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The Race to Lower Acuity

Ambulatory surgery centers out in front as procedures keep migrating from acute care.

With few exceptions, the race of procedures to the lowest-acuity setting shows no signs of letting up. Statistics indicate the ambulatory surgery market is big and getting bigger. But reimbursement issues, legislation and shifting ownership patterns will no doubt shape the outcome.

"We anticipate a variety of increasing surgical procedures to shift to outpatient," says Jason Grzyb, vice president, non-acute sales for Cardinal Health's U.S. Medical Products and Distribution business. "As ASCs continue to be met with complexities like evolving regulatory compliance, new technology advancements, supply chain management and more, we're still seeing significant growth and expansion within the industry. ASCs are providing a convenient, cost-effective alternative for surgical procedures – while still delivering safe, quality care in a highly competitive market."

According to Fortune Business Insights, the U.S. ambulatory surgical center market size was valued at $43.70 billion in 2022 and is projected to grow to $75.20 billion by 2030. In terms of ownership, the physician-owned segment accounted for the largest market share in 2022, while the corporate-owned segment was anticipated to record the highest compound annual growth rate (CAGR) during the forecast period of 2023-2030.

Complex procedures, complex technology

Improvements in medical technology continue to facilitate the migration

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of medical and surgical procedures to outpatient settings. Cardiovascular and orthopedics are often cited as two specialties likely to see the greatest growth in the near future.

“Historically, there has not been a consistent and transparent process regarding the approval of procedures for reimbursement in the ambulatory surgical centers,” says Andy Poole, FACHE, MSHA, MSPT, associate director, strategy and innovation, for healthcare technology and safety company ECRI. That makes it a challenge to predict what procedures are most likely to shift to the outpatient setting in the next six or seven years. “However, following recent trends, I would expect a continued focus on growth in the cardiovascular segment. As this is limited in many states by regulatory and reimbursement barriers, a growth opportunity for diagnostic and interventional procedures remains as these restrictions are reduced and safe outcomes are established.

“Another area of expected growth would be where there is already a history of success,” he says. “I think we can look to orthopedics to be a leader there. Given the success of total knee and total hip arthroplasties, I would expect total shoulder replacements to be next. Additionally, as more spine cases are demonstrated to be safe in the outpatient setting, there are opportunities to add additional types of procedures.”

As more procedures move to outpatient settings, new technology may need to be incorporated to ensure there is adequate monitoring of the patient, depending on the type of procedure, says Poole. “For example, with spine cases, you may need additional neurophysiological monitoring capabilities. Additional technologies that limit the risk of blood loss are also important to outpatient centers, so additional technology to aid in visualization may be useful. With all new technologies and instrumentation, there will need to be a continued investment in equipment to properly clean and sterilize to protect against infection risk.

“One of the challenges providers may face in this process is a longstanding struggle across all care settings – lack of adequately trained staff and physicians,” he continues. “It could be especially difficult to secure appropriate staffing levels of anesthesia providers. The other big challenge is reimbursement. It will need to make sense financially to add new procedures and support any new equipment, training, medication and other resources and infrastructure.”

‘As more procedures move to outpatient settings, new technology may need to be incorporated to ensure there is adequate monitoring of the patient.’

“The shift from inpatient (IP) to outpatient (OP) is a story we’ve been seeing for the past 5 to 10 years and, while this trend will continue, it is already quite mature,” says David Levine, M.D., chief medical officer, Vizient. “Simply put, there are only so many more knee replacements we can shift out of the IP setting. That said, the Vizient Sg2 2023 Impact of Change forecast projects OP surgical volumes will grow 18% over the next ten years. Much of this growth will be organic – think increasing demand as the population continues to age and the emergence of noninvasive and less resource-intensive procedures. Procedures we see with highest move to OP include primary shoulder replacement, lumbar-thoracic fusion and knee replacements.”

Pharmaceuticals will continue to enable medical management of select patient populations, which will increasingly shift case volumes to the outpatient setting over the next decade, according to Sg2. This will drive growth in outpatient infusion therapy for several service lines, including rheumatology, with a 48% growth rate; gastroenterology, 37%; endocrine, 23%; and dermatology, 18%.

The outpatient shuffle

“The bigger shift story is what we call the ‘OP shuffle,’” says Dr. Levine, referring to the movement of procedures from hospital-based outpatient settings to non-hospital-based settings, including ambulatory surgery centers and physicians offices. Insurance, availability of appointments, ease of parking and proximity to the patient’s home are factors in the shuffle.

“With many knee replacements having already moved to OP, we anticipate some movement to ASCs. Technological advancements – a main driver in moving shoulder replacements to OP – and pharmaceutical advancements will shift some procedures, such as appendectomies, to medical treatment. Treatments that can be addressed with advances in interventional radiology will also help continue the shift for some procedures.”

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The Ambulatory Surgery Center Association foresees growing numbers of cardiology procedures moving into ASCs, says association CEO Bill Prentice. In 2019, CMS added 17 cardiac catheterization procedures to the ASC Covered Procedures List, and in 2020, it added six codes related to percutaneous coronary intervention, he points out. "Since then, ASCA has supported efforts to ensure that the payment rates for these procedures are sufficient to cover the costs of the medical devices they require. More work is needed before Medicare beneficiaries will have full access to the same range of cardiovascular services in ASCs that privately insured patients enjoy and the cost savings ASCs offer," he says.

A few procedures may reverse course and move from the outpatient setting to the acute care hospital, says Dr. Levine. Those procedures could include diagnostic catheterization, which will see a net drop in outpatient volumes due to emerging use of CT fractional flow reserve as an alternative diagnostic. In addition, novel approaches requiring inpatient care as well as increasing acceptance of earlier surgical intervention will dampen outpatient growth in neurostimulation for epilepsy.

'The shift from inpatient to outpatient is already quite mature. Simply put, there are only so many more knee replacements we can shift out of the inpatient setting.'

What's next? Physician offices?

How many surgical procedures will ultimately find their way into the physician's office?

"We expect the cases that will move into the in-office procedural space will be those with a longer history of safe and effective outcomes," says Poole. "Some of the greatest areas of risk include selecting a patient with an underlying issue, and the use of anesthesia/sedation."

Says Dr. Levine, "In recent years, ophthalmology (e.g., cataract surgery, retinal repair) and gynecology procedures (e.g., LEEP procedures, hysteroscopies) are increasingly performed in the proceduralist office. We also see wound debridement, endovascular peripheral procedures, endoscopic procedures, and low acuity orthopedic procedures like manipulation and fracture repair occur in the office setting."

Jeff Kremer, senior director of business development for Henry Schein Medical's ASC Division, believes the shift from surgery center to physician office "will likely mirror in some ways the transition of procedures from the hospital to the ASC. There are certain procedures, such as plastics, vascular and ophthalmology that are generally recognized as being safe, affordable, and convenient to be performed in-office."

CME Corp. Chief Strategy Officer Cindy Juhas says, "I haven't seen massive movement in that direction, but it makes sense that it will happen. Any procedure that does not require general anesthesia would probably be the ones to move, such as many kinds of plastic surgery, colonoscopy, carpal tunnel surgery, finger/thumb surgeries, among others." ■

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Ambulatory surgery centers: Ownership trends

Ownership trends are shifting in the ambulatory surgery center market. While physicians continue to own some part or all of more than 90% of ambulatory surgery centers, per the Ambulatory Surgery Center Association, corporate ownership is growing, whether in the form of ASC management companies, health systems or joint ventures with private equity.

"That percentage has increased every year recently and I personally do not anticipate the trend reversing," says Jeff Kremer, senior director of business development for Henry Schein Medical's ASC Division. "The corporate groups provide business and financial expertise to allow the physician to focus solely on patient care, so these types of partnerships are appealing to a physician that wants to grow their market presence, revenue and profits."

'We're continuing to see larger organizations acquire more physician-owned and regional surgery centers.'

Jason Grzyb, vice president, non-acute sales for Cardinal Health's U.S. Medical Products and Distribution business, says, "Based on our customer and industry relationships, we're continuing to see larger organizations acquire more physician-owned and regional surgery centers. As the ASC landscape experiences more consolidation, it's likely the larger companies will invest in building new ASCs or expanding existing facilities, while integrating new technologies to further advance procedures and drive efficiencies across their operations."

The corporate-owned segment is anticipated to record the highest compound annual growth rate (CAGR) during the forecast period of 2023-2030, according to Fortune Business Insights. Some of the biggest players are AMSURG, with roughly 250 surgery centers; United Surgical Partners International (part of Tenet Health), with about 480 ambulatory surgery centers and surgical hospitals; Surgery Partners, with more than 180 locations; SCA Health, with 320 surgical facilities; and HCA Healthcare, 124 surgery centers.

Hospitals and health systems remain strong players in the market.

"Many of our larger healthcare systems are building or planning new ASCs," says Cindy Juhas, chief strategy officer, CME Corp. "I think that the medical technologies required will be significant. Most hospital systems are inclined to spend more money on equipment and technology, wanting their ASCs to reflect their brand." Commercial insurers are another entrant into the market, she adds.

Private equity is making its presence felt as well.

"Transition toward the ambulatory surgery center market has long been a priority for private equity (PE), especially in the areas of orthopedics, plastics, gastrointestinal, etc.," says David Levine, M.D., chief medical officer, Vizient. "PE will continue to look for new ways to drive procedures away from the acute care setting, and they have their sights set on cardiovascular as the next big service line to conquer.

"Similarly, large payers like UnitedHealth Group and Humana are working diligently to expand their provider footprints and care management capabilities to hold onto more of the premium dollar and decrease patient utilization of higher cost services," he adds. "This is especially true for private equity, venture capital and payers as it relates to mergers and acquisitions."

Bill Prentice, CEO of the Ambulatory Surgery Center Association, says that "while we are seeing an increase in the number of ASCs partnering with management companies, we are not seeing much change in the procedures they provide or the patient populations they serve when those partnerships are created. In addition, recent data shows that physicians continue to own some part or all of more than 90% of ASCs."

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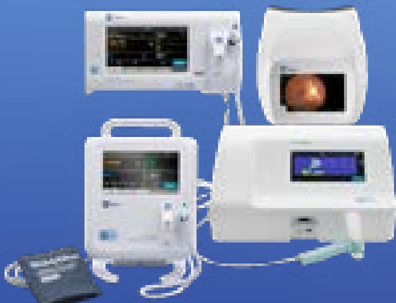

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Site-neutral payment: An issue that could shape the future of ambulatory surgery

Should Medicare continue to pay more for services provided in hospital outpatient departments than it does for similar services performed at independent ambulatory surgery centers or even physicians offices? Hospitals say yes. Payers don't agree. How this issue – called "site-neutral payment" – is resolved could shape the future of ambulatory surgery.

Here's what insurers are saying.

Medicare patients are being overcharged for healthcare services, like routine office visits and lab work, at certain practices owned by hospitals labeled as hospital outpatient departments (HOPDs), said the Blue Cross and Blue Shield Association in a February 2023 press release. "These services cost patients less when provided in a doctor's office or another setting outside of the hospital. Hundreds of millions of dollars are spent on those services with little evidence of improvement in the quality of care."

In fact, in a cost analysis of six common outpatient procedures delivered to 133 million Blue Cross and Blue Shield members between 2017 and 2022, Blue Cross and Blue Shield Association reported:

- Mammograms cost 32% more in an HOPD than in a doctor's office.
- Colonoscopy screenings cost 32% more in an HOPD than in an ASC and double the cost compared to those performed in a doctor's office.
- Diagnostic colonoscopies cost 58% more in an HOPD than in an ASC and more than double the cost when performed in a doctor's office.
- Cataract surgery costs 56% more in an HOPD than in an ASC.
- Ear tympanostomies cost 52% more in an HOPD than an ASC.
- Clinical visits cost 31% more in an HOPD setting than in a doctor's office.

Implementing site-neutral payment policies can curb rising costs, making healthcare more affordable and accessible for everyone, the company concluded.

Even the legislative and regulatory branches of the federal government have questioned the wisdom of reimbursing hospital outpatient departments at higher rates than independent ambulatory surgery centers. In its report to Congress in June 2023, the Medicare Payment Advisory Commission (MedPAC) – an independent legislative branch agency that provides the U.S. Congress with analysis and policy – said that because of payment rate differences across clinician offices, HOPDs, and ASCs, hospitals have an incentive to acquire physician practices and then bill for the same services under the Hospital Outpatient Prospective Payment System (OPPS).

Not surprisingly, the hospital industry opposes attempts to expand site-neutral payment policies, saying they could significantly impact the financial sustainability of hospitals and health systems.

"The cost of care delivered in hospitals and health systems takes into account the unique benefits that they provide to their communities," said the American Hospital Association in a May 2023 fact sheet. "This includes the investments made to maintain standby capacity for natural and man-made disasters, public health emergencies and other unexpected traumatic events, as well as deliver 24/7 emergency care to all who come to the hospital, regardless of ability to pay or insurance status. Hospital facilities also must comply with a much more comprehensive scope of licensing, accreditation and other regulatory requirements compared to other sites of care."

David Levine, M.D., chief medical officer for Vizient, agrees with the AHA. "So long as hospitals have different requirements than other care settings, it is critical that they receive appropriate reimbursement."

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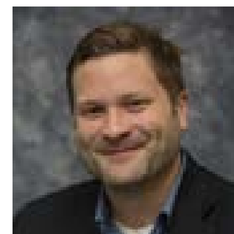

By Ben Bailey,
Director of Benchmarking,
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Physician/Surgeon-Supply Chain Relations Fueled by Circle of Trust

Clinical integration hinges on authentic partnerships with mutual respect and understanding

BY R. DANA BARLOW

Editor's note: *The following is part one of a two-part series. Look for the follow-up story in the November digital issue of* The Journal of Healthcare Contracting.

Physicians, surgeons and supply chain executives represent a different kind of circular economy that reinforces business, clinical and economic sustainability.

The round-robin process works something like this: Physicians and surgeons bring revenue into a healthcare organization – largely from payer reimbursement for procedures – but consume a tremendous number of resources in terms of costly devices, equipment and products. Supply chain executives, on the other hand, can rein in those costs through strategic sourcing, effective contracting, value analysis and facilitation and management consulting, but must equip and fortify physicians and surgeons to carry out their missions.

Without the proper, respectful and responsible balance between the two groups, everyone loses – particularly the patients.

If physicians and surgeons obtain everything they ever want, regardless of cost, quality or procedural outcomes, then the facility in which they practice will slide deeply into the red unless those clinicians overcompensate with additional – and substantial revenue.

If supply chain executives succeed in denying any or all physician and surgeon requests to keep costs in check then the facility in which they work will slide deeply into the red unless it can attract more clinicians to practice that promise to toe the budgetary line.

The equation remains simple enough: Give physicians and surgeons absolutely everything they want, and you run out of money quickly; crack down on or deny physicians and surgeons absolutely everything they want, and you drive away the clinicians who bring in the patients that generate the revenue from procedural reimbursement from payers.

Since the enactment of managed care and the passage of diagnosis-related groups for payer reimbursement in the early 1980s, healthcare organizations have bobbed and weaved in their struggles to balance budgets and economics with clinical service and patient care. Since the turn of the century and millennium, however, a small but growing number of healthcare organizations have embraced a new strategy to bridge the perceived gap between clinicians and administrators that doesn't involve money or technology for incentives – but the human touch.

They're called "medical directors of supply chain," and they encompass doctors and surgeons – actively practicing medicine or not with master's degrees in healthcare administration and business or not – who liaise with either group because they speak the language of either group and understand the aims and goals of either group.

The Journal of Healthcare Contracting reached out to three examples of these relatively new healthcare executives so they could shed some light on what they do and why they matter as well as share how their roles can be applied anywhere. They are:

Anand Joshi, M.D., MBA, senior vice president, Procurement and Strategic Sourcing, New York-Presbyterian Hospital

Stacy Brethauer, M.D., MBA, Professor of Surgery, vice chair of Quality and Patient Safety, Department of Surgery, and medical director, Supply Chain Management, The Ohio State University Wexner Medical Center

Jimmy Chung, M.D., MBA, FACS, FABQAURP, CMRP, Chief Medical Officer, Advantus Health Partners and Bon Secours Mercy Health

All three expressed optimism that more clinicians like them are emerging within forward-thinking hospitals and healthcare systems around the country, striving to achieve balance between physician influence and preference.

***JHC*: Let's talk about expectation myths vs. reality of someone with your title who straddles two realms. What should supply chain know about and expect from a medical director of supply chain?**

BRETHAUER: The role of medical director of supply chain provides the supply chain and value analysis teams with a direct point of contact to help manage new product requests and sourcing projects with the faculty. Involvement of a physician leader ensures that clinical care and quality are prioritized while making evidence-based decisions to drive value for the health system. The supply chain team and leadership should expect the medical director to engage in all decisions with a major financial impact and to act as a liaison between the clinical teams and the supply chain team and lead any change

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management efforts required after decisions are made by the clinical stakeholders.

CHUNG: Physician leaders of supply chain (e.g., medical director of supply chain) are not just physicians who happen to spend some time collaborating with supply chain or participate in committees. They are supply chain executives who happen to have an MD and experience with patient care. This means they have the following skillsets that are important for supply chain management: 1) Ability to validate clinical efficacy of a product and lead Value Analysis programs, 2) Ability to craft the language necessary to gather and communicate to physician groups 3) translate the value of supply chain initiatives to real world outcomes that affect patients and communities, 4) propose supply chain initiatives based on clinical needs and align with clinical metrics, and 5) align clinical improvement programs with goals of supply chain to reduce waste and unnecessary variations.

JOSHI: Let me set a little bit of context. Although I do have an M.D. behind my name, I never actually practiced medicine. I finished medical school but never did residency or a fellowship. In many ways, while there are more and more systems hiring what I would describe as full-fledged medical directors of supply chain – physicians who are practicing medicine and supporting supply chain in different efforts – I'm much more just a supply chain leader who happens to have a clinical background. Twenty-plus years ago I was in medical school; my management experience comes from the supply chain side. If I have to give advice on what you want a medical director of supply chain to know, it's that the range of technologies and supplies that physicians are using across any organization is enormously wide. And technology is changing really quickly.

I've often viewed it as a real challenge to think that a single medical director can cover and represent the entire breadth of a clinical portfolio of supplies that are purchased – not that it can't be done. I've seen two pitfalls. The first risk depends on the subspecialty of the medical director that you hired. If they're a general surgeon they're going to feel most at ease talking about general surgery-type technologies, whether it's staplers, suture, mesh or other classic technologies used in the OR. The risk there is that your sourcing organization may artificially limit themselves to focusing on those categories the medical director is comfortable with. Obviously, there's an enormous range of expense categories that's outside of a certain surgeon's or certain physician's comfort zone. I think that's one risk.

The second risk is, again similarly, any physician you bring into this role is going to be specialized or subspecialized in some way. If they actually feel like they can be the experts in areas even outside of their own area of practice, that also has the potential to not go over so well with different specialists in the organization. For example, if the general surgeon is trying to be the expert in electrophysiology implants, it's going to be a bit of a leap potentially because the technology in any one of those spaces is so technical and advancing so quickly. Just because you have an M.D. doesn't necessarily make you an expert in every single technology used by every single subspecialty.

The most successful medical directors will be those who recognize their limitations in terms of technical knowledge and expertise but are still able to bring the type of influencing skills and persuasive abilities to other physicians in other subspecialties even if they're not as familiar with the technologies that they use. It's more about the soft skills that the medical director brings that in my mind are more important than their exact technical knowledge about the different technologies that are being utilized.

My team, none of whom are clinicians themselves, are the ones doing the work of engaging physicians and surgeons. I think it is critical that the engagement of physicians and surgeons cannot only be handled by a select few in a sourcing organization because that would limit the scale and scope of the impact you're able to produce. It's possible that one individual or five individuals would quickly become the bottleneck to getting a lot of work done.

With the right mindset and perspectives, even if you're not a physician or clinician, you can still engage physicians and surgeons and create value out of those interactions. It's all about coming in with the right mindset. Something I noticed when I first arrived at the hospital and within the industry, was that there was a lot of demonization of physicians and vice versa. The model that we've employed at New York-Presbyterian involves building strong trust-based longitudinal relationships with key physicians in all of the key service lines and building new relationships whenever there's a new technology or opportunity. That has really served us well in the long run. We get the right physician and surgeon input on a particular category and have it a trusted partner. Ironically, we don't necessarily employ any of those physicians with official supply chain medical director titles. We just use them as key stakeholders with whom we are engaging. That's been the

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model that has worked in our environment, but it may not work in others.

***JHC*: Allow me to ask somewhat bluntly, how do you or someone in your position with your expertise respond to those who see you as a good luck charm who will solve all of supply chain's inherent problems in dealing with physicians?**

CHUNG: My best policy is transparency and humility. You have to admit what you don't know and be willing to learn from everyone. You have to be humble yourself to be a part of the team and get your hands dirty to show that you're willing to truly understand the details of the issues. Then you can acknowledge the difficulty and complexity of the problem and validate the hard work everyone else has done so far. If you wave your M.D. flag and ride in to "save the day," you will not only quickly lose your credibility, you'll also alienate everyone else, many who are admittedly smarter than you. I recall many years ago, AHRMM invited a surgeon to the annual conference to present how "easy" it was to standardize surgical instruments. He had this "what's the big deal" attitude, which I think was very condescending.

JOSHI: [Laughter.] It won't be so easy as that for the number of reasons we've already talked about. I think that having realistic expectations is critical. It's unbelievably important to have the right personality and mindset in that role because it is all about bringing people together. It's about bringing suppliers, the hospital administration and the physician body together around a contract and an agreement that everyone has bought into and understands is the right one for all three stakeholders. That takes some amount of skill to bring those parties together. Otherwise, and quite naturally, they would view themselves as adversarial in the dynamic that they're set up in.

BRETHAUER: I think hospital and clinical leadership understands that these conversations are always negotiations and involve compromise. I haven't encountered the perception that I can fix everything but have convinced people that we can prioritize projects and interventions to get the best value for the system. A lot of the job is setting expectation with leadership about what we can accomplish in a given year and explaining why certain things aren't feasible at the moment.

***JHC*: What should physicians and surgeons – including nurses and related clinicians – know about and expect from a medical director of supply chain?**

BRETHAUER: Physicians and nurses should know that the medical director is there to help facilitate their requests and to engage in the clinical discussions regarding new products or contracts. Having a medical director who actively participates in these discussions can de-escalate the tension that can sometimes exist between supply chain and the faculty when change is needed. It is important for the faculty and nurses to know that the medical director's responsibility is to help the organization make decisions that drive value based on the best available evidence and that every request can't be granted. The medical director can provide data to the clinicians about where there is unnecessary variation or preference and why certain decisions don't make sense for the organization based on the value analysis process.

CHUNG: Clinicians should be educated about the need for physician leaders of supply chain. While they may be seen as physician colleagues who are positioned to champion (or temper) their desire for new product requests, they are also there to resolve some of the biggest issues that stem from decades of unchecked tolerance of unnecessary variations in care delivery. These include patient safety and waste, both which have been shown to be unacceptably high, lead to health inequity, cause health care unaffordability in the U.S., and challenges global environmental sustainability. Physician leaders of supply chain should leverage their position to educate clinicians about the importance of reducing variability, adopting principles of High Reliability, and making health care affordable and sustainable, while representing clinical positions to the operational leaders of health systems to ensure they are focused ultimately on the patient experience and health of communities.

JOSHI: They should expect some level of technical and clinical humility about areas of medicine or surgery that aren't necessarily their area of expertise. That would be a good expectation to have, and you need to have the right medical director to fulfill that expectation. The flip side is that the medical director will have been, roughly speaking, in the shoes of the clinicians – nurses, physicians and surgeons – that the supply chain team is working with. Having someone who truly has been in their shoes and deals with the realities of requesting new technologies and recognizing the pros and cons of getting new technology, that experience is meaningful, so ideally, you'd find that in a medical director or executive of supply chain. That's one of the reasons that my medical background,

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while very helpful in understanding how physicians think about things, doesn't really serve much of a purpose with respect to saying that I've actually been in their shoes because I haven't. I've been a medical student and rounded with physicians, but I've never been a surgeon looking to get his or her cases scheduled in and out of the OR quickly. That takes experience that I haven't had, but a medical director of supply chain ideally would.

For true medical directors or executives of supply chain, I think more than anything else it's understanding how physicians think about things, which I have absorbed over the years from medical school to working with clinicians. I think that training ultimately does help.

***JHC*: In your current role, what do you see as working well vs. what's not working well and why? How might you address, if not solve, what's not working well?**

BRETHAUER: At The Ohio State Wexner Medical Center, we have had many successes in our sourcing projects to drive value with a variety of service lines including total joints, spine, cardiology, bariatric surgery, and vascular surgery. These sourcing projects have succeeded because we have been able to get the clinicians to come to the table, review the data and options and make reasonable decisions that meet their clinical needs and still drive value. Many times, we have asked our clinical stakeholders to engage in negotiations with our vendors to reach specific price points or contracts. Without a medical director leading these efforts, it would be much more difficult to get the clinicians involved and to have these sometimes-difficult discussions with our vendors.

We have come a long way over the last five years in building a clinically integrated supply chain in which clinicians are active participants in these decisions. There are still some groups, though, that resist these efforts and want to continue with their culture of physician preference, which is often pursued under the guise of innovation, research or training needs. It's important for the medical director to educate the clinicians that saving money on the big contracts and eliminating unnecessary variation actually provides more money to pursue those other interests, and they are not mutually exclusive. In the areas that still resist these efforts, we have engaged our senior leadership (CMO, CQO, COO) to help explain the "why" and manage the change that is needed.

CHUNG: Supply chain's adoption of physician leadership is gaining traction rapidly, especially after lessons learned during the COVID pandemic. Supply chain leaders and industry partners are catching on quickly that clinical integration of supply chain is critical to everyone's success. What isn't working so well is lack of commitment on the health system's side to support a centralized model to reduce variability. When the payment model is still based on volume and acuity with hospitals barely surviving on near-zero margins, there is no room for any risk of losing surgical cases. While the fear of losing surgeons to a competing hospital is largely based on myth, it is still a threat that surgeons leverage to hold their control at hospitals. However, the actual challenge is convincing hospital leadership to take that risk because 1) there is added value to standardizing that isn't immediately apparent and 2) most surgeons do not actually leave because of lack of product choice. Having a robust data platform that shows the value [that] opportunities can empower leaders to have these difficult conversations.

JOSHI: What's working well is the breadth of physicians that we're able to form relationships with. It's pretty significant. We are a 10-hospital system with two academic medical schools and lots of world-renowned, cutting-edge physicians and surgeons across those entities. We have the breadth of talent at the front-line levels so that our financial and sourcing analysts here are regularly in touch with cardiac surgeons, interventional cardiologists, electrophysiologists and working through the details of what a bid is going to look like and what the new products are and what they should be priced at. I think what's working well is that breadth of coverage we are able to have in that model.

I think what's not working well is finding exactly the right balance. There are certainly some number of those interactions where having a stronger clinical presence or background could help drive and push the envelope in terms of what we're able to achieve or trying to achieve in a particular category with particular sets of physicians. I think that some of my more seasoned sourcing team members get there over time, but it's definitely harder if you're a sourcing analyst straight out of either a graduate school program or out of an undergraduate program. Because they are early in their career it's going to be hard for them to push the envelope with the cardiac surgeons in terms of what they're utilizing. There's a middle ground that we miss a little bit, but part of it is just staffing realities and resource availability in some instances. ■

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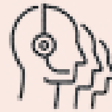

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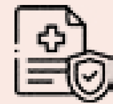

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References: 1. Data on file, Allergan Aesthetics, March 2024; Plastic Surgery Aesthetic Monthly Tracker. 2. Data on file, Allergan Aesthetics, July 2023; Surgical Scaffold AU Surgeon Perceptions 2023. 3. Data on file, Allergan Aesthetics, January 2022; Allergan Plastic Surgery Order Form. 4. Data on File, Allergan Aesthetics, January 2023; AlloDerm SELECT Ordering Information. 5. Data on file, Allergan Aesthetics, July 2023; Artia Ordering Sheet. 6. Data on file, Allergan Aesthetics, January 2023; STRATTICE Ordering Information.

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A shift to ambulatory, understanding manufacturing's role in healthcare's changing landscape

The future of care delivery is undergoing a fundamental transformation to become patient-centric, virtual, ambulatory, home-based, and value-based. This transformation is driven by data and analytics and while it is integrated, it remains fragmented.[1]

As the possibilities for care continue to grow, so do the complexities of safeguarding the well-being of both business and patient health.

The rise of ambulatory sites reflects the shift in medical care from hospitals to outpatient sites. And while hospital care is still the largest healthcare market segment overall, ambulatory settings continue to see disproportionate growth.

Ambulatory market outlook[2]

- Hospital outpatient departments and ambulatory surgery centers (ASC) will continue to experience patient growth (19% and 25% by 2029), with patient volumes projected to increase by 15 million from 2019 to 2029. In addition, the shift in procedures from inpatient to outpatient will help drive down the cost of surgical procedures
- Physician clinics will see pronounced declines in in-person visits (-19%) as patients shift to virtual, but those patients seen in the office will be more likely to need specialized diagnostic services. Non-visit services in physician clinics, such as office-based diagnostics, laboratory testing, and imaging, are projected to grow 18% by 2029

What role does manufacturing play in meeting the needs of today's ASC?

One of the primary concerns for ASC leadership is cost reduction, with a central focus on gaining control of their supply chain management. Medical supplies represent a significant portion of the budget, second only to staffing costs. Recent supply chain disruptions and escalating inflation have presented notable challenges. It is imperative for ambulatory centers to promptly address internal issues such as operational inefficiencies, high wastage, and excessive costs.

Because the supply chain function oversees most of a health system's external spend, which accounts for up to 40% of total costs, working with a high-performing supply chain can boost resilience, enhance care and reduce supply spend, placing ASCs in a better position to achieve growth goals.

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[1] www.mckinsey.com/industries/healthcare/our-insights/the-next-frontier-of-care-delivery-in-healthcare
[2] www.businesswire.com/news/home/20210604005089/en/Sg2-Impact-of-Change- Forecast-Predicts-Enormous-Disruption-in-Health-Care-Provider-Landscape-by-2029

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Down But Not Out

Cyberattack hits physicians hard, but industry stakeholders respond.

On Feb. 21, a company many in the industry were not familiar with – Change Healthcare – experienced a cyberattack that critically impacted the U.S. healthcare system. At the time, the healthcare clearinghouse, touched one in three patient records and processed 15 billion healthcare transactions annually. Potentially devastating to many physician practices and their patients, the cyberattack provided distributors an opportunity to step in and help them weather the storm.

"Cyber incidents are the new normal," says Ryan Hungate, DDS, MS, chief clinical officer, Henry Schein One.

"The numbers are increasing because of growing vulnerabilities in healthcare systems," wrote the editors of The Lancet in late May. "Electronic health records, medical devices, laboratory services, pharmacies, clinical decision support systems and many more applications and services are digitally interconnected and used by many different users.

"Use of new digital technologies, such as mHealth, telehealth, and AI-supported diagnostic tools, accelerated during the COVID-19 pandemic and were added with little consideration of security issues. At the same time, many healthcare

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providers and services still use outdated technologies and software. This interconnectedness makes healthcare systems an easy target. Cybercriminals only need to find one weak entry point to paralyze the entire system."

What is Change Healthcare?

For many physicians, hospitals, and health insurance companies, Change Healthcare serves as a clearinghouse through which eligibility inquiries are received and responded to, claims are submitted and processed, and remittance is sent back to the physician or health care provider, pointed out the American Medical Association in a May 1 statement to the U.S. Senate Committee on Finance, which was investigating the cyberattack. For some payers, Change Healthcare even handles claims payment.

"Change Healthcare also plays a primary role in communicating prescriptions to pharmacies and determining pharmacy, insurance and patient costs. It facilitates exchanges between physicians, hospitals and labs – including the ordering of labs and the sending of results. Change Healthcare supports the exchange of information related to prior authorizations and other utilization management requirements. And it has products and services that reach into practice management systems and electronic medical record systems for dozens of other practice management, clinical and revenue cycle purposes."

Impact on physicians

In his statement to the Senate Committee, Anders Gilbert, senior vice president, government affairs for the Medical Group Management Association (MGMA), pointed out that MGMA members experienced myriad negative consequences following the cyberattack, including severe billing and cash flow disruptions, inability to submit claims, limited or no electronic remittance advice (ERA) from health plans, an inability to transmit electronic prescriptions, a lack of connectivity to data infrastructure, health information technology disruptions and more.

"Physician practices diligently instituted workarounds for various processes to remain operational, which required significant labor costs and time to institute, diverting critical resources from patient care. The lack of cash flow led to medical groups having to make difficult financial decisions as it was early in the year and practices already had limited working capital on hand due to tax considerations. Smaller practices were particularly affected given their tight margins and had to utilize lines of credit with high interest rates just to keep their doors open."

Even a month after the cyberattack, the American Medical Association reported its members were experiencing ongoing difficulties. An AMA survey showed that 90% of the surveyed physicians reported that they were still losing revenue from unpaid claims. More than one-quarter said that their practice revenue for the prior week was down by more than 70%, compared with an average week before the cyberattack. Among other findings:

- 85% continued to experience disruptions in claim payments.
- 79% still could not receive electronic remittance advice.
- 75% reported barriers with claim submission.
- 60% faced challenges in verifying patient eligibility.

In addition, 62% of respondents said they were still using personal funds to cover practice expenses and 34% were not able to make payroll.

From a fiscal perspective, the cyberattack affected stand-alone hospitals (i.e., those not part of a larger IDN), rural hospitals and physician offices that lacked the financial resources to weather the storm, says Tim House, national vice president of sales, Concordance Healthcare Solutions. "When a breach occurs, it can impact the ability to order product, pay for product and submit claims. The financial burden has a domino effect. But a strong relationship between the distributor and the care provider can help facilitate the continuity of care that the patient needs. During this breach we offered our support to multiple facilities, and that strengthened our relationships with them."

'A strong relationship between the distributor and the care provider can help facilitate the continuity of care that the patient needs.'

Distributors respond

"Our two biggest concerns were helping make sure our customers could see patients during and after the cyberattack, and making sure they had enough money to keep their doors open," says Dr. Hungate.

Henry Schein One was able to help

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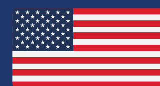

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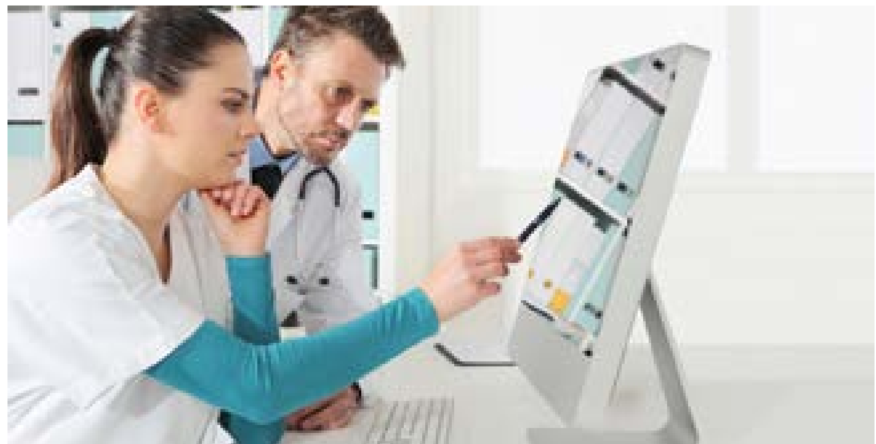
customers transition quickly to alternate clearinghouses, he says. "For those who were more adversely affected we were able to facilitate financial assistance. It was a matter of letting them know 'we've got you, here are the steps you need to take next, and here's what you need to understand about how you may be affected in the weeks or months ahead.'" The company created dedicated websites with the latest news about the cyberattack. As helpful as these measures were, practices still had technological kinks to iron out, such as re-registering for electronic remittance advice.

Concordance was able to replicate orders from previous days'/weeks' orders without the need for customers to submit a new order if their system became inoperable, says House. "Our system is smart enough to see patterns, provide predictability and demand forecasts so that we can meet their needs. We worked tirelessly in a manual setting to ensure we got product to their docks and ultimately to the patient.

"Another action that we took was to extend payment terms for some customers. One medium-size hospital in particular was very appreciative of those efforts, he says. "We extended DSO from 15 days to 180 days, which took the burden off their entire system, allowing them to pay their physicians and other past-due bills that were mission-critical.

"Our reps worked directly with customers to replicate orders that were in our system from prior weeks to ensure they had product on their docks," says House. "We also leveraged our Surgence tool to look at proactive inventory reports and on-hand inventory." (Concordance describes Surgence as a healthcare supply chain ecosystem that fully connects providers, distributors and suppliers by bringing visibility to supply and demand information.)



'Our two biggest concerns were helping make sure our customers could see patients, and making sure they had enough money to keep their doors open.'

What happens next time?

"The cyberattack on Change Healthcare made it evident that there are significant vulnerabilities in our healthcare system, which must be addressed, especially as the threat of such attacks only continues to rise," Gilbert told the Senate Finance Committee. "Moving forward, health plans, clearinghouses and other third-party vendors must have safeguards and contingency plans in place to better protect physician practices from cash flow and administrative impacts resulting from a cyber incident.

"Physician practices must continue to work to ensure they have adopted iron-clad cybersecurity policies and procedures to best protect the data of their patients and their ability to provide high-quality care. When contemplating the fallout, we urge against establishing penalties, or conditioning relief funds, for medical groups in response to cyberattacks perpetuated against other healthcare actors. There are a multitude of security and data privacy regulations governing medical groups; introducing barriers to future relief would work against supporting medical groups' ability to operate in the face of considerable interruption."

Says Dr. Hungate, "Overall, to protect against future cyber incidents, it is important for the healthcare industry to continue to remain educated on, and aware of, cyber threats. Additionally, being resilient and having the ability to respond swiftly is critical. By fostering a culture of adaptability, and remaining vigilant, healthcare teams can mitigate risks and maintain trust in an evolving healthcare landscape.

"This incident affected basically every doctor in the United State. That forces all of us to ask, 'What do we do next time?' We will offer technology outreach and help our customers understand what they need to do to survive. Those customers who are most engaged with our reps come out on top of this." ■

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Ortho Trauma and the Supply Chain

Why meaningful data for the orthopaedic trauma service line is key for today's supply chain teams to make more informed purchasing decisions.

By 2030, one in six people in the world will be aged 60 or older, according to the World Health Organization (WHO). This aging population is more susceptible to fractures and other musculoskeletal injuries.

Fortunately, advancements in technology and surgical techniques have made orthopaedic trauma devices safer and more effective in treating patients whether they are older or have suffered injuries from traffic-related accidents or through physical activity. Devices include implants such as plates, screws, rods, and external fixation to stabilize and immobilize fractures. New materials and designs are more biocompatible to better withstand the forces generated by the musculoskeletal system.

"Traumatic orthopaedic injuries can threaten a patient with loss of life, limb or functional impairment," said Stephanie Falconer, RN, Manager, Strategic Marketing for Stryker Trauma. "These injuries are often associated with long-term care that can incur significant costs."

Indeed, the care can also be costly for health systems if they don't have the visibility into spending patterns, product utilization, waste and efficiencies to drive standardization and savings. Better visibility will lead to an actionable plan for contracting and purchasing decisions in the orthopaedic trauma service line.

"Quality and safety record, supplier reliability, cost effectiveness and clinical compatibility are critical keys to consider when sourcing," Falconer said. But navigating various surgeon specialties, product

preferences and supplier portfolios without access to reliable, actionable data is difficult.

Inventory management, supply chain visualization and data analytics are the top three areas in which orthopaedic device companies plan to invest in, according to a LogiMed industry research study. These areas of investment can translate into a more effective supply chain and inventory management that helps lower operating costs, reduce capital expenses, eliminate waste and improve patient outcomes.

Virtua Health's orthopaedic excellence

One health system that has prioritized its supply chain infrastructure is Virtua Health, an academic nonprofit healthcare system in southern New Jersey. Virtua operates a network of hospitals, surgery centers and physician practices. It is South Jersey's largest healthcare provider, and uses Stryker as a preferred vendor for orthopaedic trauma.

Virtua Health's orthopaedic and spine department has over 60 specialists treating unexpected injuries, back pain, joint problems and other issues, and it has been recognized for excellence by *U.S. News & World Report.*

Virtua Health aims to be clinically integrated through all its service lines, from leadership to supply chain, with its strategic sourcing and procurement team and its clinical materials resource management team leading the way. They partner with physicians to help bridge the gap between clinical interests and business aspects.

"We act as the liaison and promote the evidence-based value analysis we're finding and provide data to help make product selections," said Christina Bobco, Department Manager of Clinical Materials Resource Management for Virtua Health. "We seek to understand what the market share looks like and what are the next innovations."

Bobco's team provides clinical benchmarking data that Virtua Health has invested into the strategic sourcing and procurement team, led by its director Michele Walker, to help determine pricing, standardizations and contract compliance.

This includes data for the orthopaedic trauma category.

Virtua's physicians are asked to lead initiatives based on utilization to help move the needle with leadership when there is a potential market share issue.

"It's a shared partnership between clinical and supply chain, and physicians have to be on board," Bobco said. Her team also consists of many clinical RNs. Critical conversations between clinicians and vendors Virtua Health produce better patient outcomes, she says.

"Communication also plays a large part," Walker added. "There are more items in the orthopaedic trauma category than in other categories and communication with vendors is critical."

> **"So much goes into standardization. If you don't have a physician relationship or people to give you clinical feedback, they're going to choose the items they're used to. We value those relationships."**
>
> **– Christina Bobco, Department Manager of Clinical Materials Resource Management, Virtua Health**

"The vast cost of trauma and our spend plays a large part," Walker said. "It's important because of market share, which contracts are usually dependent upon. We must track market share and stay within the parameters of our contracts. The health system has incorporated some analytics/ business applications to track our market share. "

Walker says Virtua Health looks at its current spend and market share, and reviews products with its orthopaedic services product committee, in the case of orthopaedic trauma, and gets feedback from physicians, supply chain and other leadership within the OR.

"Then we decide if we're sending an RFP or doing a benchmark for pricing and negotiating with vendors individually," she said.

Having the opportunity to negotiate beyond GPO pricing in the trauma space is important, according to Walker. "Not everyone is as standardized as we are," she said. "We have two major players in basic trauma which account for over 80% of the market share, and we have some niche items."

"So much goes into standardization," Bobco added. "If you don't have a physician relationship or people to give you clinical feedback, they're going to choose the items they're used to. We value those relationships."

Greater insights

Most supply chain departments struggle with data and analytics. There's been a

tremendous focus in the last five years to improve this, whether it's through ERPs, financial system upgrades or bolt-on solutions from third-party vendors.

Indeed, data and analytics is becoming the way to get to the granular detail needed to make better decisions. "The struggle has always been the validity of that data, because it's subjective to how things are documented at the encounter," said Ana Sanchez, Vice President of Supply Chain & Support Services for Virtua Health. "We're all chasing it. The challenge is, how to get the true accuracy of consumption, because it is subjective to a clinician entering in information."

If supply chain teams have the granularity of how complex the cases are, the credibility with clinicians is higher because they can show how the information is compiled and sliced. For instance, analytics can show that Dr. A's trauma cases are primarily car accidents and not a slip-and-fall type of older patient, so, you're not generalizing the cases in your discussions with clinicians. There is a myriad of factors that could justify why one procedure would be $10,000 and the other would be $20,000. "Today, oftentimes it's all just bundled together because you don't have that dissection of the data to keep drilling down to why it's different," Sanchez said.

"That's the end of that spectrum," said Walker. "If you find out that there really is not a difference in the two procedures, but there is a large cost difference in the two procedures, it can be presented to the physicians to show them that maybe there's a less costly way to perform the procedure."

Ten years ago, health system supply chains were completely dependent on what vendors said their consumption was, down to the physician and patient type, because financial systems were not talking to clinical systems, Sanchez said. "Very few people had the resources to marry it up, and because the way the reimbursement worked, you weren't worried; the more that something cost, the more you got paid back."

That's no longer the case. Now providers are told how much they're going to get paid for these cases, so they are working backwards to figure out what the supply cost needs to be to maintain a margin or just break even. "Hospitals work at a 1% net after if you're lucky," she said. "Right now, most hospitals are working at a loss."

Today, systems analytics and applications have been developed, and hospital systems have hired analysts to mine the data. The silos between electronic medical records and the financial systems have continued to drive a lot of this mystification of the data, but there is more crossover between the two, Sanchez said. And that can only lead to lower costs and better outcomes.

"Whether it's trauma or any other service line, the data gathered by supply chain teams will hopefully drive some further conversations about pricing and how the model works overall."

Stryker's Alliance Program

To help health systems break down those silos and gain greater visibility in the orthopaedic trauma category, Stryker introduced Alliance – a trauma and extremities value program that provides meaningful data to help hospital supply chains make more informed, more confident purchasing decisions.

With more items available in the orthopaedic trauma category than in other categories, supply chains must make purchasing decisions while navigating surgeon specialties, product preferences and supplier portfolios.

Access to the right data to make decisions is a challenge. Alliance filters, compares and analyzes critical data to help make those decisions and reduce costs for hospitals and provide better outcomes for patients.

"Visibility into the trauma and extremities service line can help with predictive spending, cost analysis and efficiencies around inventory management," Falconer explained. "Optimization is important for maximizing resources and ensuring that the surgeon and patient have what they need."

Stryker's Alliance Program helps health systems unlock value through increased visibility to trauma utilization data and programs and solutions that drive standardization, promote efficiencies and maximize contract and operational performance. ■

Pain Points

The biggest pain points for hospitals in the orthopaedic trauma category include:

- Multiple vendors
- Lack of standardization
- Inventory management
- Cost

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Trauma is a complicated service line.

Balancing physician preference while managing inventory makes bringing in new products challenging.

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Trauma360 is our proprietary analytics suite that translates your trauma utilization and inventory data into objective, actionable insights. We know how to go beyond identifying pain points to provide pathways to drive standardization, promote efficiencies and maximize performance. At Stryker, we are dedicated to ensuring your success, and our Alliance team will **tailor the details to align with the unique objectives of your health system.**

This information is intended for the use of healthcare professionals. A surgeon must always rely on his or her own professional clinical judgment when deciding whether to use a particular product when treating a particular patient. Stryker does not dispense medical advice and recommends that surgeons be trained in the use of any particular product before using it in surgery. The information presented is intended to demonstrate the breadth of Stryker's product offerings. A surgeon must always refer to the package insert, product label and/or instructions for use, including the instructions for cleaning and sterilization (if applicable), before using any Stryker product. Products may not be available in all markets because product availability is subject to the regulatory and/or medical practices in individual markets. Please contact your Stryker representative if you have questions about the availability of Stryker products in your area. Stryker Corporation or its divisions or other corporate affiliated entities own, use or have applied for the following trademarks or service marks: Pangea, Stryker. All other trademarks are trademarks of their respective owners or holders. Copyright © 2024 Stryker

Mind Share

Embracing the supply web of ingenuity requires unchaining from the past.

BY R. DANA BARLOW

Some may characterize the COVID-19 pandemic experience as uncovering cracks in the fortress of and frayed seams in the fabric of the global-national-regional-local supply chain(s). These represent pessimists masquerading as realists or simply cloaked in the cape of realism.

Others may use the pandemic experience to stretch the creative possibilities, open unique opportunities and establish fresh new strategies and tactics for the "supply web" in the post-pandemic world – not to pass blame, point fingers and wave the white flag. These represent optimists prime! Big difference.

For the former, the glass might only be half-full or half-empty; for the latter, the glass always remains full because they see air occupying the top half and a liquid the bottom half. Attitude and perspective.

In short, the crisis either brought the blame-and-shame game and a retreat to a different career, job or profession, or it unlatched the shackles and chains that handcuffed the minds of those who equipped and fortified clinicians to keep people healthy and the economy chugging.

Just like standing in a long queue in the grocery store with nearly empty carts interspersed among the teeming loads until a cashier opens an adjacent line for you to slide over for faster service, the optimists both self-aware and alert among their surroundings were able to pivot quickly – emotionally,

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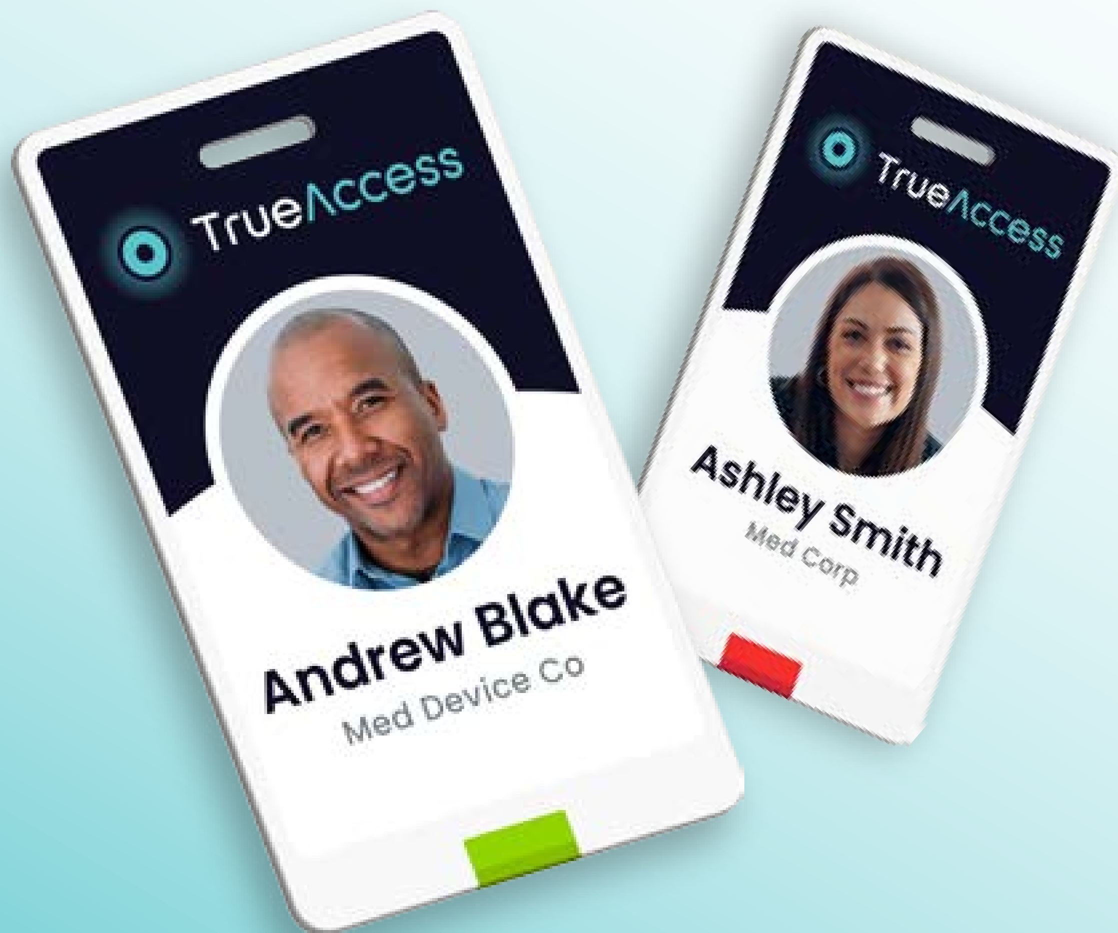

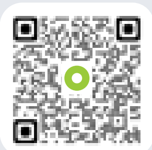

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mentally, physically and operationally, to satisfy their customers clinically and their employers financially.

Those three years between 2020 and 2023 required the retirement of conventional thinking and the way it's always been – prematurely perhaps for some, but permanently for others. The global crisis ignited cleverness, composure and creativity when it was sorely and holistically needed.

Some supply chain leaders and professionals, energized by easing federal rules, engineered ways to reprocess selected products that had been classified as single-use-only for limited repurposing.

Others turned to beverage companies that dedicated manufacturing efforts and hours to produce hand sanitizer to offset supply shortages, stockouts and backorders.

Automotive manufacturers and textile companies dedicated manufacturing lines to producing protective face shields and face masks.

A handful of integrated delivery networks (IDNs) invested in 3-D printing equipment either directly or indirectly as a purchased service from airplane and rocket manufacturers to produce selected items that could be molded and shaped as quickly as possible.

A select number of healthcare organizations dispatched supply chain professionals from their own teams to international hubs and ports under the guise of enabling closer access to sourcing raw materials for manufacturing of personal protective equipment (PPE) and other medical/surgical products as well as linking labor to production.

Others embraced their competitors – whether nearby, across town or even over the state line – to share available supplies and/or unoccupied space in consolidated service centers, makeshift storage units from cargo containers and warehouses, some of which were vacated retail locations under lease. Further, they shared strategies, tactics and tips to move forward.

Automation – via online communication, enterprise resource planning (ERP) systems, robotic process automation (RPA), blockchain and the blossoming emergence of artificial intelligence (AI) offered possibilities and promise if you could harness the horsepower reliably and accurately.

The crisis also cemented closer ties between supply chain and information technology (IT) as the two teams collaborated on demand planning and forecasting procedures, processes and tools to streamline communications between myriad points in the supply web – from all points within the IDN or healthcare organization to manufacturers, distributors, third-party logistics companies inside and outside of healthcare.

Automation – via online communication, enterprise resource planning (ERP) systems, robotic process automation (RPA), blockchain and the blossoming emergence of artificial intelligence (AI) offered possibilities and promise if you could harness the horsepower reliably and accurately.

They recognized that the solid-line demarcations between external and internal conditions and factors needed to blur or dot to streamline the assembly line of product design, manufacture, delivery, use and disposal (with a potential element of recycling for sustainability as webs tend to be circular) and keep production fluid in a malleable masterclass of end-to-end operations.

Most importantly, perhaps, is that they've been sharing their experiences in traditional and social media, print and online, at conferences and trade shows, in mentoring and training, so that everyone remembers the ingenuity needed to escape a tightening knot – not to self-congratulate but to perpetuate the open-mindedness necessary for when – not if – that next crisis emerges.

Through effective planning, bolstered by backup planning and fortified with backup planning to the backup planning, the supply chain – or web – today can approach, treat and ward off tomorrow's uncertainty with certainty. ■

R. Dana Barlow serves as a senior writer and columnist for The Journal of Healthcare Contracting. Barlow has nearly four decades of journalistic experience and has covered healthcare supply chain issues for more than 30 years. He can be reached at rickdanabarlow@wingfootmedia.biz.

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