The ABCs of ASC supply management

by Jeannie Akridge

In the wake of healthcare reform initiatives, ambulatory surgery centers (ASCs) in particular face an uncertain future. With reimbursement rates hanging in the balance and already constrained by limited resources, those ASCs that want to thrive will need to focus their efforts on reigning in supply costs.

Amanda Llewellyn, assistant administrator, Johns Hopkins Hospital, Baltimore, MD, described the changing ASC model as moving from one dedicated primarily to “lumps and bumps” and cataract surgeries, to where, for example at the Johns Hopkins-affiliated ASCs they’re performing double mastectomy procedures and even cochlear implant surgeries involving devices that can cost anywhere from $20-50,000.

“[Procedures] that used to be traditional outpatient, we just keep pushing them further and further out, almost to the doctors offices at this point,” explained Llewellyn. “ASCs are providing care that pretty much will no longer be provided at the hospitals of the future. They are definitely on the cusp of taking on more complex cases, like we are doing here, out into the community. And when that occurs they have to be prepared to take on more complex supplies, more complex physicians, stocking a multitude of different items, increasing their costs pretty significantly in order to do these larger cases. So the focus will really need to be on how we evolve. Do we have the right processes in place? Do we have the right people in place in order to support it?”

In a strategic move at Gainesville, FL-based Shands at University of Florida, outpatient surgeries are being delegated to one of its two ambulatory surgery facilities, Childrens Surgical Center and Florida Surgical Center for adult patients. “We’ve made an active campaign to move outpatient surgery to our ASCs,” said Maggie Downey, vice president of supply chain analytics and non-acute operations at VHA Inc. “There is great anxiety about the impact of healthcare reform, particularly the potential for further reductions in reimbursement, and uncertainty about how the emerging emphasis on Accountable Care Organizations will impact ASCs. The health reform provisions on physician-owned hospitals play into that anxiety.”

Llewellyn pointed to the need for ASCs to have a visible dedication to the supply chain. “With the changes in reform, changes in reimbursement, having visibility to the supply chain is going to be a huge part of how ambulatory moves forward. The reason that we need to drive the savings is the reimbursement won’t be there in the future. As the scope of healthcare changes, how we get reimbursed, the money as it flows, it will be so much more important that we control our costs in order to ensure that we’re capable of keeping the doors open.”

Added Downey, “We have a flat or downward turn in reimbursement, and then supply expenses, especially for higher dollar implants, tend to increase. You’re finding your true profitability dwindling over time.”

Certainly capital equipment expenditures are subject to increasing scrutiny, noted Russ Ede, VP of non-acute contracting for Amerinet. “The CFOs are really making a center justify a return on investment before they’re going to push through some of those larger capital equipment expenses, things like diagnostic imaging equipment, etc. I think that’s just a trend of the times with the capital dollars being hard to come by.”

At the same time, “a surgery center’s challenge is to be more efficient with less resources than some of their hospital competitors,” said Ede.

According to Greater New York Hospital Association (GNYHA) Services President Christopher J. O’Connor, unique challenges for ASC staff include: “shorter procedure times (therefore faster turns for the OR suite) require closer monitoring of product usage and par levels to ensure product availability; and less storage space demands a more streamlined process such as electronic cabinetry product distribution for product inventory, order and purchase.”

Added Walters, VHA, “A few key differences are space available for inventory storage, resulting in smaller deliveries; and low unit of measure of supplies purchased, resulting in higher cost per item than is typical for a hospital. Taken together, these result in the need for more frequent deliveries from distributors, not all of which are consistent on a ‘just in time’ basis. As most ASCs are off the grounds of an acute care facility, they must be prepared for emergencies, such as an unexpected complication, that have to be stabilized on-site, without an ICU or ER right down the hall.”

Prioritize supply chain

Whether they be physician-owned, affiliated with a hospital or health...
system or stand-alone, sources agreed that many ASCs fail to adopt the supply chain models proven successful by their hospital counterparts.

“The biggest difference between acute and ambulatory settings is the amount of resources available to bear on the supply chain,” related Walters. “Many ASCs have elected not to or have not had the financial means to invest in hiring professional materials managers. Supplies are ordered by an OR tech, a nurse, or by an administrator who is also responsible for billing, payroll, and physician relations. Others have a materials management department, but have not invested in an MMIS. Occasionally, we find ASC administrators who spend hours negotiating every line item in the inventory or shopping different distributors to chase minor price advantages.”

“In contrast, hospitals are becoming increasingly more focused and disciplined in their approach to the supply chain,” added Walters. “The competition amongst and the value provided by GPOs is a contributing factor. That same competition and infiltration of GPOs in the ASC market will help increase their ability to impact supply chain in the next several years.”

Elevating supply chain in the ASC may require a new way of thinking, noted Ede, Amerinet. “Depending on the size, they may or may not have a materials manager, but somebody’s responsible for getting the supplies. We find that in the non-hospital market that’s a big issue. When a facility is large enough and they recognize that managing their expense warrants someone with that kind of background, there’s a benefit to be had from it. But sometimes they don’t; sometimes it’s the lowest person on the totem pole that gets asked to bring in the supplies because they view it as more customer service instead of an opportunity to manage expense.”

“By placing a concerted focus and really making it someone’s job that it is to manage that supply chain – although that requires another person, it really does pay off in the end,” said Llewellyn.

As corporate purchasing director for Westchester, IL-based Regent Surgical Health, Amy Gagliardi shared some insights into what it takes to succeed in the ASC world. “The biggest challenge by far is developing a cohesive team that integrates supply chain. So often I hear, ‘I am responsible for lowering supply cost at my facility but I have no authority to make changes.’ Managing inventory and supply cost is truly a team effort. Simple changes in the layout of a facility offer an ASC the opportunity for successful inventory control and reduced supply cost. Having the OR manager and materials manager share an office and locating accounts payable in close proximity to the materials manager can make an immediate impact.”

Tools and technology

For the most part, technology and information systems also tend to be lacking in the ASC environment.

“Typically they have fewer tools and technology specific to managing supply expense compared to a hospital,” acknowledged Ede. He added that traditional materials management information systems (MMIS) used in the hospital setting may not be appropriate in the ASC setting. “Some of those tools don’t actually fit well with the surgery center but there are some specific MMIS systems for the surgery center market that if they’re not using those they need to have a tool like that to help them manage their expenses. It can also help them manage their surgery scheduling.”

Llewellyn described the degree of technology implementation as being as varied as the current ASC model – from those that are still completely paper-based to those that are integrated with the hospital and utilize their information systems. “Some places do have [automated supply cabinets] even that they utilize to charge the patient, and they’re very savvy. And then other places they’re still using stickers to charge the patient or hand written sheets that a billing [clerk] or coder puts into the system.”

Just because an ASC is affiliated with a larger health system doesn’t necessarily guarantee a strong technology investment, Llewellyn added. “Sometimes they get lost in the sauce with their health system, because they’re not as much on the radar screen, or it would cost too much to invest in the ASC to have that. Even though it’s there, still sometimes it’s not close enough for them to touch.”

On the other hand, “in some of the larger health systems, like a Hopkins or somewhere else, they want to have complete standardization across the board and that’s quite well done,” she said. “And when you have the ability to get into those systems and spend some time, really are afforded the option, it’s a great thing.”

Gagliardi commended the growing trend of ASCs implementing barcode technology and case costing models. “With a fully implemented MMIS that uses barcode technology, an ASC has live data to analyze and help manage par levels, vendor pricing, contract connections and costly waste. Once an ASC begins case costing and develops a model based on net revenue and contribution margin, the data will impact every part of the budget and purchasing decisions. At Regent, we use this data for contract negotiations, capital equipment decisions, purchasing, recruiting and operational efficiencies.”

Conversely, “not managing your inventory data base is the biggest mistake I see,” she said describing common missed opportunities by ASCs. “Not properly managing critical components such as adjusting unit of measure to accurately account for your ‘each’ cost, keeping updated preference cards and tracking products with expiration dates, has a negative impact on your bottom line.”

Sometimes distributors or group purchasing organizations can be a great source for implementing technology resources that can help bridge the gap between manual and fully automated and integrated processes.

For example, suggested Walters, “ASCs should see if they have access to an e-commerce platform through their distributor or GPO and have tools to help them manage their supplies more efficiently.” In addition to the benefits of an MMIS, he noted that RFID technology can help track supply utilization and charge them to particular cases.

Shared Llewellyn, “For most ASCs across the board for supply chain one of the best things that’s available to them through these major distributors is the ability to purchase on the Web.” In addition to ordering supplies online, “it provides some nice granular history” regarding payment and ordering information.

“There are really two different types of ASCs,” indicated O’Connor. “There are ASCs that have been created and developed with more of a business-minded mentality, and run more like a hospital than a ‘doc in the box’. They have good data, understand they need clean item masters and charge masters, and need to tie those systems together for appropriate and correct billing. Then you can start to track. Successful ASCs are all about tracking and having metrics associated with everything. What is your supply cost per surgical procedure? Take a
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look at that across all the docs who do that procedure. And it’s actually easier to do it in an ASC than in a hospital with inpatient procedures.”

With an undergraduate degree in computer science and a mathematics degree, Downey worked in the healthcare IT environment for 17 years before moving to her current position as fiscal coordinator of surgical services. Her strong IT background has given her “an understanding of what data, and process and systems can do for an organization.”

She described the advantage of using an automated inventory management system such as the Omnicell system in place at Shands. The facility uses Omnicell cabinets for high-dollar supplies with higher tracking demands such as implants, and a shelf cabinet system with barcode scanners and touchscreens to account for items in the OR suite.

In their second year of realizing a 2-year return on investment, Shands eventually plans to roll out the Omnicell system to its ASCs.

In addition to ensuring that supplies are available when needed for surgeries, said Downey, “to me the advantage of having this data and this information, especially the level of detail that the Omnicell system can provide, is you really understand then your real costs per case.”

Physician partners

With physician preference products accounting for a large portion of ASC supply expenses, partnering with surgeons on standardization initiatives is essential to achieving cost savings. “They can’t dictate. They have to work with those physicians and show them the benefits of standardizing to as few suppliers as possible that will still meet the needs of the doctors,” said Ede.

“Traditionally hospital-based service lines [orthopedics, neurosurgery, cardiac] are now scheduling procedures in ASCs that require more physician preference discussions, consideration for product standards, and physician-led value enhancement committees for the ASC,” said O’Connor.

Data collected by the ASC Association shows that for 2010, physicians have an ownership interest in 91 percent of ASCs (including wholly physician-owned and joint-ventured ASCs). In addition, hospitals have an ownership interest in 21 percent of ASCs (includes those wholly owned by the hospital and those that are joint ventured).

The good news is that physician ownership of ASCs may mean those surgeons will be more receptive than their hospital peers.

“What we see is when a physician has an ownership stake in a facility they are much more open to making decisions based on standardization and trying to make the best decisions possible for the surgery center when they’re financially on the line,” reasoned Ede. “When they’re with a hospital sometimes they’re not financially tied to the hospital, they just refer business there, they do their case, and they’re a little less responsive.”

Observed O’Connor, “In the for-profit or physician-owned ASC, it’s amazing how they standardize. The better ones track their costs and are so mindful not to waste that they don’t open up packs they don’t need, because it all flows to their bottom line. Because if it’s their bottom line, they’re managing the store as opposed to most hospitals where voluntary physicians or surgeons just have privileges there. They have a personal investment in every decision.”

He described what he views as commonly made mistakes in the ASC setting, among them: “limited committee membership to monitor and decide supply chain purchases; lack of alignment between physicians and C-suite and supply chain and clinical leadership; and lack of value enhancement policy and procedures and vendor relationships.”

“Successfully managing supply costs requires ASC leadership to study cost-per-case benchmarks to identify manageable variations,” noted Walters. “Because physicians are typically focused on the clinical aspects and outcomes of procedures, educating them on the costs associated with product variation is a critical step in bringing these costs under control. Establishing a budget based on industry benchmarks for particular procedures is one basis for allowing physicians some autonomy in selecting products they prefer while keeping the case cost in line. Another strategy is negotiating consignment agreements to have access to high cost implants without the carrying costs of keeping them in inventory.”

Llewellyn agreed that consignment opportunities, in particular for expensive products such as custom or specialty implants, can be extremely beneficial for an ASC — provided they ask for it. “A lot of places don’t take great advantage of it and they probably should. And it’s because the sales reps don’t always offer it to ASCs because they’re smaller.”

“You only pay for what you use, and that’s so terribly important because an ASC is typically much more financially constrained than a hospital system. They can’t wait for a credit in 90 days,” she explained.

Similarly, ASCs, even freestanding models, should consider taking advantage of standardizing on a regional basis with their distributor. “Asking their distributor, what do other places use? If your distributor doesn’t need to stock something special for you, and you can use ‘xyz’ that they use at the hospital, you’re getting economies of scale. They’re going to cut you a better deal on what they already have in stock, because then all they have to do is increase their stock level from their distribution center rather than add an additional item. You have to get a little creative, especially when you’re a standalone,” she said. “You may not have formal alliances with these places but you can definitely leverage them.”

At Johns Hopkins, when a new surgeon comes aboard to work in the ASC, or even when new services are added, Llewellyn’s team organizes a multi-disciplinary committee meeting involving the surgeon, radiology, pharmacy, supply chain, nursing staff, clinical engineers – “everyone that would be a stakeholder, in order to understand what the setup would be,” she said. “And for some of them we go as far as we set up an entire back table and have them look at it and say ‘yes or no’ to what we have here.”

“In an ASC setting I’ve found that the biggest thing that makes a project successful is definitely communication and teamwork. If we set up a back table with the things that we already have here, through the expertise of our clinical staff for a new surgeon most of the time they’re not going to flinch at it. They’re going to use what we already have, rather than add to our expense to any dramatic extent,” said Llewellyn, adding, “They like to look, feel, see, touch; they’re very tactile individuals.”

“We’re very transparent with our surgeons about their case costs, their revenue back to the organization,” she continued. “We have a Surgical Advisory Council from each one of the specialties that one of the physicians sits on once a month. We go through volumes, we talk about costs and we look for positive deviants, which is what I think somewhat unique in the industry. We look for people who are doing best practice first, rather than who’s costing us...
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