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Orthopedics This Week

"Value" Will Change Everything You Are Doing

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Michael Leavitt (former HHS [Health and Human Services] Secretary under George W. Bush, and former governor of Utah) said at a recent conference "Value based purchasing is the most important thing happening in healthcare today. It will change everything you (in the medical device business) are doing" and that we are going to be in this turbulent new value environment for the foreseeable future.[i]

"Value based purchasing is the most important thing happening in healthcare today. It will change everything you (in the medical device business) are doing."

Source: Wikimedia Commons and U.S. Navy

This transition from "volume to value" is also keeping the hospital CEOs awake at night. A recent survey said this is the top concern of 64% of all hospital administrators, above even employee retention and regulatory compliance. The Federal Government is weighting 40% of Medicare reimbursement on efficiency and complication avoidance by 2020, just four years from now, that rises to 60%.

At a recent hospital CEO meeting[ii] there was a presentation by Cleveland Clinic on how the CEO realized that they would have to make their operation run on Medicare/Medicaid reimbursement margins. This meant chopping out $550 million in expenses out of the CCF [Cleveland Clinic Foundation] system. They looked at everything including shedding vendors and turning the escalators off at night. Making a healthcare system work on Medicare and Medicaid margins is now considered the "new normal." On top of this they have to prove value in the new Medicare calculations.

There is also a massive consolidation trend in hospital systems right now. The old critical mass revenue number for a hospital chain used to be $1 billion. That went to $2 billion and now its $4 billion. Not only are hospitals consolidating, they are vertically integrating with their own narrow-network insurance products where there is outcomes and complications data sharing between the insurance plan and the hospital. If a hospital is not #1, 2 or 3 in their market they will get sold, or they will go out of business. Many rural systems and community hospitals may not be able to survive. We are in the middle of a compression from 5000 hospitals to 500 health systems or fewer. These large systems are federating with other large systems. Data that used to be scattered across independent hospital systems and kept secret by insurance companies is being aggregated, data-mined, and shared. Complications now have nowhere to hide.

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Surgeons, even the high volume ones that used to be able to get their preferences because they contributed a meaningful percentage of revenue to an individual hospital now don't have the same influence on buying decisions in these bigger systems. The priorities of the administrators on the "carpeted areas" are driving purchasing, and they are using this newly aggregated data to make decisions.

Value is outcomes over costs. Some hospitals are still trying to attack the cost denominator to the value equation with things like BroadJump price shopping. However cost cutting does not really drive the value they need to see,

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and they know it. The hospitals know that the low hanging fruit of easy cost cutting wins are gone. Trying to attack the cost side of the equation alone has hard limits. Vendors know that with this cost cutting approach hospitals customers will just keep demanding bigger discounts and forcing more margin erosion. The financial investors in the publicly traded vendor companies will still demand their operating margins. One way forward under the cost cutting alone scenario seems to be approaches like S&N [Smith & Nephew] Syncera that offers "tried and true" implants with automated self-service that cuts out the sales rep support cost.

The other way forward is to attack the outcomes numerator with efficiency, waste prevention, and complications avoidance. This has 10X the impact of cost cutting with discounts alone. However it takes investing in innovation, and designing it into the device from the beginning, and also paying attention to the lower cost devices that can add cost 5 to 10 times their price in avoidable complications.

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Did you ever stop to think about how limited cost-cutting and discounting really are in driving value? If value is outcomes over cost (V=O/C) as Michael Porter, Ph.D. (the Harvard "Five Forces" fellow[iii]) says, then look what happens to value when you discount. Take a $1 product. Give it a 50% discount. Score the value. (1/.5=2). It's 2. Can you give out a 50% discount and make money? I didn't think so. Now, look at another scenario. Take a $1 product and save $1 in avoidable complications. (1+1/2=2) What's the value score on that? That's a 2 also, with no discounting. What about getting to a value score of 3? That would take a 75% discount, or you could figure out how to save the customer $3. Saving $3 with better outcomes is much more feasible than a 75% discount, unless there are inflated retail prices. Discounting hits a brick wall very quickly. Outcomes are nearly unlimited. In fact outcomes are 10X more powerful in driving value scores according to the V=O/C formula than discounting alone.

If outcomes are so powerful then why have they gotten so little attention? Who will be interested in a value product that cuts an infrequent complication but adds per-procedure cost? One reason is the traditional sales model in orthopedics that sells to the surgeon in the "tiled area" of the hospital not the administrator in the "carpeted area." The other is this value must be designed in from the beginning, and can't be pasted on later to a conventional product.

What if you have a complications-solving solution that adds $20 to a case but solves a 1/5000 problem that costs $75,000 to fix? It has no therapeutic or diagnostic function at all. What if a surgeon does five cases a week? Now you want to sell that to the surgeon. You know what the response will be: "You have a great solution to a problem I don't have. I won't see that problem in 20 years, and if it happens I don't have to pay for it, and I can't add $20 to the case." Now, take that very same item to the administrator at a chain of hospitals. They will say: "We do at least 5000 cases every year in our system, and we see this problem once a year, and its costs our system over $75,000 plus Medicare penalties, plus the malpractice hit, and $750,000 over 10 years. We are very interested." Does this scenario sound farfetched? It's not. This is the story of Patient Safety Solutions,

a startup that made an automated surgical sponge counter that Stryker paid $120 million to acquire.

A recent *OTW* article talked about the "Simple Suture Passer" that is suddenly attracting scrutiny because it has been identified a vector for cost and complications. What is even seemingly simpler that the "lowly suture passer?" The arthroscopic portal cannula.

However, what if a simple cannula can add significant value by preventing a hazardous (and expensive) complication that interferes with every shoulder surgery and can put a patient in a hospital overnight (occasionally in the ICU) for an unreimbursed overnight stay, and is implicated in slower healing and more post-operative pain?[iv] What if that complication can add up to $225 to every shoulder arthroscopy when amortized over all cases? That problem is fluid extravasation, which is implicated in FDA MAUDE [Manufacturer and User Facility Device Experience] reports in numerous patient injuries. The Cannuflow EntreVu® cannula, cuts extravasation by up to 70%.[v] It costs no more than a conventional quality cannula, and saves the hospital system 5X its cost in avoided complications, patient risk and needless post-op pain. This is real value. It's better than getting cannulas for free! The "carpeted areas" of the hospital are taking notice.

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Value purchasing is here to stay. According to a recent video by Dr. Michael Porter, this concept is taking hold around the world, not just the United States. Value is much more that just chopping costs, discounting, or making an existing product cheaper by "value engineering." Value can't be pasted in later, it must be designed in from the beginning, with new, innovative thinking that takes on previously ignored complications and improves outcomes.

Cost can help value but outcomes, as defined by greater efficiency, avoided waste, elimination of needless workarounds, and avoiding complications are 10X more powerful than cost cutting alone to drive actual value. The numbers prove it. The "carpeted areas" of the hospital are demanding it. ♦

[i] *"Don't Fight the Shift to Value-based Payments, Leavitt Warns" AAPC Newsletter April 2016*

[ii] *Becker's HR CEO Summit 2016*

[iii] *"The Strategy That Will Fix Health Care" Michael E. Porter, Thomas H. Lee, MD Harvard Business Review October 2013*

[iv] *"Tracheal compression during shoulder arthroscopy in the beach-chair position" Current Therapeutic Research December 2010*

[v] *"Fenestrated Cannulae with Outflow Reduces Fluid Gain in Shoulder Arthroscopy" CORR January 2010*

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