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Surgeons and the Value Analysis Committee: Agents of Change

VAC Dynamics Through the Eyes of the Surgeon

I. INTRODUCTION

The surgeon has long been the key driver and decision maker concerning what new surgical products will be adopted for use in the operating room. Often considered a barrier to achieving cost efficiencies, surgeons now find themselves at a crossroad of innovation and fiscal responsibility.

This whitepaper publication resulted from interviews conducted by Blueprint, a healthcare research and practice solutions organization, and provides insight into the dynamics of the surgeon's influence and expanding role as a champion of patient care and VAC relations. In this whitepaper, the term VAC will be used to represent Value Analysis Committee and Value Analysis Team, as both are accepted references to the hospital group charged with making new product adoption decisions and reducing inventory costs for surgical products.

You may recall reading the whitepaper "Is Your Value Analysis Committee a Leader in Change" (published early 2010 by Blueprint). In that document, Blueprint focused on some of the best VAC practices being adopted in the healthcare community today. While conducting research among 50 surgeons, a recurring topic was discussed during the interviews with supply chain management; the surgeon can be the "make-or-break" factor in achieving VAC success.

This document will focus on the surgeon and how they view and interact with their respective VAC. If you are struggling with your VAC success or interested in learning how other Value Analysis Committees interact and collaborate with surgeons, then you should find this whitepaper helpful. The goal of this document is to help identify the surgeon perceptions and experiences that help influence the success or failure of a hospital VAC.

All quotations cited in this report resulted from Blueprint interviews with surgeons and VAC members.

Improved Outcomes without the Cost

Cost management is paramount to hospitals today. The current economic pressures have brought some surgeons and material managers together with a common goal to improve patient outcomes without increasing costs. In an environment where the economic viability of a hospital is now at stake, surgeons are becoming more aware of the implications of ignoring cost pressures and the need for their hospitals to meet financial performance goals.

Having more surgeons guarantees a steady stream of patient referrals, and bolsters care through better coordination in services, according to hospital executives. It also emphasizes the impact of the new healthcare overhaul, which rewards creation of more efficient, integrated models of care.

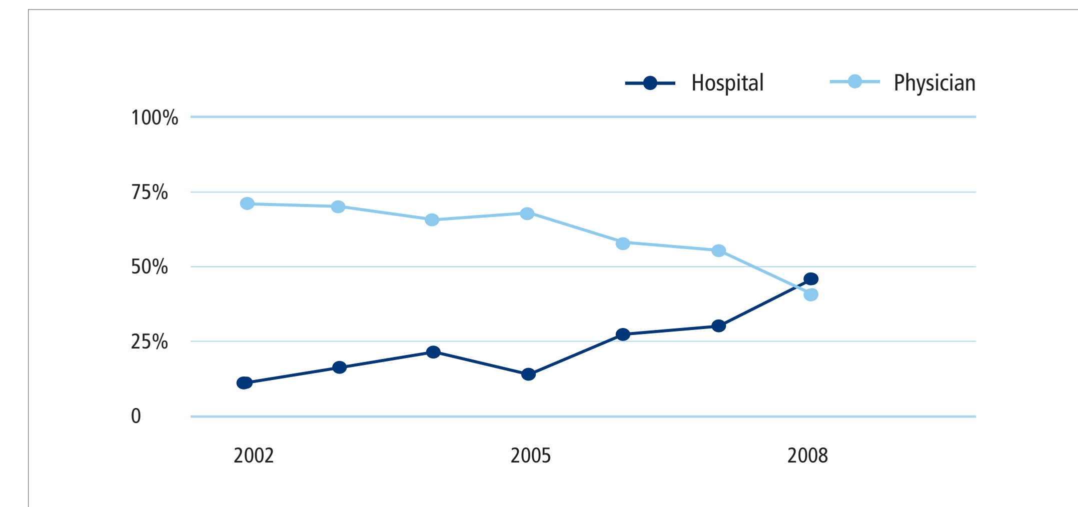
Surgeons have been affected by the economy and rising healthcare costs. They are now making hard decisions concerning the economic realties of remaining independent or seeking salary security with hospital employment. Rising financial pressure of running a private practice and the depleting economic payoff have forced surgeons to rethink how to best serve patients while achieving professional success.

49%	Physicians hired out of residency or fellowship placed in hospital-owned practices
(2%)	Annual decline, over past 25 years, of number of physicians who own at least part of a practice

The Health Care Advisory Board, "The Accountable Physician Enterprise; Partnering with Physicians to Transform Care Delivery." (2010, slide 14) Source: HSC Community Tracking Study Physician Survey, 2007, Center for Studying Health System Change; Health Care Advisory Board 2008 Survey on Physician Employment.

Greater transparency in surgical procedures, zero tolerance for surgical errors, malpractice fears and the continuous reduction of reimbursement payment seem to have accelerated a trend in surgeon employment. In 2010 half of all new doctors were hired by hospitals, according to the Medical Group Management Association, a professional organization for physician practices. Doctor Steven Schwaitzberg, a surgeon with the Cambridge Health Alliance and president elect of The Society of American Gastrointestinal and Endoscopic Surgeons, recently surveyed his peers in the state of Massachusetts concerning private practice viability. According to Doctor Schwaitzberg, 62% of surgeon respondents stated they could not generate enough revenue to sustain a private practice.

Physician Practice Ownership



2010-2011 Health Care Advisory Board National Meeting Series, "Playbook for Accountable Care." (2010, slide 15) Source: Harris G, "More Doctors Giving Up Private Practice," The New York Times, 25 March, 2010, available at http://www.nytimes.com/2010/03/26/health/policy/26docs.html; Health Care Advisory Board interviews and analysis; SOUTHWIND.

As more hospitals move toward a staffed-physician model, hospitals will continue to find it easier to get doctors involved in value analysis and cost-reduction efforts. Surgeons are staff members at nearly 50 percent of hospitals involved in the HSC Community Tracking Study Physician Survey, compared with 30 percent whose physicians are independent practitioners; many respondents noted that their facilities have mixed models for physician relationships.

Changing a Mindset

In the past, surgeons were in a better position to demand their preferred surgical products without much consideration for price or other key purchase justifications. The surgeon represented an elite, limited resource that provided big revenue dollars for any hospital fortunate enough to gain the surgeon's affiliation. The hospital, motivated to acquire the case load of the surgeon and all the revenue that came with it, would attract surgeons with the promise of flexibility in operating room time and the desire to meet their every surgical need.

A large number of surgeons had their own practice or belonged to a surgical group. They became hospital affiliates, many times with more than one hospital, to further improve their income and serve more patients. With a limited or non-existent stake in the success of the hospital, surgeons rarely responded to the hospitals persistent call for controlling costs in material acquisition and inventory management.

The lack of a formalized approach to supply chain management and the limited influence of the newly formed VAC allowed many surgeons to ignore the hospital's efforts to gain their cooperation. In many cases, surgeons that were affiliated with a hospital, but not employed, would often undermine the cost management effort with demands for products that really could not be justified. Blueprint interviewed a surgeon who reported one incident where a non-employed surgeon demanded a preferred surgical product. The surgeon interviewed stated that his peer demanded the hospital to purchase a surgical instrument that was $400 more expensive than an equal product. But when questioned about the usage of that product in his surgical center, he simply said, "No, we don't have the case margins to afford it".

"There are many surgeons unaware of the cost implications within the hospital, but know to protect their bottom line in their own private practice."

According to the surgeons Blueprint interviewed, hospital Value Analysis Committees often undermine their own authority. Earlier this decade, when VACs started becoming more prominent in the healthcare community, they were predominantly run by supply chain managers who had little time or understanding to consider such variables as patient outcomes, healthcare economics and procedural innovation. The supply chain manager viewed the surgeon as disinterested in the bottom line and as a major contributor to inventory waste. This perception negatively influenced the trust in the surgeon. On the other hand, surgeons often looked at the supply chain manager as myopic and one-dimensional when it came to making important product acquisition decisions.

II. TRUST CAPITAL

The surgeon remains a critical audience to the VAC and many continue to have varied opinions of their VAC, including the committees' motivations and effectiveness. The surgeons interviewed by Blueprint were asked some critical questions concerning their opinions on VACs and their interaction and active roles. The results, albeit far from providing any statistically relevant data, provided key insights into the mindset of the surgeon and their perspective on a host of topics important to any VAC member.

The surgeon's role and interaction with the VAC has evolved significantly over a short period of time. Historically, the surgeon was someone who initiated many of the VAC evaluation efforts. The surgeon simply asked the committee to consider a new surgical instrument for which they had a strong preference. These informal requests for Physician Preferred Instruments (PPI) required little cost justification on the part of the surgeon and were often approved because of the status of the surgeon within the hospital.

Eight to ten years ago, it was unusual for a PPI adoption request to be denied because many hospital administrators considered it to be a surgeon entitlement and were reluctant to ruffle feathers. The long lasting recession and the mandate from the C-suite to look under every rock to cut more costs have forced surgeons to make hard decisions.

"The recession has ushered in a golden age for the supply chain manager. There are no more sacred cows in the procurement process."

Hence, over time the surgeon role with the VAC became one of product champion. Materials Managers began putting mandatory surgeon justification tasks behind most surgeon requests. Almost all surgeons interviewed said they are required to present the potential clinical benefits and justify the associated increase in costs. However, surgeons who are ill-equipped or unwilling to spend the extra time justifying the clinical and business rationale, often simply ignore the request to represent or defend the product merits.

Formalization of surgeons' roles and responsibilities related to VAC interaction has helped improve active surgeon participation. Close to half of those surveyed said involvement in their VAC is part of their job description. This number is expected to rise as surgeon hospital employment provides the opportunity to integrate the surgeon VAC activity into their overall employment duties.

Several surgeons stated that when they first become employees, they were given the added benefit to have their product adoption requests "fast tracked". Providing an accelerated decision making bonus allowed surgeons to keep their preferred instruments without proper clinical and financial benefit analysis. Other surgeons commented there were added financial bonuses if an overall cost reduction objective was met at the end of each year.

The introduction of new accountability payment models—which shift financial risk for cost and quality to providers—places a premium on physician alignment as a means to achieve more efficient, coordinated and consistent care. To survive in this emerging environment, hospitals and physicians will need to assume a level of functional integration far deeper and broader than most have in place today. While always a key issue for hospital executives, physician alignment is now taking on an even greater sense of urgency in today's market.

Hospitals and health systems must make critical decisions regarding relationships with all affiliated physicians moving forward. Assembling an accountable physician enterprise capable of partnering with the hospital on key cost and quality initiatives will be essential for success in new payment paradigms, especially Accountable Care Organizations (ACOs), where providers will jointly take risk for the total cost of care for a patient population. Similar to an ACO, the affiliate surgeon relationship with the hospital VAC must progress into a mutually respected partnership with equal value for success. How to effectively motivate the affiliate surgeon continues to challenge many hospitals.

Health Care Advisory Board, "The Accountable Physician Enterprise; Partnering with Physicians to Transform Care Delivery." (2010, slide 36) Source: Lee T and Mongan J. Chaos and Organization in Health Care. Cambridge: The MIT Press, 2009; Health Care Advisory Board interviews and analysis.

The increase in surgeon employment in hospitals has also placed surgeons in a much larger role in the VAC formation and on going oversight. Some surgeons take on direct control and often are the lead in forming and driving cost and innovation optimization.

Cooperative participation between surgeons and materials managers has built trust and mutual respect between the clinical and business side of the hospital. The Trust Capital that is formed is an essential ingredient in the success of any VAC, particularly when the materials manager trusts that surgeons have true interests at heart for both the hospital and patient, and the surgeon accepts the realities that cost control is in everyone's best interest.

Fifteen Lessons for Partnering with Physicians to Transform Care Delivery

I. Creating a Culture of Value-based Physician Partnership

Selecting Premium Physician Partners

1. Identify physicians with shared strategic vision
2. Ensure cultural compatibility in all partnership decisions

Engaging Physicians in Governance and Leadership

3. Empower dynamic physician leaders with tools to succeed
4. Enfranchise frontline physicians in leadership and governance
5. Unite with physicians around shared culture and responsibilities
6. Formalize shared control in governance and management

II. Ushering Physicians into the Performance-Based Market

Extending Resources for High Performance

7. Support PCP transition to team-based care
8. Lay the groundwork for data exchange

Crafting Strategy-Aligned Physician Incentives

9. Introduce independent physicians to performance-based incentives
10. Revamp conversation to target accountable care objectives

Investing in Performance Management

11. Deploy principled referral management infrastructure
12. Invest in robust performance management systems

III. Organizing for Shared Accountability

Building Next-Generation Physician Relationship Platforms

13. Develop strategy-aligned contracts with "ACO Partners"
14. Design joint contracting-capable model with "ACO Principals"
15. Deploy common performance-focused infrastructure across alignment platforms

Health Care Advisory Board, "The Accountable Physician Enterprise; Partnering with Physicians to Transform Care Delivery." (2010, slide 20) Source: Health Care Advisory Board interviews and analysis.

Continuous Improvement

Despite the improving environment for collaboration among surgeons and non-clinical members of VAC, there still remain significant barriers to overcome. Three topics seem to draw the most passionate responses by surgeons:

1. Managing expectations and recognizing surgeon contributions
2. Perceived VAC inefficiencies and conflicting policies
3. Misalignment on philosophies and priorities

1. Managing expectations and recognizing surgeon contributions:

It is no surprise that most surgeons surveyed strongly believe that they should be compensated in some fashion for the time they take to fulfill the sometimes laborious task of requesting and representing new surgical products. Most surgeons surveyed said that it is a time-consuming and a convoluted process. Because of this, more than half of the surgeons surveyed believe some form of compensation is necessary.

Some hospitals have embraced several innovative methods to maximize surgeon participation via incentives. Blueprint identified several hospitals that offer cost reduction incentive bonuses to surgeons who participate and support cost management efforts by the VAC. Another group of hospitals simply require surgeons to participate in one or two committees outside the operating room. It does not necessarily require participation in a VAC, but the VAC is one committee from a list of many from which they can select. Failure to meet the basic participation requirements results in as much as 25% reduction in the surgeon's bonus compensation.

However, these incentives are an exception, as many hospitals use product exclusion to motivate participation. Common practice in most hospitals is to require surgeons to act as product champions. During the review process, each product must be properly represented by a surgeon. If the surgeon fails to meet those requirements or does not show up at the evaluation meeting, the product falls off the VAC product review list or is postponed indefinitely.

Many surgeons view this policy and others as VAC strategies to reduce the number of product evaluation requests going to the VAC. They even mention the fact that these meetings are often scheduled very early in the morning to further demotivate surgeon participation or conflict with scheduled surgeries. Research confirmed that this perception is fairly common and many surgeons are responding exactly as predicted — poor surgeon participation.

In addition, the failure to manage expectations with newly engaged surgeons contributes to further disenfranchising the surgeon. Many of the surgeons interviewed stated they were never made aware of their expected VAC contributions. Furthermore, the responsibilities and duration of the surgeon's active participation continues to grow over time.

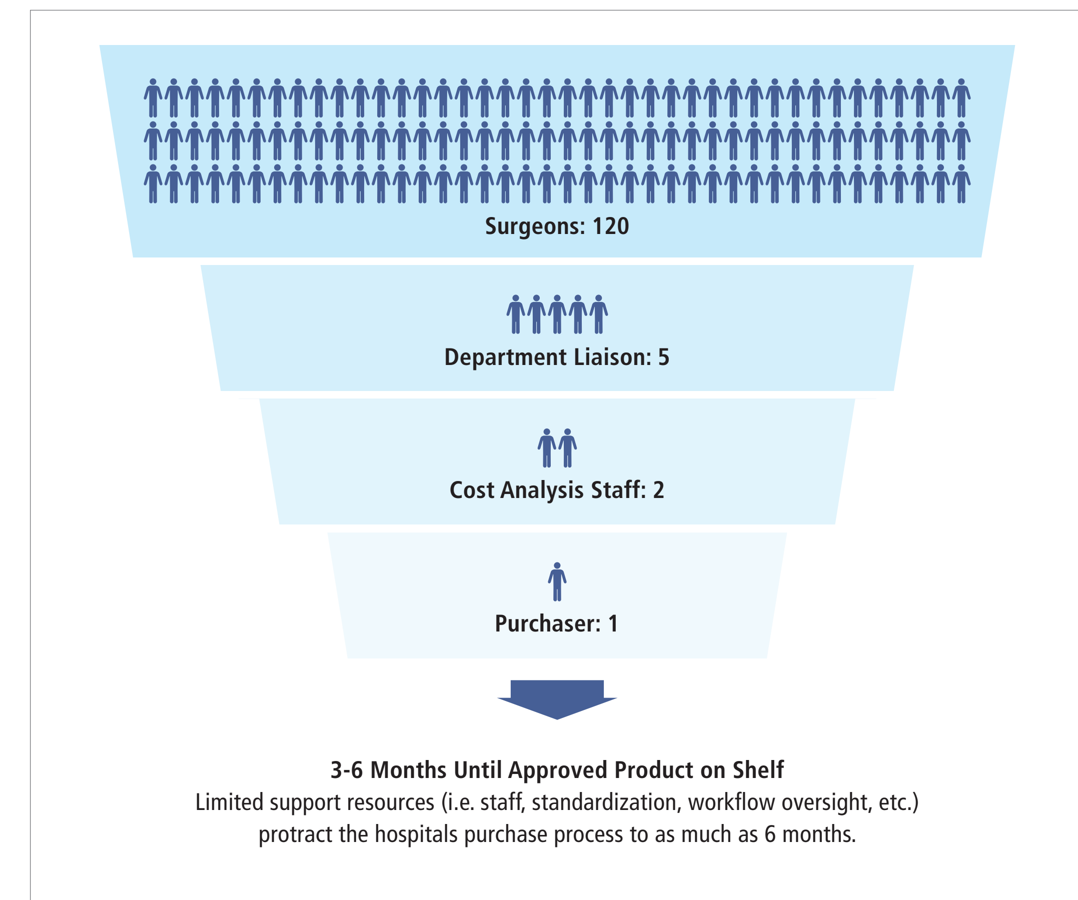
"On some occasions, I have received new surgical products that were superior to others, but chose not to approach the VAC for review."

2. Perceived VAC inefficiencies and conflicting policies

A common perception among surgeons is that the core role of a non-clinical VAC member is to provide financial analysis and product price comparisons. Almost universally, the surgeons Blueprint spoke to agree that the process takes far too long and many think VACs are ill-equipped to manage that very important task.

Surgeons stated that they have collaborated with other surgeons, agreed to trial a new product, conducted extensive product evaluations and have written outcome papers to justify the products; yet, the final cost analysis process can take six to nine months to complete. Keeping in mind that the cost analysis process is often conducted by one administrative person, the delay is unacceptable according to the surgeons interviewed.

Request-to-Shelf Delays

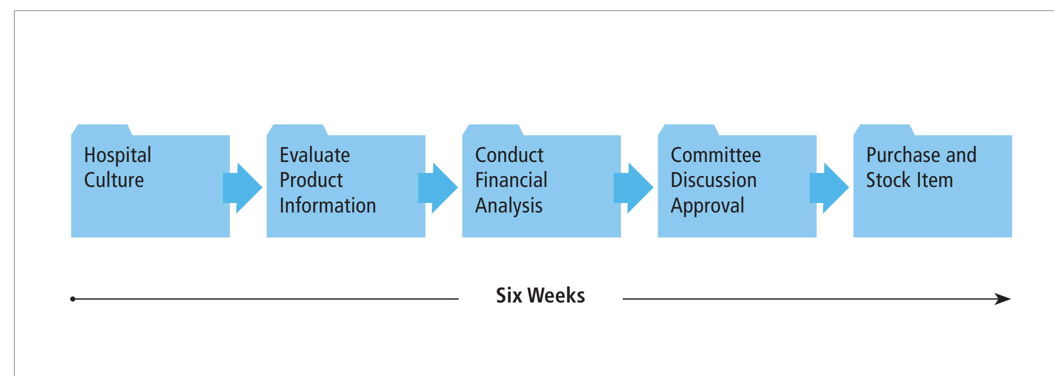


"A VAC needs to have a lot of layers of sophistication to be effective. If they do not enjoy the buy-in from the surgeon and the administration, they will not be successful."

Surgeons surveyed believe their VAC can improve in many ways. Gaining efficiencies in cost analysis is a common concern. Many surgeons believe the cost analysis process takes too long and cite that in many cases, a product properly justified and unanimously supported by the surgical department may not be added to the product shelves for another six months. Some have also cited that their VAC is too literal and has a "black and white" perception of how and why a product is adopted. In one reported incident, a surgeon, after spending considerable time justifying the cost of a new product, was granted approval to use the product in the most narrowly defined surgical situations, which was perceived by the surgeon to be counter productive.

In many situations, the absence of a clinical liaison compounds the VAC's ability to make good and timely decisions. Many hospitals will lean heavily on the surgeon or active nurse to act in the capacity of a clinical liaison in lieu of a dedicated resource. Both situations are less than ideal. Clinical liaisons are critical in that they often bridge the communication gap between surgeons and the administration team. A break down in communications usually results in misunderstandings, false assumptions, mistrust and more delay.

Some processes are perceived by surgeons as over engineered and unnecessary. One example cited was a VAC that required all new product evaluations and/or product trials go through the VAC process. Surgeons would question why they would spend six weeks navigating through a VAC process for a product they have been unable to trial beforehand. In one situation, a surgeon cited the fact that this policy dampened innovation and found that this particular hospital had fallen behind in procedural innovation. For an entire year, while this policy was in place, virtually no new innovative products were adopted by the hospital. The surgeons found it too time consuming and cumbersome to pursue. At first, the VAC interpreted the drop in evaluation requests as a good thing. However, the administrative team questioned why they had fallen behind in procedural innovation areas such as Single Port Incision.



3. Misalignment on philosophies and priorities

Most surgeons who are in VAC roles did not sign themselves up to participate. Most were not provided any training on how best to champion a product nor consider the time implications of such a requirement. However, many are committed to contribute the best they can to advance the goals of the committee. Those that are more closely involved with the VAC and are voting members, have a deeper understanding and appreciation for the overall role of a VAC. The surgeons Blueprint spoke to mostly agree that their financial success is tied to the hospital and are willing to support any effort to help ensure costs are controlled. But fundamental differences in philosophies still exist between the clinical and non-clinical members. These differences manifest in policies that don't always make practical sense.

Discussion with physicians revealed an interesting dynamic. Some hospitals are motivated to distinguish themselves in the market through procedural innovation. They invest time and resources in building a presence, awareness and reputation as having the most advanced and innovative patient care. These hospital VACs are often more open-minded to new product adoption, particularly as it relates to new procedures. In these environments, surgeons find their relationship with the VAC more progressive and more aligned with their philosophies of improving patient care.

Other hospitals are currently focused on cost reduction and cost management. In these environments, surgeons often find the VAC product evaluation process complex and time consuming. It is in these environments that they feel more conflict with the general philosophies of the hospital VAC.

An example of conflicting philosophies between surgeons and material managers or buyers is the growing mandate to limit or prohibit manufacturer sales representatives from meeting with surgeons to discuss product innovation. On the surface, the policy is intended to streamline decision-making and avoid surgeons from being influenced by outside forces. However, it is the sales representative that is currently considered by surgeons to be the most important and sometimes only source of new product education and awareness in the healthcare community. In some cases, the sales representatives cannot enter an operating room to demo a new product unless the buyer or material manager approves it.

Often, the materials manager will require permission before a sales representative can speak to the surgeon, or have the sales representative meet with the materials manager before meeting with the surgeon. Policies established by materials managers, which are made with the best intentions, often undermine their trust capital with surgeons, creating greater divides and negatively impacting collaboration.

The Role of the Sale Representative

It is a common belief among many VACs that the technological innovation and the sales goals of vendors are in direct conflict with the cost-containment goals of the hospital. The sales representative's primary goal, according to Blueprint's survey respondents, is to facilitate what the surgeon does. The sales representatives speak the surgeon's language, wear the surgeon's uniform, assist the surgeon with the device components and understand what the surgeon is trying to accomplish.

The hospital's efforts to foster collaborative models with surgical specialists and also restrict relationships between the vendor and the sales representative have accelerated in the past year. The sales representatives are confronted with more and more methods to restrict their efforts within the hospital.

The relationship between the manufacturer sales representative and the surgeon is unique and often under-valued by other non-clinical VAC members. Surgeons, surveyed by Blueprint, all agree that the sales representative is one of their major connections to procedural innovation and new product introductions. But equally important is the sales representative's ability to provide insight to each surgeon regarding industry trends and other procedural application and training observations.

"The best representatives today are educators, not just sales people."

The sale representative is a connector, providing key procedural trends and insights derived from their interaction among many surgeons. Individual surgeons often do not interact with their peers frequently enough to gain timely insight into how new products are being used in procedures, or learning the particular nuances of how products are used across the surgical community.

Surgeons further explain that with limited access to sales representatives, they have nothing but trade advertisements and the occasional industry event to gain access to innovation and peer trends.

"The sales representative often facilitates my awareness of innovation in both product and procedure. Today, there are no other comparable resources to deliver us the insights into procedural advancements."

Learning Snapshots:

Motivation of the VAC: The sale representative is a connector, providing key procedural trends and insights derived from their interaction among many surgeons. Individual surgeons often do not interact with their peers frequently enough to gain timely insight into how new products are being used in procedures, or learning the particular nuances of how products are used across the surgical community.

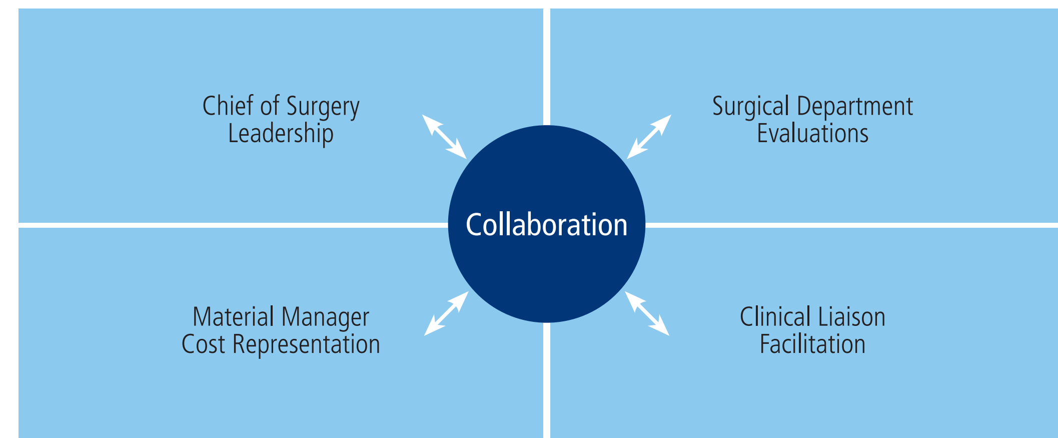
VAC collaboration: Most doctors interviewed thought there was a good level of collaboration between the surgeons and administrative groups within VAC. However, surgeons emphasized that a deeper understanding and appreciation for surgeon motivation, patient care philosophies and commitment to innovation is needed between the two groups.

Influence: Although surgeons generally look upon themselves as being equal partners in the VAC and are treated as such, they note a need to build surgeon advocates prior to defending a new product adoption request. The voting right of a surgeon to a VAC is usually outweighed 2 to 1 by non-clinical votes.

Working relationships: Although the current trend is surgeon employment, many see the downside of that relationship. Private practice surgeons realize their ability to leverage the patient case loads with a hospital to influence the VAC to be more accommodating when it comes to new product adoption. Surgeons view employment as an economic necessity, nothing more. When hospitals treat surgeons like customers, their working relationships are more effective.

Improving the VAC: Surgeons reference the cost analysis process as not only inefficient, but also as being the single variable driving the financial equation. Many hospitals use a zero sum budgeting approach without consideration of positive impact to the contribution margins. To be a true functioning VAC, the bottom line must be the contribution margin, not the amount of money spent on new products.

Surgeon Led VAC



- New product evaluation left to surgical experts
- Cost management and procedural innovation
- Clinical staff are decision-makers
- Material logistics support cost analysis, but don't drive evaluations

Surgeon Formed Value Analysis Team:

Steven Schwaitzberg, MD is the Chief of Surgery at Cambridge Health Alliance. The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) recently elected Steven D. Schwaitzberg, MD to serve as President. He has a clinical background in critical care and infectious diseases and an acute interest in technology. Cambridge Health Alliance (CHA) is an integrated health structure that serves seven major communities north of Boston.

In addition to his significant accomplishments as a surgeon, Dr. Schwaitzberg provides a leadership role in Cambridge Health Alliance Value Analysis Team. Discussions with this team provided key insights into a VAC that is physician formed and managed. Dr. Schwaitzberg shared experiences on how his team collaborates to ensure costs are controlled and procedural innovations are achieved.

Cambridge Health Alliance VAC is contract-driven, like most others. Unlike others however, the hub of the CHA VAC is the surgical department. The non-clinical, administrative side provides valuable services, but they do not determine which manufacturer is awarded the contract. That decision is made outside the VAC and completed at the department level. When a new product is being considered, Dr. Schwaitzberg brings in the surgical department associated with that product into one room. The materials manager attends the meeting armed with all associated product prices and the department performs the value analysis.

"Our VAC does not drive innovation, they drive contract changes."

Dr. Schwaitzberg developed this approach, not to circumvent the VAC, but rather to offset the little expertise in a focused area for a VAC member to provide much evaluation value. He did not see the logic in relying on individuals that did not have the expertise to determine the value of the product. When CHA identifies an established product line they want to bring in, they get the surgeons in a room as a group and review the merits of the product and the costs.

"The key to success is establishing true capital on both sides."

Dr. Schwaitzberg finds that surgeons are very value conscious when you give them all the information. The CHA value analysis process is a unique approach where many of the traditional committee value functions have been moved to the surgical department. They continue to work with some of the same people on the committee in a collaborative and constructive forum. This approach has greatly reduced their inventory and saved millions of dollars.

Looking Forward:

Clearly, there are measurable advancements in the working relationships between the VAC and the surgeon. Surgeons are gaining a better appreciation for the delicate balance between innovation, improved patient outcomes and cost management. Even the most critical surgeons agree that it is in the best interests of the surgeon to contribute their time to the VAC under the right circumstances. A clear indicator of the advancement in the surgeon mindset is how often surgeons cited disappointment that their peers are not more actively participating in VAC sessions and failing to attend product review sessions. Many surgeons called for more organizational discipline among their peers and improved methods to help surgeons collaborate more effectively.

As surgeons embrace the mandates of the VAC, gain a better understanding of the financial considerations and play a larger role in establishing and structuring the decision-making process, the more they develop into a truly integrated component of their VAC, rather than a passive, reluctant contributor. Many surgeons believe the effectiveness of a VAC is best served when a surgeon, rather than the administrative department manages the oversight of the team. Citing their surgical expertise and ability to assess the true clinical value of a new product, they believe it is more realistic for the clinical specialist to oversee new product adoption efforts in collaboration with materials managers and pricing specialists.

The hospital VACs are in varying stages of relationship and process evaluation. Some continue to struggle with the surgeon relationship and effective collaboration, while others continue to achieve their VAC goals and expand their impact and success. Many hospitals have advanced VAC efforts to monitor the total expense of a case (which includes labor, supplies, and purchased services) in order to determine marginal contribution of each surgery. Evaluation and strategy development for the implementation of Accountable Care Organizations, vendor access control systems, benchmark pricing data, implementation of IT business intelligence tools and other noteworthy efforts are well underway in many hospitals as a result of healthcare reform.

The industry has recently seen some of the most tumultuous events in the past two years that challenge the hospital's business and patient care models. It is certain that the partnership of surgeons and the hospital administration is essential to weather the current economic conditions and map out a new course of improved patient care and cost efficiencies.

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