. But it requires a new way of looking at costs. And suppliers, including IMDA members, need to help out. That’s the opinion of Robert Yokl, chief value strategist for Strategic Value Analysis In Healthcare®, Skippack, Pa. (www.strategicva.com).

“Taking the time, effort and expense to prove your value to your customers is what being a value analysis advisor is all about,” says Yokl, who spoke about the topic recently with IMDA Update. True, not all materials managers or suppliers want to devote the time to do that. But in today’s environment, it’s simply something that must be done, particularly as more materials managers adopt a broader, more sophisticated view toward cost.

Prior to founding his company in 1987, Yokl spent many years in materials himself, first in a number of stand-alone facilities, then in a 926-bed multihospital system. He also served as vice president of support services for a nursing home chain and vice president of operations for a small med/surg distributor.

He created Strategic Value Analysis in Healthcare® to provide healthcare organizations with software, training and consulting services to give them better information and better focus, so they could make better decisions and exert more control over their supply chains.

For some time, hospitals and IDNs have used so-called “value analysis teams” to help them decide whether to bring in new products and equipment. But those teams have lost much of their power, says Yokl. “They’re focused solely on price, GPO contracts and standardization,” or what Yokl calls “traditional value analysis.” What’s more, committee members too often are selected on the basis of their titles – e.g., director of nursing, infection control practitioner, etc. – rather than on the basis of their abilities or enthusiasm for the process. Consequently, hospitals are missing the boat on somewhere between 7 percent to 15 percent of new savings opportunities.
Perhaps the biggest missed opportunity – and the one that IMDA members must help providers address – is what Yokl refers to “utilization misalignment,” which he defines as “wasteful, inefficient consumption, misuse, misapplication and value mismatches in products, services and technologies.” Example: Prior to a surgical procedure, the surgeon routinely orders three cartridges of staples, and ends up using one and throwing out the other two. Or the surgeon routinely orders a specialized electromechanical in his or her custom pack, but uses it only in only a fraction of the cases.

Rather than sit around a table over coffee and discuss how much an item costs, then, the hospital’s value analysis members need to venture out into treatment areas and see firsthand how – and in some cases, whether – devices are being used appropriately. Just as important, the team members need to measure how the hospital’s or IDN’s usage compares with others of similar size, demographics, etc. Are the surgeons using more devices than others? Are their total costs per procedure higher? Although data like this provides important clues for value analysis team members, it is almost impossible to collect manually, that is, without the help of automated systems and a database that spans several hundred hospitals, says Yokl.

In one case, using his company’s automated information system and database, Yokl’s team found that a hospital client was using many more point-of-service diabetes tests than others. Upon investigation, they found that the test itself was defective, necessitating the use of multiple strips for each test. They also found that the nurses, out of generosity and goodwill, were giving their diabetic patients some tests to take home upon discharge.

What IMDA members can do

The question for IMDA members is, “What does this have to do with me?” Plenty, says Yokl. More and more materials executives and clinicians are recognizing that the potential savings through correction of “utilization misalignment” is greater than that through price-shopping. That means they are going to be more demanding of their suppliers to prove not only the clinical efficacy of their products, but their cost-effectiveness as well. “You have to validate your claims,” he says.

“I get calls several times a month from manufacturers who are scrambling for ideas” on how to sell their products, he says. “I tell them, ‘You can’t use studies you’ve done somewhere else,’ though that’s a nice place to start a
conversation. “You have to do a study at the hospital.”” The goal is to demonstrate in the hospital that the total cost (not the purchase price) of your device is lower than that of your competitors or of existing technologies, he says.

The supplier must first develop the metrics, or “measuring sticks,” which it will use to prove its case; then observe the new device in use; then compare the cost of the new device or procedure with that of the customer’s existing technology or procedure. “It has to be with data in order to be credible,” he says. And it has to be quantifiable. In other words, the supplier must assign a dollar amount to every benefit – even the soft ones – which its device brings the hospital or IDN.

“This isn’t theory,” says Yokl. “We do it.” And so must suppliers, including IMDA members.

“Cost management is everybody’s business,” he says. “It’s something that has to be done, like putting gas in your car or brushing your teeth in the morning.” That’s true for both the customer and the supplier. “The alternative is that millions of dollars are left on the table.”

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