As predicted, suture prices remained stable last year, the only exceptions being when renegotiated contracts permitted modest increases.

Market leader Ethicon, Summerville, N.J., allowed price decreases averaging 0.05%, based on responses to this month’s HMM price survey.

Last year, materials managers complained that Ethicon, a subsidiary of Johnson & Johnson, New Brunswick, N.Y., was inflexible in its pricing, and notorious for appealing directly to clinicians in efforts to boost sales.

While the company got no specific pats on the back this year, the survey indicates individual hospitals and IDNs have managed to negotiate deep discounts in local contracts. For individual products, price declines sometimes reached double digits (as did increases for other items).

Use of staples, adhesives up

One factor the industry has been watching is the impact of advanced wound closures such as surgical staples and new adhesive materials. Indeed, hospitals are uniformly investing in more varieties of skin closure technology, but so far they have not identified any resulting

(See Suture, continued on page 12)
HIGPA, MDMA clash; OIG finds fees useful

The Health Industry Group Purchasing Assn. (HIGPA), Arlington, Va., has been citing a recent Health and Human Services Inspector General’s report on the impact of contract administrative fees as proof that GPOs provide financial benefit to the health care system.

“It was found that without adding to the hospital’s operating costs these GPOs were able to generate significant revenue through administrative fees, the vast majority of which were immediately returned to providers,” HIGPA said in a June 9 statement.

GPOs have been on the defensive since 2000, when the Senate began looking into their operations at the behest of small manufacturers claiming to be locked out of the medical device marketplace.

Past investigations such as one by the Government Accountability Office (GAO) indicated that GPOs did not necessarily save money for hospitals.

Manufacturers weigh in

During the latest OIG probe, the Medical Device Manufacturers Assn. (MDMA), Washington, wrote to acting inspector general Daniel Levinson that GPOs should lose their special status under anti-kickback laws and be restricted in the amount of administrative fees they can charge vendors.

The MDMA letter said in part:

“Congress originally granted GPOs special marketplace status because it thought the GPOs would hold down health care costs. Instead, GPO contracts frequently exclude safe, effective, and competitive medical technologies that need to be made available to physicians and patients.

“Paradoxically, GPOs are financed by the very companies whose products they evaluate for sale to hospitals, not by the hospitals that buy those products. Furthermore, since GPO fees are based on a percentage of the contract price, they actually generate more revenue the higher the contract price.

“As a result, GPOs have no incentive to negotiate for lower prices. We believe this system limits competitiveness in health care purchasing and thus fails in its

(See Fees, continued on page 15)
HOSPITAL PURCHASING

■ Hospitals invest in price and savings audit tools from Amerinet subsidiary

LRGHealthcare, Laconia, N.H., began in May to implement the price auditing program of Diagnostix, a subsidiary of Amerinet, St. Louis.

LRGH will use the AccuPrice and AccuSave systems under a contract that took effect Feb. 1 and runs for five years. At the same time, LRGH renewed its membership in Amerinet for five years.

The Diagnostix system includes tools and training to identify savings and negotiate and manage primarily pharmacy contracts. Savings range up to 10% annually, according to an Amerinet statement.

LRGH is an integrated delivery network with two acute-care hospitals: Franklin Regional Hospital, Franklin, N.H., 49 beds, and Lakes Regional General Hospital, Laconia, N.H., 143 beds.

As a member of Amerinet, it will participate in the Global Healthcare Exchange (GHX) e-commerce platform and the Amerinet Clinical Advantage Program.

Also signing up for the Diagnostic AccuPrice program was The Washington Hospital, Washington, Pa., 248 beds. In May, Washington agreed to automate pharmacy contract tracking.

AccuPrice is a software tool that combines master file maintenance with automated daily price audits to allow a health care facility’s staff to quickly identify and resolve pricing errors.

Purchases are automatically reviewed every day to determine the number of invoices and lines, favorable and unfavorable variances, and items that are not on file.

Staff then use the daily report to correct errors that negatively affect supply costs and identify opportunities for additional savings.

■ New York hospital taps Eclipsys Corp. to provide OR and patient record systems

Community General Hospital, Syracuse, N.Y., 356 beds, selected Eclipsys Corp., Boca Raton, Fla., to provide electronic medical records and other technology.

Installation began in May. Eclipsys was one of three candidates for the contract, and the selection was made based on product demonstrations.

The hospital will install the company’s Sunrise Clinical Manager package for electronic records, and Sunrise Clinical Manager to connect operating rooms to other departments.

According to Mitch Rozonkiewicz, chief information officer at Community General Hospital, the goal is to reduce paper and give clinicians faster access to patient information.

■ Selecting prime procedure tray vendor proves beneficial to Exempla Health

Three-hospital Exempla Health, Denver, is saving $450,000 annually on custom procedure trays since standardizing in early 2004.

The prime vendor is Professional Hospital Supply (PHS), Temecula, Calif., under a contract from VHA, Irving, Texas. Director of materiel management Pete McGuire had issued an RFP and, based on bids, selected PHS.

The resulting contract lowered prices by 15% based on annual spending volume of $3 million on the covered trays. The three-year contract ends in 2006, and McGuire said he intends to rebid at that time.

■ IDNs lead the way in using data cleansing services from Neoforma to find savings

Genesis Healthcare System, Zanesville, Ohio, an integrated delivery network with two hospitals totaling 373 beds, was among the first to sign up for data management and maintenance services recently introduced by Neoforma, San Jose, Calif.

As a member of VHA, Irving, Texas, Genesis has access to Neoforma’s electronic commerce site through Novation, also in Irving. According to Jack Medkeff, director of materials services, the supply chain analysis software revealed $400,000 in potential savings.

The software generates reports showing where the hospitals are purchasing products with off-contract prices. “Information is power, and Neoforma DMS gave us access to data that allowed us to perform analyses across our system in a way that wasn’t possible before because the condition of our data wouldn’t allow it,” Medkeff said.

Neoforma DMS’s database has 2 million records provided by suppliers, including vendor and product information with auto-matching technology for cleaning item masters.

Genesis was able to reduce the number of records in its item master by nearly 30% by eliminating erroneous and duplicate entries, as well as those items that had not been purchased for years. Neoforma specialists helped convert the Genesis item master to the UNSPSC product classification system.

Another hospital that uses the DMS application is University Healthcare System, Augusta, Ga., 551 beds.

It worked with Neoforma specialists to use the UNSPSC code to correctly classify 10,000 individual products in the hospital’s item master.

University Healthcare found it could save $600,000 annually on drug-eluting stents, a 14% discount, by agreeing to increase its market share with a single manufacturer.
Other VHA hospitals that have signed up to use Neoforma DMS this year include Scott & White Memorial Hospital, Temple, Texas, 625 beds; Community Medical Center, Missoula, Mont., 125 beds; Baptist St. Anthony’s Health System, Amarillo, Texas, 756 beds; DCH Health System, Tuscaloosa, Ala., 610 beds; Maine General Medical Center, Augusta, Maine, 200 beds; and, Memorial Health System, Springfield, Ill., 602 beds.

VA hospital selects Boston Scientific as sole source of drug-eluting stents


The one-year deal took effect in May. It covers the company’s Taxus Express line, approved by the FDA in March 2004. The stents will be provided on consignment, to be paid for only when used.

The agreement includes four one-year renewal options.

Kaleida Health System awards prime distribution pact to Medline Industries

Kaleida Health System, Buffalo, N.Y., named Medline Industries, Mundelein, Ill., as its prime distributor of medical-surgical supplies.

The deal took effect in May and runs for three years. It is valued at $8 million in annual spending. Annual savings from the conversion to Medline products are estimated at $750,000.

Kaleida also will use Medline’s logistical standardization and utilization services.

Hospitals ink agreements to provide FDA-regulated software for blood banks

William Beaumont Hospital, Royal Oak, Mich., 1,061 beds, in May awarded a contract to Mediware Information Systems, Lenexa, Kan., for blood transfusion software for its three facilities.

Beaumont chief of transfusion medicine services A. Bradley Eisenbrey, M.D., said Mediware was selected because its package is easy to use, contains needed safety features, and is compatible with the hospital’s current laboratory and clinical information systems.

Also selecting Mediware in May was Yale-New Haven Hospital, New Haven, Conn., 944 beds. The hospital had a previous contract with Mediware and is expanding it to include the transfusion product.

Meanwhile, in June, Pomona Valley Hospital Medical Center, Pomona, Calif., 436 beds, chose a different transfusion system vendor.

Pomona selected Wyndgate Technologies, Denver, to provide its SafeTrace Tx advanced transfusion management system.

Crystal Lester, a systems analyst at Pomona, said the laboratory and information technology staff made the choice “primarily because of Wyndgate’s strong industry reputation and the system’s ease of use and flexibility of application.”

Blood bank software is regulated by the FDA as a medical device.

Florida hospital buys medical ‘device’ that cries, wets, sneezes for training

Shands Jacksonville Medical Center, Jacksonville, Fla., 528 beds, in May became the first hospital in the world to acquire an infant-sized patient simulator.

A grant from the Children’s Miracle Network made it possible for the hospital to purchase the $52,000 BabySIM, made by Medical Educational Technologies Inc. (METI), Sarasota, Fla.

BabySIM appears to be a three- to six-month-old infant, and contains substances resembling blood and other body fluids. It contains a computer with advanced software to simulate behaviors such as crying, wetting and sneezing.

Shands will use the device for pediatric and emergency medical training.

Adult patient simulators have been on the market since 1996, when METI was founded. Its sales are about $25 million annually worldwide.

Customers include NASA, the military and local disaster planning agencies.

On June 9, Riverside Methodist Hospital, Columbus, Ohio, 640 beds, opened its Center for Medical Education and Innovation, featuring METI simulators.

Medical Education Technologies, Inc.’s Learning in a Virtual Environment, or LiVE, is the commercial version of the U.S. Army’s Combat Trauma Patient Simulation (CTPS) system used to train military medics.

The $3 million cost to build and equip the center as well as another $2 million for operational expenses was a gift from a foundation fund organized by the Riverside medical staff.

Presbyterian re-ups with McKesson for medical-surgical distribution

Presbyterian Healthcare Services, Albuquerque, N.M., in May renewed for a second five years its distribution contract with McKesson Medical Surgical, Richmond, Va.

Based on its experience in the previous deal, the integrated delivery network expects to save $1.2 million annually on spending of $20 million on med-surg supplies under the contract.
VHA hospitals get fatter rebates based on reorganization, greater contract use

Members of VHA, Irving, Texas, are seeing the results of last year’s reorganization in their rebate envelopes.

As a result of a series of layoffs of VHA staff and other cost-cutting measures, along with greater participation in group contracts, VHA completed distribution in June of $367 in cash payments to hospitals.

VHA estimated that members saved $925 million on purchases through Novation, VHA’s group contracting arm, also in Irving.

That adds up to $1.3 billion in total value, a 13% increase over 2003.

“VHA delivered a double-digit increase in value for 2004 for two reasons – more member participation and VHA’s success in reducing our operating costs,” said VHA president Curt Nonomaque.

Total cash value includes cooperative cash, patrons’ equity redemptions and manufacturers’ incentive payments. Members earn cooperative cash and equity based on their participation levels in VHA. They earn manufacturers’ incentives throughout the year, and they receive cash redemptions of their patron’s equity each year.

Checks for the cooperative cash was to be distributed to 1,954 patron members in early June. In addition to the cooperative distribution checks, members received a detailed report outlining their specific participation levels and the value they received through VHA during 2004.

Last year, VHA members purchased $20.1 billion worth of supplies and services through VHA and Novation contracts, a 14% increase over 2003.

A more detailed analysis shows that VHA members purchased $1.7 billion in services through VHA agreements and $18.4 billion in supplies through Novation contracts. VHA manages approximately 60 vendor contracts for services, and Novation manages more than 600 contracts for medical supplies.

Staffing, data management among top worries of materials managers in survey

Among the greatest challenges facing materials managers today are staff shortages due to financial cutbacks and maintaining cumbersome information systems, according to an online survey.
GROUP PURCHASING

Affiliation with MedAssets proves wise
decision for Shared Services Healthcare

CEO Sandra Green resisted for several years entreaties from national group purchasing organizations to merge with the regional group she heads, Shared Services Healthcare (SSH), Atlanta. But when John Bardis, CEO of MedAssets, Alpharetta, Ga., came calling in 2002, the time seemed right.

Two-and-a-half years later, the deal is working even better than expected, with members' equity (a measure of income from several sources) up to $4.25 million from just over $2 million when the deal was signed in April 2002.

"It was just a win-win for both of us," Green said in a recent interview. Local contracting, especially for outsourced services such as textile processing, remain with SSH, but members now have access to MedAssets' national agreements for medical-surgical and other supplies.

Meanwhile, SSH brought $320 million in annual purchasing volume to MedAssets along with its 550 hospital members. What made the MedAssets offer attractive, Green said, was that SSH had not been growing for some time; purchasing volume remained stable, but the large integrated delivery networks in the Southeast region had eluded efforts to draw them in as members.

"Because we couldn't match the technology [of national GPOs] we were not able to crack large facilities." Along with increased income came savings from the merger, Green said. By eliminating its own contracting department, SSH found it could move into smaller—but more desirable—office space.

SSH also retained one of its specialized services, Epic Concepts, which provides pre-employment screening to hospitals. Epic reported $137,475 in revenue for 2004. That was a drop of 13.8% from the $159,400 reported in 2003.

But administrative fees from promoting contracts rose to $4.8 million in 2004 from $4.1 million in 2003, an increase of 15.3%.

While there have been other ups and downs, the bottom line for SSH is an increase in net income to $4.25 million from just over $2 million when the deal was signed in April 2002.

That would be Novation, Irving, Texas, shaping up as an arch rival to MedAssets, though it still retains many loyal members.

Marketing vice president Gary Johnson said the decision of a total of 16 large IDNs in the past 2.5 years to join MedAssets indicates hospitals are moving from traditional contract and price considerations to the kind of customized service MedAssets provides.

The most recent was Ochsner Clinic Foundation, in February of this year.

VHA to route vendor admin fees directly
to hospitals under new business model

As part of a reorganization that began last year with office consolidations and staff layoffs, VHA, Irving, Texas, on July 1 adopted a new business model and new logo.

While CEO Curt Nonomaque described the change as a return to core supply chain services and member networking, industry observers instead have focused on the financial aspects of the change, especially a plan to pass administrative fees paid by vendors directly to hospitals.

Under the new model, members will pay a single charge for core services such as access to purchasing contracts from Novation, also in Irving. The core charge will include access to the electronic commerce site Marketplace@Novation. Members may elect to purchase custom services for additional fees.

The change, VHA said, is designed to create more transparency in relating what members pay to what they receive.

In the past, members did not receive an exact accounting of the administrative fees or the cost of services; they saw only the cash amount that VHA returned. VHA will now distribute 100% of the fee revenue it collects from suppliers net any core or custom charges.

Beginning in December with the third-quarter statement, members will receive value statements and payments electronically each quarter, as well as an annual value report.

Nonomaque said he began alerting hospital CEOs in January of the planned changes, and response was "overwhelmingly positive."

Richard Hastings, president of Saint Luke’s Health System, Kansas City, Mo., and VHA board member, said, “VHA has done a tremendous job over the last two years of listening to member requests to provide more value and sharpen its focus.

Other hospitals have been less enthusiastic. "It’s
too early to tell; let’s see how it really works,” was the response of David Reska, director of purchasing at Hartford Hospital, Hartford, Conn., 830 beds. In principle, however, he said, it appears to be a positive change: “You never quite knew about those administrative fees. Now, it’s quite open.”

Somewhat predictably, suppliers have been skeptical of the change. Several are quoted on StratCenter.com, an online newsletter aimed at suppliers, questioning why there should be any admin fee at all, if it is to pass directly to the members in proportion to their contract participation.

“My cynical mind,” said one, “tells me this is so every time VHA hands out another check to a member, it will be positioned in the hospital’s mind as their benevolent protector against the evil forces of wayward vendors.”

Another argued that nothing has really changed under the new system: “It seems that though the terminology is different, the math is the same. Members will still only receive between 45% to 50% of the administrative fees collected on their behalf since the cost of ‘core charges’ and other ‘regional’ services will consume the same percentages that they do today under the term ‘operating equity.’

StratCenter reported that VHA said it would consider doing away with admin fees (creating a member-funded GPO) if it could trust suppliers to reduce prices to reflect their savings from not paying fees. The chart on this page compares the old and new ways of transmitting funds among vendors, VHA and members.

■ VA names Zassi Medical Evolutions source of devices used in bowel management
The Dept. of Veterans Affairs selected Zassi Medical Evolutions, Fernandina Beach, Fla., to provide devices used to process fecal matter for patients with limited mobility. The agreement took effect in April and runs for five years.

It covers the company’s bowel management system, which is designed to divert fecal materials to aid in skin and wound care and assist in the reduction of the incidence of nosocomial infections in non-ambulatory patients.

■ Broadlane group buy for CR equipment nets 70 participants at early stage
Broadlane, Dallas, selected Konica Minolta Medical Imaging for a computed radiography group buy beginning in May.

About 70 hospitals pre-committed to the group buy, which is not limited to Broadlane members. Konica is the sole source.

Under Broadlane’s group buy rules, hospital clinicians agree to purchase a piece of equipment before bidding begins. This lets suppliers know what a winning bid would be worth in market share.

For participating hospitals, it assures the best technology with the most favorable terms, conditions and pricing for capital equipment.

“Broadlane’s group buy program continues to provide significant savings through our customer-driven processes and proven sourcing strategies, which leverage the committed buying power of our group buy participants,” said Michael Berryhill, vice president, strategic sourcing services at Broadlane.

“Broadlane’s group buy program is an excellent opportunity for health care providers to review the technology in person and purchase the most technologically advanced capital equipment at the lowest possible price.”

■ Cardiology supplies featured in new pact between Premier and CardioDynamics
Members of Premier, Charlotte, N.C., are expected to spend about $25 million annually on cardiology

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**VHA funds flow—then and now**

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<th>Suppliers</th>
<th>VHA</th>
<th>Members</th>
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<td>Admin fees</td>
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<td>PEC/services</td>
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<td>Regional assess.</td>
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<td>Pay for services</td>
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**Then:** Manufacturers rebates and incentives

**Now:** Manufacturers rebates

Source: VHA, Irving, Texas
supplies under a new agreement with CardioDynamics, San Diego.

The deal will take effect July 1, and will run for three years. It covers ECG electrodes, lead wires, and cables produced by CardioDynamics subsidiary Vermed. It will be part of a three-source agreement.

**New e-commerce services provide ways to project savings from better utilization**

Novation, Irving, Texas, added two new services for members using the electronic commerce site MarketPlace@Novation.

One is the Contract Value Assessor, software that allows a hospital to cross reference current line-item purchases with new contract pricing. The hospital can then assess potential savings that would result from standardization on one or a few vendors.

The calculation software was launched April 1 for the wound closure and endomechanical contracts and other contracts will be added later this year, Novation said. One of the first users was Meriter Hospital, Madison, Wis., 448 beds.

Purchasing coordinator John Teppo said the automated process makes it easier to identify savings.

“Previously,” he said, “a more time-consuming manual process was necessary. With the new tool, we can quickly upload our purchasing data and get an idea of what contract savings suppliers could possibly offer us.”

The other online service is the Contract Potential Savings Report.

It enables hospitals to review purchases both on and off contract and track usage patterns. It then helps identify products for which lower priced equivalent products are under contract. The effect is to increase contract utilization.

The service covers all but pharmaceutical products. A separate pharmacy report was introduced in January 2004, and Novation members have credited it with $10 million in savings.

**Amerinet deal with Gaymar covers variety of temperature-management products**

Amerinet, St. Louis, awarded a contract for temperature management and fluid warming to Gaymar Industries, Orchard Park, N.Y. The deal took effect April 1 and applies to the Amerinet choice program.

It covers convective warming blankets, hyper- and hypothermia blankets, localized temperature therapy pads and fluid warming sets.

Amerinet also renewed its general contract with Gaymar for warming devices and pressure ulcer management surfaces.

**Plain-paper X-ray printing projected to save 90% on imaging in Novation pact**

In a departure from its usual bidding procedure, Novation, Irving, Texas, did not issue an RFP for new-generation radiology printing products.

The reason was that the vendor, Aycan Medical Systems, Rochester, N.Y., has the only plain paper X-ray printing device on the market. The deal took effect in May and runs for two years,

Savings of up to 90% on printing costs are estimated with the company’s Aycan X-ray printing system. Savings will result from the capability of printing images on plain paper instead of film.

The Aycan uses a high-resolution laser printer with a print server to produce any medical image on plain paper, up to 11 in. by 17 in.

The system eliminates the need for light boxes, processing equipment and film sleeves.

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Once again, Hartford selected IKON, and discussions began on contracting for additional equipment, such as high-speed printers.

“**They saw inefficiencies**”

At that point, the IKON rep suggested revamping the entire printing and document management function, according to the print shop unit leader, Jeff Lawton, who later was in charge of the hospital’s participation in the reorganization.

“IKON recommended a centralized printing center,” he said. “They saw inefficiencies.”

“They” meant primarily account executive Bill Lawson, who has been IKON’s representative at Hartford for the past 10 years. “He understands our vision,” Lawton said.

Materials management director Sharon Fried agreed. “We knew that our document management processes required an overhaul,” she said. “IKON took the time to understand our vision and goals.”

That vision was far from what Lawson saw back in 2001 when the project began.

The hospital had three areas where print functions were performed: a print shop, a copy center, and the information services department (data center), all run by separate vice presidents. In addition, some $314,000 worth of printed forms were outsourced.

The hospital owned 14 high-speed devices, including presses, printers, and copiers, but each ran for just one eight-hour shift per day.

Document management costs had been rising every year, Reska recalled.

Along with the redundancy in equipment, there were duplicate processes and systems. Thousands of dollars of forms were destroyed each year due to policy, regulatory changes or obsolescence. Requesters were often confused on where to send jobs. Print jobs could take up to three weeks to complete.

**Big warehouse, obsolete forms**

Printed forms were stored in a 7,500 square foot on-campus warehouse.

During 2003, $100,000 worth of printed forms were discarded as obsolete. Large portions of the hospital’s color marketing material and black and white prints were outsourced. Monthly printing volume exceeded 4.2 million impressions.

Looking back on those days, Reska drew a dismal picture: “We lacked an integrated forms management and forms control function, fulfillment and distribution methodology were inadequate, and productivity was constrained by underutilizing technology.”

Reska, Lawton and Fried heard Lawson’s concerns and began an extensive document assessment that would measure forms control, equipment, personnel utilization, ordering procedures, print processes, and storage. They named the project “Improving The Print Output System.”

The administrators of the areas where printing was done sponsored this continuous quality improvement process: information services, materials management and corporate communications. IKON’s Lawson acted as facilitator.

In its research, the project team interviewed press operators, equipment operators, forms designers,

(See Print, continued on page 10)
(Print, continued from page 9)

programmers, hardware and software engineers, distribution staff, print material buyers, printing vendors, facilities planners and end users.

Meanwhile, the hospital’s administration made it clear to the team that whatever model was chosen for printing operations, current hospital employees should keep their jobs.

**Partial outsourcing was the answer**

Following the analysis, the team settled on the following solutions:

- Black-and-white and color digital equipment was acquired.
- All three print areas were consolidated into a central Digital Print Center (DPC).
- Hartford and IKON developed a unique hybrid/partial outsource contract to run the center.
- The DPC was positioned under the purchasing division of materials management to leverage existing relationships with printing vendors and maximize the DPC’s digital printing capabilities.
- A web-based requisitioning system (Digital Store Front) was created with a forms library and an online ordering system.
- Forms would be printed on demand.
- A forms committee was created to reduce redundancy of forms, insure compliance to hospital and regulatory standards and evaluate need.
- Four-color marketing material could now be produced in house.

“I wish I had a picture of that old warehouse full of forms,” Reska told HMM. “I never would have dreamed that it would have come this far this fast.” Today, that 7,500-square-foot warehouse has shrunk to a closet-sized 125 square feet.

**High-speed printers, online requisitioning**

Since the entire print process was to be re-engineered, the team decided to install the latest technology, in the form of high-speed digital printers capable of 450 impressions a minute.

To provide one-stop shopping for forms, copying and billing, an online ordering system called Digital Store Front was selected.

The system allows requesters to go on-line to order “print on demand” forms from an electronic forms library, submit copy and print jobs and get e-mail notification of the status on each job. Previously, hard copy requests were sent through the mail, adding up to two days to the production time.

Reska noted that “print on demand” means the print center will generate forms at the request of a user following departmental approval.

It does not mean downloading a form to a nurse’s desktop and printing it there. “We try not to encourage desktop printing, because of the cost,” he said.

When the budgets from all three print areas were compared to the cost of one combined print center, the team found savings of $1 million over the four-year contract period.

**Forms committee ensures consistency**

A forms committee was established early in the project to bring the forms process under control and maintain control going forward. The committee consisted of representatives from each department using forms, including nursing.

It started by writing the hospital’s specifications and guidelines for all forms (including electronic forms) and created a procedure for new form requests and changes.

Before the new print center opened, hospital employees received e-mails about it, and it was featured in articles in the hospital newspaper.

The project team held training and information sessions for customers in the hospital. A grand opening celebration in the DPC provided an opportunity to for customers to gain confidence in using the new center and to make face-to-face contacts.

In one dramatic result, the initial conversion of 44 forms from an outside printer to in-house produced enough savings to equal the monthly equipment cost.

Customers receive an e-mail confirmation when they enter an order and again when the job is completed. From the system, the status of jobs is tracked including time to completion and billing information. At the end of every month, graphs are produced to show number of jobs and dollars ordered through the system (see example page 9).

**Saving space and dollars**

The following table shows the result on the changes in terms of dollar and space savings and improved efficiency.

<table>
<thead>
<tr>
<th>Feature</th>
<th>Before</th>
<th>After</th>
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<tbody>
<tr>
<td>Impressions</td>
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<td>.2 million</td>
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<tr>
<td>Warehouse space</td>
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<td>125 sq. ft</td>
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<tr>
<td>Dollar value of forms inventory</td>
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<td>$53,320</td>
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<tr>
<td>Manual submission of copy jobs</td>
<td>400</td>
<td>200</td>
</tr>
<tr>
<td>Number of inventoried forms</td>
<td>900</td>
<td>257</td>
</tr>
</tbody>
</table>

**Savings Examples**

- Hospital newspaper $4,000 per year
- Doctors’ orders $6,283 per year
- Posters $45,228 per year
- Business cards $13 per box
- All print impressions (52% reduction) $10,000 per year
- Operational Savings per year including forms conversion $400,000

All in-house printing is now done in one department. Instead of 14 high-speed duplicating machines

(See Print, continued on page 11)
running eight hours per day, there are just seven that now run up to 18 hours per day. The DPC now provides services that were not available in-house, such as digital four-color printing and digital wide-format printing.

The forms committee ensures that:
• The latest version of a form is printed
• All forms meet hospital guidelines
• All forms meet regulatory guidelines
• Forms are printed in the most cost-effective manner
• There are no forms that duplicate a process.

The processes that have been put into place are measurable and sustainable. Some of these include:
• Requesters now use one on-line system to order forms and print jobs
• Requesters place orders and receive print jobs at their desk instead of walking to the copy center to drop off or pick up jobs
• Pallets of printing paper are delivered to one location instead of three
• One charging system is utilized instead of three
• To date, no forms have been destroyed due to obsolescence
• Improved quality
• Improved lead times
• Review of each form to determine the most cost effective way to produce it.

Forms are not all that became consistent after the project. IKON generates reports to document cost savings and improved efficiency.

Volume reports are generated each month for the jobs submitted through the digital print center, commonly referred to as “DPC.” These reports break down each business entity and how many requests are processed.

Each quarter representatives of IKON and the hospital hold a quality review meeting to discuss progress towards current goals, establishing new goals, reviewing cost savings from the previous quarter, volume graphs, and process improvements.

Non-core, but efficient
“In a time when most companies are completely outsourcing non-core competencies, we determined that the savings and efficiencies of bringing most printing in-house, using internal hospital resources, was the most cost-effective,” Reska said.

It ties DPC production with convenience copier output to allow management of all print impressions with the flexibility to send printing to the most appropriate cost-effective device.

Low volume reproduction is done on the convenience copiers while high volume jobs are sent to the DPC. A formal process has been set up to review every form, copy job and marketing piece to determine the most cost effective print source, whether it is outsourced or produced in-house.

The DPC features a ‘closed’ system where all jobs are produced by a centrally located dedicated internal staff. Jobs are tracked electronically and systematically scheduled for delivery to end users. Customers are happier, Reska said, and the number of STAT requests is down sharply.

“Hybrid” staffing
“We used a unique hybrid approach to manage our labor costs,” Reska explained. “The DPC is staffed by three equipment operators from our hospital and a supervisor from IKON.”

The operators were valued employees that Hartford didn’t want to lose, but the IKON supervisor has extensive knowledge of commercial printing in various industries. Even the prices of print jobs that are outsourced, such as the annual report, have been coming down, according to Reska, because the hospital shop is seen as a potential competitor. Under the contract, the hospital pays the IKON supervisor’s salary.

Reska would not say how much the hospital pays IKON for its services, citing contract confidentiality provisions, but said not all the compensation is monetary. “We’re looking to be a show site for them,” he said. “This is truly a partnership.”

There are still two years to go on the initial contract, which will expire in June 2007.

Making the rounds
Reska, Fried and Gregg Groenemann, IKON’s director of marketing, have been making the rounds of document management conferences from Coronado, Calif. to Boston, telling their story of outsourcing in a hospital setting.

“Companies often don’t realize the savings that can result from rethinking the way they manage their documents,” Groenemann said.

Hartford Hospital also invited fellow members of its group purchasing organization, VHA, Irving, Texas, to visit the DPC and learn whether it could be an option for their hospitals.

During VHA’s annual Leadership Conference in May, Hartford was the only hospital to receive the President’s Award of Excellence, a triple crown for clinical, operational and supply chain achievements.

One of the keys to success, according to Reska, was bringing in the information systems and corporate communications departments from the beginning. “Not only were they a great resource, but they also insured that the new digital equipment and on-line system integrated with the current hospital system.”
decrease in prices or demand for sutures.

Materials managers polled in this month’s HMM price survey rely mostly on group contracts for suture and other wound closure products, but some have left GPOs behind in negotiating local deals with deep discounts.

Other than Ethicon, the only vendor mentioned was the Kendall Healthcare division of Tyco Healthcare, Mansfield, Mass., and at that only for a few products. According to one industry member, “Ethicon’s on top, Tyco’s U.S. Surgical is next, and everyone else is fighting over what’s left.” For most suture types, respondents reported using a single source—Ethicon.

Replies to this month’s survey reflect the experience of about 1,100 hospitals totaling 122,000 beds.

Average annual spending on sutures among those who reported was $685 per bed, up 20.2% from the $570 per bed reported last year.

Additional data were provided by ECRI, a not-for-profit health services research agency in Plymouth Meeting, Pa. ECRI’s ongoing surveys of 400 hospitals cover a wide range of products.

From gut to polymer
Suture materials vary by their intended use. Traditional gut and silk are favored for closing skin lacerations or incisions. Nylon and polyester also appear in skin sutures.

For internal organs, such as the heart, sutures are made from polymers that remain permanently. They are coated to make them slide more easily through tissue without injuring it. As engineered products made from other than natural substances, polymers are generally more expensive.

Steel is used to suture bones together, such as when the sternum is closed following heart surgery. An example is Ethicon’s M655G size 7-0 steel suture, priced at $14.04 on average.

Size, construction matter
Sutures also are distinguished by their construction. Monofilament is of a single piece, like fishing wire. Multi-filament is several strands braided together like sewing thread. It is more flexible than monofilament and easier to knot.

Suture size indicates the diameter of the filament. Up to a certain level, the higher the number, the smaller the size, so that 8-0 is thinnest and 0 is widest.

However, another scale beginning with 0 and numbered with single digits (0, 1, 2, 3, and so on) indicates progressively wider diameters; on this scale, 3 is larger than 2.

Gluing alternative to sewing
Tissue sealant is the latest development in wound closure, and its use is increasing gradually, but it has not yet made a significant impact in the industry.

For those who reported annual spending on advanced products, the average was about $1,400 per bed. That is double the average amount per bed for suture. However, like cardiology devices and other high-priced products, the use of sealants is very unevenly distributed among patients.

Doctors, apparently, are still reaching for the suture in most cases.

Leading products are the surgical glue Dermabond, and its next generation, Liquiderm. Both are made by Closure Medical Corp., Raleigh, N.C. Ethicon also makes a tissue sealant, Ethibond. Several Ethibond prices were reported in the survey and are included in the table.

One materials manager reported using both Dermabond and endomechanical stapling, but said it was “difficult to analyze the suture impact.” Another indicated that the same vendor is used for both suture and advanced products. This materials manager plans to move suture business from Ethicon to other vendors next year, and said adhesive and staple purchases would follow suit.

Mergers and competition
Johnson & Johnson’s Ethicon remains the most popular suture brand, both among survey respondents and in industry reports. According to a study by Frost & Sullivan, San Antonio, Texas, Ethicon has had more than 75% of the U.S. market for the past several years.

Ethicon’s two strongest competitors, U.S. Surgical Corp., Norwalk, Conn, and Sherwood Davis & Geck, St. Louis, were acquired in 1998 by Tyco Healthcare. Sherwood had previously merged its suture business with Kendall, though the brand name lives on, as the table shows.

In October 2003, Tyco renamed the suture division Syneture, and combined suture with tissue sealant products under the same management.

Among the sealants is Indermil, first developed by U.S. Surgical and approved by the FDA in 2002. It is a cyanoacrylate monomer packaged in single-patient 5-gram ampules. When exposed to air after application to the wound it cures, or polymerizes, and seals the skin edges together.

While sutures are considered physician preference products, volume discounts provide a strong incentive for standardization with a single vendor.

(See Suture, continued on page 13)
Habit, not science

According to a memorandum by Consorta, Schaumburg, Ill., “Suture selection is mostly habit, guesswork, or tradition (used during surgical training), and not scientifically-based.”

Consorta, which did not participate in this month’s survey, has a sole-source contract with U.S. Surgical (now Syneture) that expires in 2007. It issued the memo in response to efforts by Ethicon sales reps to convince members to switch to Ethicon products.

Among respondents to the HMM survey, incentives for inking or using Ethicon contracts included volume discounts, rebates of administrative fees, and guaranteed price protection for specified periods. But most alluring for some was the willingness to drop prices across the board. One hospital reported it contracted locally for a discount of 49% of list price in return for 90% compliance.

While U.S. Surgical had no representation in this survey, it is not out of the running. Respondents named U.S. Surgical, along with several lesser players, as candidates for future deals despite their current loyalty to Ethicon.

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Consorta taps West-Com for nurse call systems

Consorta, Schaumburg, Ill., awarded an agreement for nurse call systems to West-Com Nurse Call Systems Inc., Danville, Calif.

West-Com is a supplier of patient communications systems.

The three-year deal took effect July 1, 2005. Spending and savings estimates were not disclosed.
Gainsharing: more trouble than it’s worth?

To the editor:

Here we go again: a business technique migrating to the health care industry without being adapted before it is adopted.

Gainsharing (see *HMM*, June 2005, p. 11) has the makings of adding to the already overburdened regulatory, litigious, quality degradation, misalignment and waste of more scarce health care resources, time and dollars.

Gainsharing is the latest “experiment” where selected hospitals have been approved by government agencies to offer incentives to some physicians to gain their support for limiting the use of some orthopedic and cardiovascular devices as a cost cutting strategy.

There are a couple of aspects of this gainsharing program that need to be more closely scrutinized. If physicians are seeking to supplement their deteriorating incomes by accepting or ultimately demanding such incentives, what happens to the probable majority of physicians who routinely and voluntarily collaborate with materials managers to find such opportunities?

Doesn’t this inequity set the stage for a potential dual standard of behavior for the physicians? It is only cardiac and orthopedic specialists and selected implants now, but will this model encourage other physicians to demand some incentives in other product categories?

Can you imagine the potential magnitude of such a system of incentives for gloves, dressings, IVs, surgical instruments and the thousands of other products for which physicians may express a preference or dislike? There seems to be a need to create some equity for such programs, if they survive the trial period.

Senior executives need to very carefully examine the potential scenarios of such gainsharing arrangements. If the physicians are entitled to incentives, why shouldn’t nurses, technicians, department directors, materials managers, OR supervisors or others receive the same incentives and benefits?

Such a potentially broad application of these incentive programs would probably lead to some very interesting arbitration, as hospital executives try to determine just who introduced what that led to savings, or how to split the incentives if multiple parties were involved in the savings initiative.

The government has already established an oversight function with multiple agencies officially engaged just for the trial year. You just know that no government activity ever fades away that quickly. This one-year experiment will no doubt linger for years.

Device manufacturers and their shareholders are initially moaning about the potential impact on their bottom lines. If their devices are on the wrong side of the economic incentive balance beam, it would have severe impact on their bottom lines, and on their shareholder relations.

However, their marketing strategists and lobbyists are probably already conjuring up some creative response, so they can appear to be sympathetic to the cause of controlling spiraling health care costs, while they can lower their costs of sales, enhance their profits and still not disturb the carefully nurtured relationships their reps have grown with many physicians.

Thomas MacVaugh
Vice President
Strategic Initiatives In Healthcare
Jackson, N.J.

Another point of view

The following article is adapted from comments made by Joane Goodroe, CEO of Goodroe Healthcare Solutions, Norcross, Ga., responding to an article based on MacVaugh’s views in a recent issue of the online newsletter StratCenter.com.

[The article] highlights a clear misunderstanding of the approved model, and also included some significant inaccuracies. First, the model is not a new demonstration project. Second, it is not limited to high-ticket items, and third, it does not create more waste. In fact, the approved model is focused on accomplishing just the opposite.

Following are several important considerations regarding the approved gain-sharing model:

- The HCFA Coronary Artery Bypass Demonstration Project (1998) showed that aligned economic incentives between hospitals and physicians led to better quality and dramatic decreases in overall costs.
- There is tremendous variation between physicians in the way each performs the same procedure. It is the variation in the process that reveals waste and eliminating variation provides the largest opportunity for savings.
- Physicians utilize all supplies differently. This includes more than just implants. Included in the seven approved opinions are many items the OIG categorizes as clinically insignificant (low cost items such as gloves, dressings, and IVs) as well as clinically significant items. Once again, this is an opportunity to determine best practice in the use of all supplies.
stated mission of lowering costs for hospitals.

“Of particular concern is the GPO practice of bundling products and offering rebates only for hospitals maintaining high compliance levels of purchasing within these circumscribed bundles.

“Bundling unrelated products and unrelated companies results in limiting hospitals’ and physicians’ choices, since hospitals are punished for purchasing outside of these bundles.

“In addition, these bundled arrangements prevent a highly efficient company with a clinically preferred product at a lower price from participating in the bid process simply because they cannot offer a broad product line.

“In fact, some GPO contracts are so anti-competitive that hospital customers are not even permitted to consider the purchase of more advanced and safer—and in some cases less costly—medical products. The result is that caregivers are denied access to the latest in life-saving and potentially cost-saving technology.”

HIGPA responded that “A scheme that uses the safe harbors to regulate GPOs can only needlessly add to the administrative burden and expense of health care, not only for GPOs but for suppliers, providers, payers and ultimately the patients.”

**HIGPA: Fees part of revenue**

Calling the MDMA comments “untrue,” HIGPA argued to the OIG, “First, the OIG’s audit found few instances of payments in excess of 3%.

The fees fund the costs of purchasing activities that would otherwise be borne by the hospitals.”

Besides, HIGPA added, hospitals consider distributions based on rebates of admin fees part of their revenue.

“Second,” the HIGPA statement added, “MDMA’s assertion that GPOs only sell market share to suppliers is without basis. GPOs negotiate various types of discounts and rebates that benefit their members, regardless of quantities of purchases.”

To do otherwise, HIGPA argued, would actually reduce GPO revenue because higher prices (that would in theory bring higher fees) mean reduced contract participation and fewer members for the GPO. “MDMA ignores the marketplace realities.”

The IG audit, released June 9, reviewed fee income and disposition records of three unidentified GPOs from 2001 to 2003.

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**New technology credited with boosting Novation contract spending over $23B**

Members of Novation, Irving, Texas, spent $23.7 billion on contracted supplies, equipment and drugs in 2004, a 10% increase over the $20.7 billion spent in 2003. Novation, which negotiates contracts for VHA, also in Irving, and University HealthSystem Consortium (UHC), Oak Brook, Ill., said the increase is mainly in innovative but expensive technology. Novation now has about 1,000 contracts with 700 suppliers.

In a year-end survey, 72% of materials and pharmacy managers reported Novation’s portfolio was more competitive than the overall market.

The GPO’s private label program, Novaplus, reported purchases of $1.57 billion on a variety of products such as waste can liners and patient footwear, saving an average of 9% over branded items.

Hospitals are adopting electronic commerce more rapidly as well. VHA and UHC members spent $10 billion through the Marketplace@Novation site, a 44% increase over 2003.

Meanwhile, Novation and other traditional GPOs continue to lose large hospitals and integrated delivery networks to newer groups that concentrate on local and customized contracts. MedAssets, Alpharetta, Ga., estimated that, in the past 2.5 years, it has picked up $2 billion in annual purchasing volume from Novation alone. Recruits include Scripps Health, Rush System for Health, Clarian Health Partners and North Mississippi Health Services.
Could drug prices begin stabilizing this year?

While every category of pharmaceutical index was up in the first quarter, the pace of increases has slowed since last year, especially for cardiovasculars.

The composite index for 1Q05 was 107.41, up 2.18% from the fourth quarter, and up 7.41% from a year previously. This represents an increase in the rate of growth of the indices.

Even non-cephalosporins, which posted a 10.15% 10.75% jump for the year, showed a slight moderation from the 10.75% increase recorded over the four 2004 quarters.

HMM obtains its indices from IMS Health, Plymouth Meeting, Pa. The base period for this report is the fourth quarter of 2002.

The base period is changed each quarter so that the index for one year earlier is set at 100.

System finds integration takes work, planning

One of the primary benefits of forming an integrated delivery network is cost reduction from combining operations and purchasing power. But too often, these savings are not realized because the separate components never quite learn to work together.

Such was the case at Diakon Lutheran Social Ministries, Topton, Pa., in 2004. Materials management executive Richard Benjamin brought his many years of acute-care purchasing experience to a review and overhaul of the materials management system.

Among his findings were:
- Multiple vendors for the same medical products
- No product review committee or process in place.
  “Contract management was a bit vague,” Benjamin reported to Lutheran management, “and there seems to be a general lack of databases for service contracts, leases and rental agreements.” The system used a combination of local contracts and contracts from the portfolio of AllHealth, Blue Bell, Pa.

Benjamin developed the following recommendations for Lutheran, or any IDN seeking to reap the benefits of integration:
- Educate staff on the value of materials management and group purchasing components
- Limit the number of people who can engage in procurement and contractual activities
- Establish a centralized procurement system with purchase requisitions, purchase orders and invoice matching functions at one location
- Create a Products Review Committee, conduct regular meetings and review current and proposed products
- Identify preferred vendors and develop long-term relationships that are mutually beneficial
- Develop standards for equipment, products and services and distribute them to all facilities
- Utilize group purchasing contracts
- Create and share databases for service contracts, leases, rental agreements, copiers, cell phones, vehicles and pagers.
May PPI up slightly for med-surg products

**Detailed Producer Price Index**

The Finished Goods segment of the Producer Price Index (PPI) for May was 154.1, the same as in April.

For the selected medical-surgical products, the average index change between April and May was +0.2%.

The average annual change was +0.7%. The highest monthly increase was 1.4% for diagnostic apparatus, and none of the selected categories declined during the month. Three were unchanged.

### Detailed Consumer Price Index: Medical Care Commodities

The unadjusted medical care commodities component of the Consumer Price Index for May was 274.6, up 0.4% from April and 2.0% higher than it was one year before.


*The index for 1982-84=100, except for non-prescription drugs and medical supplies, where the base period is December 1986. The CPI indices shown are unadjusted, which generally are more useful in calculating prices actually paid at the time of purchase.*

### Recent price surveys

- **Endoscopic instruments (June)**—Endoscopic instrument prices are continuing to rise.
- **Hip implants (May)**—Prices of hip implants are expected to rise but will stay in the realm of inflation.
- **Protective apparel (April)**—Depending on contracts, prices are expected to stay level or drop as much as 10%.
- **Syringes and needles (March)**—Prices rose modestly in 2004, but are expected to decline this year, now that hospitals have converted to safety products.
- **Stents (February)**—Stent prices will stay level in 2005, rather than continue to decline.
- **Gloves (January)**—Glove prices are expected to increase, but the extent will vary by material and use.
- **Paper (December)**—Paper prices overall will stay level or rise only slightly in 2005.
- **Foley catheters (November)**—Materials managers expect to pay more next year for certain models.
- **IV solutions (October)**—Prices of intravenous fluids are expected to begin rising in 2005.

To order copies of previous price surveys, call 1-800-328-3211 and ask for the appropriate month’s issue at $15 per copy.

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**Product category** | **Index** | **% change in month** | **% change in year**
--- | --- | --- | ---
**Medical care commodities**
May | 274.6 | + 0.4 | + 2.0
April | 273.5 | + 0.1 | + 1.9
March | 273.2 | + 0.1 | + 2.2
February | 272.8 | + 0.4 | + 2.3
January | 271.6 | + 0.3 | + 2.3
**Non-prescription drugs and medical supplies**
May | 151.4 | – 0.2 | – 0.6
April | 151.7 | + 0.3 | + 0.7
March | 151.3 | + 0.5 | + 0.0
February | 150.6 | + 0.1 | + 1.2
January | 150.4 | – 0.4 | – 1.4
**Non-prescription medical equipment and supplies**
May | 179.7 | – 0.1 | – 1.0
April | 179.8 | + 0.5 | + 1.1
March | 178.9 | + 0.8 | + 0.0
February | 177.4 | – 0 | – 2.2
January | 177.4 | – 0.5 | – 2.4
**Category** | **4Q04 Index** | **% change**
--- | --- | ---
Med-Surg Overall | 98.52 | 0.12%
Autotransfusion | 104.49 | –1.90%
Bandages & dressings | 101.03 | –0.74%
Bandages elastic | 95.56 | –1.61%
Catheters, tubules | 102.63 | –0.99%
Diagnostic, catheters | 91.99 | –3.86%
Diagnostic instruments | 100.19 | –0.20%
Electrosurgical | 103.63 | 2.68%
Endoscopy | 100.54 | 0.37%
Garments & textiles | 99.86 | 1.31%
Gloves | 95.39 | –0.70%
Orthopedic | 102.62 | 0.82%
Paper | 102.73 | –0.77%
Respiratory therapy | 97.60 | –0.17%
Solutions/delivery | 94.11 | –1.46%
Sponges | 95.67 | 0.76%
Surgical instruments | 106.80 | 7.11%
Surgical packs | 98.08 | 0.17%
Syringes & needles | 100.74 | 0.04%
Urological | 100.41 | 0.31%
Wound closures | 102.41 | 0.18%
X-ray | 97.17 | 1.07%
**Prescription drugs and medical supplies**
May | 274.6 | + 0.4 | + 2.0
April | 273.5 | + 0.1 | + 1.9
March | 273.2 | + 0.1 | + 2.2
February | 272.8 | + 0.4 | + 2.3
January | 271.6 | + 0.3 | + 2.3
**Prescription medical equipment and supplies**
May | 151.4 | – 0.2 | – 0.6
April | 151.7 | + 0.3 | + 0.7
March | 151.3 | + 0.5 | + 0.0
February | 150.6 | + 0.1 | + 1.2
January | 150.4 | – 0.4 | – 1.4
**Source:** IMS Health
People on the move
LeAnn R. Born was appointed vice president of contract and program services at Novation, Irving, Texas, effective April 18. Prior to joining Novation, Born worked for 12 years at Allina Hospitals & Clinics, Minneapolis. Most recently, she served as interim vice president of supply chain. She served in other corporate roles as director of material operations, resource manager, and standardization consultant, and in operational roles as clinic manager in the Allina Medical Clinic, and as administrative fellow and interim director of materials management at Abbott-Northwestern Hospital, Minneapolis, 958 beds.

Daphne Bobbitt has been named a buyer at Franklin Square Hospital Center, Baltimore, 391 beds. She previously was a buyer at Greater Baltimore Medical Center, Towson, Md., 330 beds.

Robert Parolisi and Lucinda Garwood recently left their positions as contract specialists at University of Virginia Medical Center, Charlottesville, Va., 638 beds. The hospital is seeking candidates to fill those posts.

Mark Miriani was promoted to senior vice president of contracts and member services at MedAssets, Alpharetta, Ga., effective Aug. 1. He will succeed Gene Banner, who will retire on that date. Miriani came to MedAssets when it acquired Health Services Corp. of America (HSCA), Cape Girardeau, Mo., where he was vice president of materials management.

Laura Webb (Mullins) resigned as manager of corporate purchasing at Aurora Healthcare, Milwaukee. Aurora is seeking candidates for the vacant position (see page 5).

Positions available
Bayhealth Medical Center, Dover, Del., 211 beds, is seeking a surgical material services manager and a warehouse distribution services manager. Contact Robin Roberts, Human Resources Dept., phone 866-305-5627 or fax resume to 866-866-6442.

University of Virginia Health System, Charlottesville, Va., 632 beds, is seeking two contract specialists and a supervisor of medical center accounts payable. Apply online at www.healthsystem.virginia.edu/internet/humanresources.

Parkland Health and Hospital System, Dallas, 987 beds, is seeking a director of value analysis. Contact Yolanda Roach, fax 214-590-6918.

Cooperative Services of Florida, Ft. Myers, Fla., is seeking a contract negotiator for pharmacy and other therapeutic and diagnostic supplies. Contact William Tousey at 239-303-3458 or fax resume to 239-303-0754.

Barlow Respiratory Hospital, Los Angeles, is seeking a purchasing assistant. Contact Judy Meister, Barlow Respiratory Hospital, 2000 Stadium Way, Los Angeles, CA 90026 or e-mail jmeister@barlow2000.org.

Kaiser Permanente, Oakland, Calif., is seeking a materials cost specialist for its Redwood City, Calif. facility. Fax resume to 408-342-6690 or e-mail tessa.r.guerrero@kp.org. Reference code RW.0500028.

Childrens Hospital Los Angeles, 330 beds, is seeking a supervisor of supply processing and distribution. Contact Childrens Hospital Los Angeles, 4650 Sunset Blvd., Mail Stop #87, Los Angeles, CA, 90027. Phone 323-669-2159. Fax 323-663-1645.

Triumph HealthCare, Houston, is seeking a manager of materials management for one of its long-term acute-care hospitals. Contact Triumph Hospital Clear Lake, 350 Blossom St., Webster, TX, 77598. Phone 713-807-8686.


Broadlane, Dallas, is seeking an expeditor for an outsourced materials management department in Cincinnati. Fax resume to 972-813-8439.

Roanoke-Chowan Hospital, Ahoskie, N.C., 124 beds, is seeking a director of support services with responsibility for materials management. Contact Roy Lewis at 252-209-3263. Fax 252-209-3252.

Pine Creek Medical Center, Dallas, is seeking a materials manager. This new acute-care hospital opened in March.

Christiana Care Health Services, Newark, Del., 1,000 beds, is seeking a logistics manager. Fax cover letter and resume to S. Ellsworth at 302-623-0324 or apply online at www.christianacare.org.

Marian Community Hospital, Carbondale, Pa., 112 beds, is seeking a director of materials management. In July,
Marian became a member of Catholic Health East, Newtown Square, Pa., through its membership in Maxis Health System. Contact Marian Community Hospital, 100 Lincoln Ave., Carbondale, PA 18407. Phone: 570-281-1000.

Los Gatos Surgical Center, Los Gatos, Calif., is seeking a materials/facility manager responsible for purchasing, inventory and storage of equipment and supplies. Fax resume to Kathleen O’Connor at 408-358-3924.

La Rabida Children’s Hospital, Chicago, 77 beds, is seeking a materials manager. Fax resume to 773-363-7905.

South Texas Health System, McAllen, Texas, is seeking an assistant director of materials management. Fax resume to 956-388-2450.

Methodist Hospital of Southern California, San Gabriel, Calif., 274 beds, is seeking an OR materials coordinator. Fax resume to Christina Trejo at 626-446-1709.

Cirrus Health, Beverly Hills, Calif., is seeking a surgical technologist/materials manager. Fax resume to 817-837-1105.

Regency Hospital Co., Covington, La., is seeking a materials management assistant. Contact Leigh Venturella at 985-867-3978; fax 985-867-3976.

Medbuy Corp., London, Ontario, is seeking a director of pharmacy contract development. Contact M. Peers, Medbuy Corp., 4056 Meadowbrook Drive, Unit 135, London, Ontario N6L 1E4, Canada. Phone 519-652-1688; Fax 519-652-2788. Email: mpeers@medbuy.ca.

Temple University Hospital, Philadelphia, 514 beds, is seeking a support services coordinator; to be responsible for purchasing equipment and supplies for nursing units. Contact Temple University Hospital, 3401 N Broad St., Philadelphia, PA 19140. Phone 215-707-2000. Fax 215-221-2775.

Kaweah Delta Health Care District, Visalia, Calif., 501 beds, is seeking a supervisor of laundry services. Contact Human Resources, Kaweah Delta Health Care District, 400 West Mineral King Ave., Visalia, CA 95291. E-mail myresume@kdhcd.org.

VHA, Irving, Texas, is seeking a materials manager with expertise in sterile processing to work with members in the North Carolina area. Apply online at www.vha.com.

Alta Bates Summit Medical Center, San Francisco, 1,082 beds, has three openings in distribution and materials management. It is seeking distribution technicians in logistics and materials management, and an administrative assistant responsible for materials management in the emergency department. Contact Human Resources, Sutter Health, 3012 Summit St. 3rd Floor, Oakland, CA 94609. Phone 510-869-6800, Fax 510-869-8258.

Chandler Regional Hospital, Chandler, Ariz., 138 beds, is seeking a materials manager. E-mail resume to jperna@chw.edu.

The Catholic Healthcare Initiatives national office in Tacoma, Wash., is seeking a purchasing assistant to provide support for buyers and contract administrators. Contact Tracie Grant, Human Resources Manager, Catholic Health Initiatives, 1999 Broadway, Suite 2600, Denver, CO 80202. Phone 303-383-2792; Fax 303-383-2695.

Centura Health, Englewood, Colo., is seeking an assistant vice president of value analysis. Contact Human Resources, Centura Health, 5570 DTC Parkway, Englewood, CO 80111.

St. Joseph Medical Center, Towson, Md., 460 beds, is seeking a director of materials management and a clinical resource manager for materials management. Contact Ann T. Bures, Employment Manager, St. Joseph Medical Center, 7601 Osler Drive, Towson, MD 21204. Phone 410-337-1447; Fax 410-337-1203.

Kaiser Permanente, Oakland, Calif., has 12 openings for materials management specialists in its California hospitals. These positions include material services coordinator, materials specialist, sterile processing supervisor, storekeeper and warehouse specialist. For information visit www.kaiserpermanentejobs.org.

Moving on? Need help?
To place an announcement in Job Mart/People, call editor Paula DeJohn at 303-967-0136, or fax information to 303-290-9025.