



Change Happens



19th Century



Circa 1940



1964 MGH



2008



1990's





Who or What determines which products are used in the Hospital?

Is product choice determined by:

- ✧ The Physician?
- ✧ The agreed/desired outcome for the Patient?
- ✧ The desires of the Patient?
- ✧ The Device Manufacturer?
- ✧ The GPO?



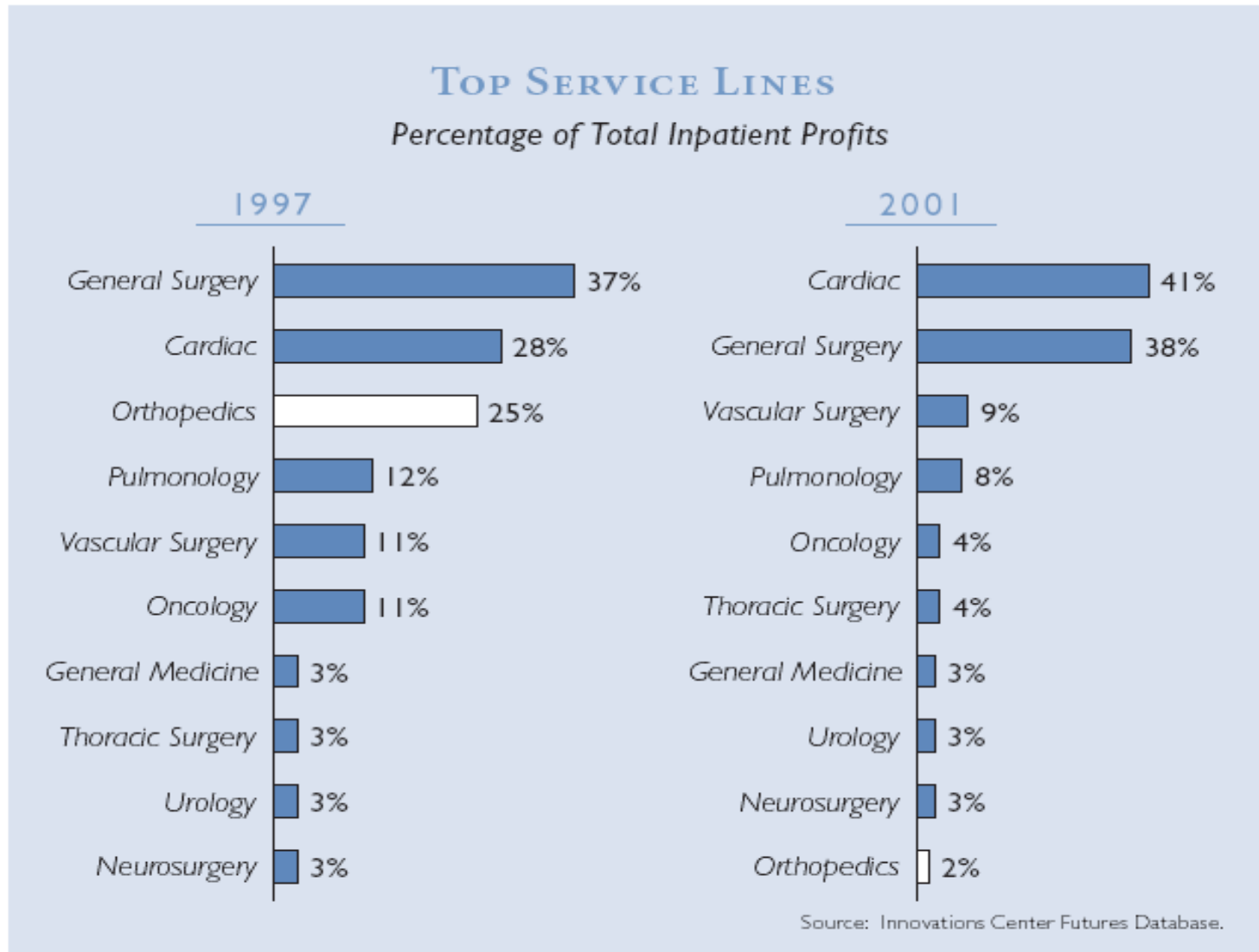
Consider the following questions:

- ✧ Who educates the Physician on choice?
- ✧ Who introduces and provides product that exceeds the need of the Patient?
- ✧ Who spends 5-10 times more on selling, general and administrative costs than they do research?
- ✧ Who provides five layers of sales/marketing protection around each product category?
- ✧ Who trains their people excessively on the art of negotiation and *upselling*?





Hospital Profitability By Service Line





Changing Profitability of Clinical Service Lines

Profitability

| | | |
|------------------------|---|---------------------------------------------------------------------------------------------------------------------------------------------------------|
| Cardiac | ↓ | Once the “Cash Cow” of hospitals, profitability declining due to technology costs outpacing reimbursement. CABG still profitable but declining volumes. |
| General Surgery | ↑ | Most cases continue to be profitable |
| Orthopedics | ↓ | High % Medicare and high cost of implantables. OP procedures profitable but being skimmed-off |
| Neuro/Spine | ↔ | Positive margins highly dependant on payer-mix and ability to “carve out” spinal implants |





What these clinical service lines have in common.....

- High percentage Medicare (fixed reimbursement)
- High surgical/procedural volume
- High supply costs
- Managed by a relatively small number of specialty

physicians





What these clinical service lines have in common..... **PHYSICIANS**

■ Physician Attributes

- ✧ Ego
- ✧ Technical Capabilities
- ✧ Knowledge Base

■ Physician Stimuli

- ✧ Cutting edge technologies
- ✧ Differentiator in the community
- ✧ Income enhancement
 - Declining procedural reimbursement
 - Bigger patient load
 - *Ancillary income*





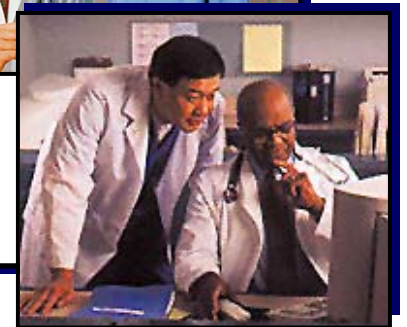
To successfully engage physicians in the adoption of change, you must...

..understand the issues of daily professional practice

Physicians face competing demands for their attention and time.

Major factors influencing how physicians spend their day include:

1. **Providing direct patient care** –
Clinical decision making and procedural interventions
2. **Running their practice** –
Efficiency, productivity, coding, billing, regulatory compliance, administrative responsibilities, economic credentialing etc.
3. **Managing their overall time** –
Professional and personal; balancing patient care and administrative responsibilities; teaching and research in an academic setting



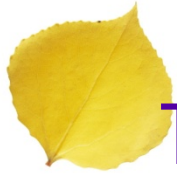


The First Rule of Physician Engagement

In God we trust, all others bring data.

--Anonymous





To Engage Physicians: Enable Them to Share the Clinical and Business Case for Change

■ Identify key drivers for change

- ✧ Quality
- ✧ Safety
- ✧ Efficiency/Cost





Isolated CABG Program Indicators

| Indicator | Hosp X | Aspen Programs |
|----------------------------|---------------|-----------------------|
| Annual Case Volume | 477 | 260 |
| Avg Severity | 2.77 | 3.1 |
| Average Patient Age | 64.5 | 65.3 |
| Percent Female | 29.2% | 31.7% |
| % AMI (initial) | 25.1% | 32.6% |
| AF Rate | 31.5% | <30% |
| IMA rate | 91.6% | 78% |
| Outlier Rate | 1.5% | 1.0% |
| Mortality Rate | 2.1% | <2.0% |





CABG LOS

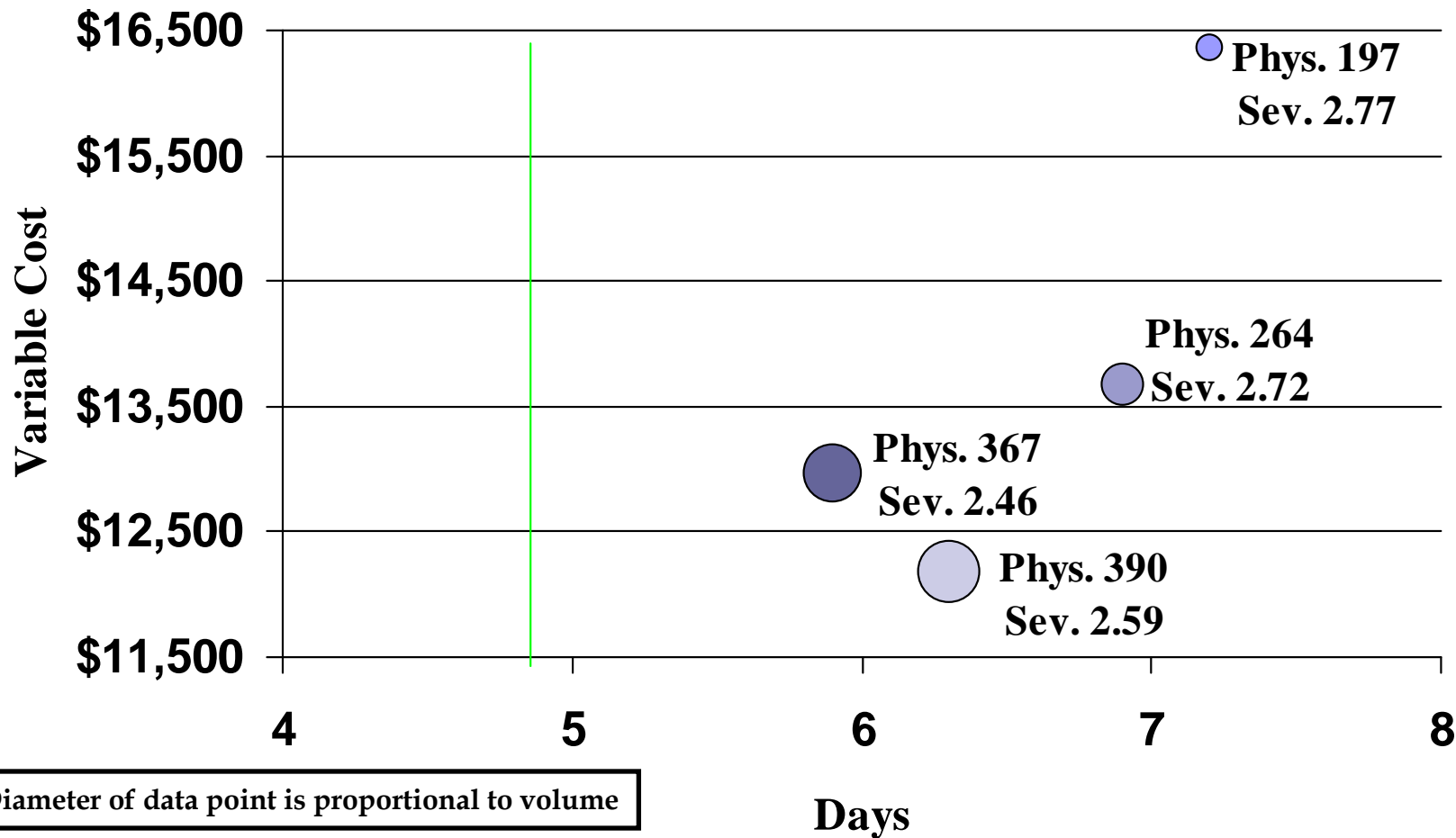
| <i>CABG/cath</i> | Hosp X | Target |
|-------------------------|-----------------|-----------------|
| Admit to Cath | 0.7 days | 0.5 days |
| Cath to Surgery | 2.1 days | 0.9 days |
| Surgery to DC | 5.9 days | 4.7 days |
| Total | 8.7 days | 6.1 days |

| <i>CABG w/o cath</i> | Hosp X | Target |
|-----------------------------|-----------------|-----------------|
| Admit to Surgery | 0.8 days | 0.2 days |
| Surgery to DC | 5.6 days | 4.7 days |
| Total | 6.4 days | 4.9 days |



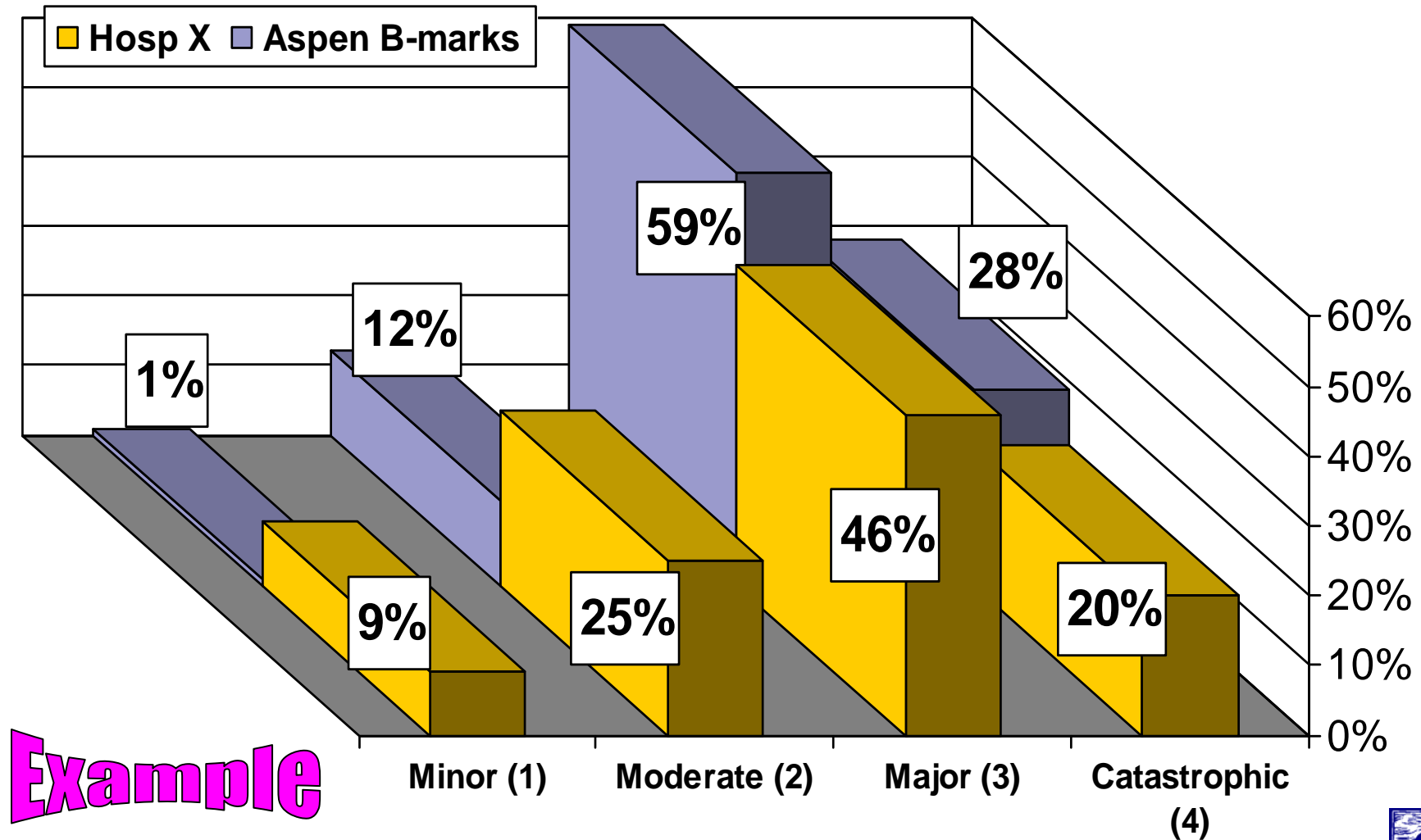


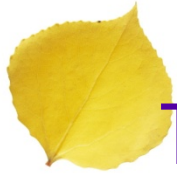
DRG 109 Coronary Bypass w/o Cardiac Cath Avg. Total Cost , LOS by Surgeon





Isolated CAB Severity Compared to Other Programs (avg. 2.77)





To Engage Physicians: Enable Them to Share the Clinical and Business Case for Change

- **Identify key drivers for change**
 - ✧ Quality
 - ✧ Safety
 - ✧ Efficiency/Cost

- **Deliver a consistent, simple message with accurate data**
 - ✧ From Senior Administration leadership

- **Achieve quick wins to demonstrate success**





Develop Physician Supported, Prioritized Opportunities

Key Discussion Steps:

▪ Physician Interviews

- Supply preferences
- Product carve outs

▪ Supply Chain Knowledge Transfer

- Financial and efficiency driven opportunities
- Supply Chain efficiencies support better patient care
- Supply Chain savings can support capital needs
- Capital expenditures can support:
 - Better patient care
 - Better equipment, which can equate to:
 - An improved work environment
 - Additional support staff
 - Better information systems
- Benefits to hospital

It is essential that the program supports the Physician and that the Physician supports the program





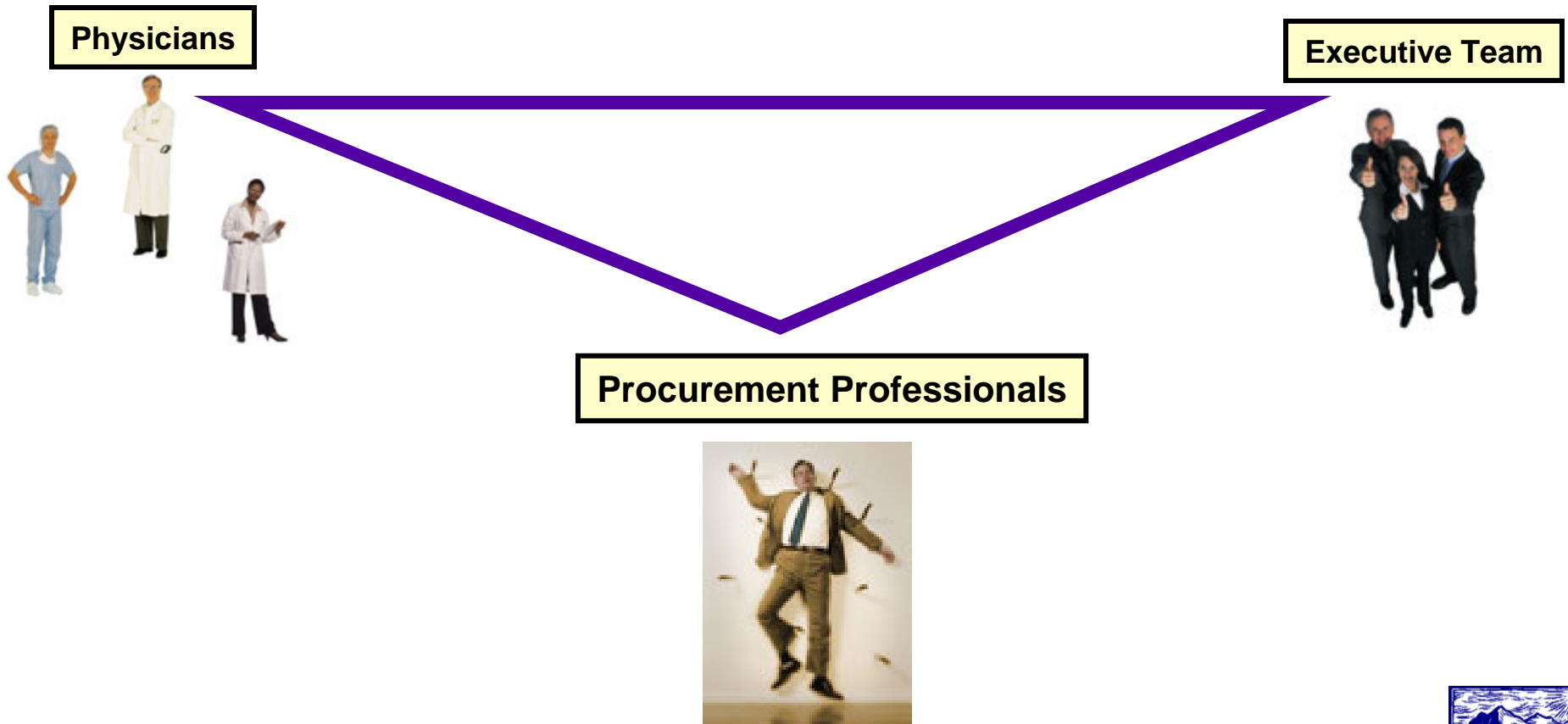
Physician Readiness Checklist

- Do I Have Accurate & Appropriate Data
- I HAVE GAINED A TRUSTING RELATIONSHIP W/ MY DOCS
- I HAVE IDENTIFIED THE TARGET PHYSICIAN GROUPS
- I UNDERSTAND EACH PHYSICIAN'S PRACTICES
- I KNOW WHO THE LEADERS/DECISION MAKERS WILL BE
- I RECOGNIZE POTENTIAL ROADBLOCKS
- I HAVE A PLAN TO DEAL WITH ROADBLOCKS
- DO I HAVE A HIGHLY FUNCTIONAL TECHNOLOGY ASSESSMENT COMMITTEE WITH SENIOR LEADERSHIP SUPPORT





Alignment is Key: *The View from Materials Management*





Alignment is Key:

Device Manufacturers



Physicians



Hospitals

