New disease codes, p. 10
Pressure from all sides of the healthcare industry is causing the Department of Health and Human Services and its Centers for Medicare & Medicaid Services division to change the way the government pays hospitals for treatment. The change also would make it easier to account for new technology in supplies and devices.

Boosting their image, p. 10
Tufts-New England Medical Center in Boston agreed to purchase an image-guided radiation therapy system, a CT simulator, and related services from American Shared Hospital Services in San Francisco.

Pacemaker alternative, p. 11
A team of researchers at Children’s Hospital Boston, the pediatric teaching hospital of Harvard Medical School, has replicated tissue that can conduct the electricity needed to pump the heart.

Group purchasing coop, p. 12
Following the path of a highly successful New York-based alliance, the Illinois Hospital Association in Naperville, IL, has formed a group purchasing cooperative for its 200 members.

PHYSICIAN PREFERENCE
Growing popularity of gainsharing brings pushback from manufacturers

by Paula Defohn

A battle is brewing between docs and manufacturers over gainsharing.

A study shows that the concept of sharing savings from standardization of medical devices is gaining popularity with doctors, but manufacturers are not quietly accepting the erosion of their long-held influence with physicians.

Although the study was published in October 2005, the issue is still emerging.

Splitting the difference

In a gainsharing arrangement, hospitals standardize their use of various devices to negotiate lower prices with manufacturers, and then split the first-year savings with participating physicians.

So far, the Department of Health and Human Services (HHS) has approved gainsharing arrangements on a case-by-case basis, but support is growing at HHS and in Congress for a wider application of the concept.

(See Physician preference, continued on p. 2)

PRICE SURVEY
Expect price hikes for scrubs

Protective apparel prices will be heading up in 2007, according to nearly 30% of materials managers who responded to this month’s HMM price survey. The other 70% are confident that there will be no change in the coming year.

Most respondents reported that prices were unchanged overall during 2005, but about 25% saw increases. According to their survey responses for selected products, however, price changes were minimal.

This month’s survey information comes from groups, integrated delivery networks (IDN), and hospitals that represent approximately 4,900 hospitals with a total of 823,000 beds. ECRI, a not-for-profit health services research agency in Plymouth Meeting, PA, provided additional data. ECRI’s ongoing surveys of 400 hospitals cover a wide range of products.

Annual spending on surgical gowns and related medical textiles averaged $285 per bed, down 44% since last year, when the average spending was $509 per bed.

The increase may be in part because of a return to reusables, which have a higher price up front but which some hospitals believe are more economical in the long run.

(See Price survey, continued on p. 3)
Market Strategies, Inc. (MSI), a consulting firm in Livonia, MI, polled cardiovascular physicians and senior hospital administrators, some of whom currently participate in gainsharing arrangements.

Physicians and hospital administrators—especially those currently participating in the arrangements—are firm believers in gainsharing, but medical device manufacturers voiced opposition, claiming that gainsharing will limit access to the latest innovations and advances in medical technology.

According to the MSI study, gainsharing can result in lower average selling prices for devices.

However, from the suppliers’ viewpoint, this will bring increased market share to a few chosen companies, leaving out the smaller or pricier competitors.

Newer technology left behind

According to Mark Leahey, executive director of the Medical Device Manufacturers Association in Washington, DC, whose members tend to be smaller manufacturers that develop new products, dominant suppliers would likely become entrenched.

“People also have to look away from the short term,” Leahey said in the MSI report. “In the long term, gainsharing will lead to more consolidation within the industry, and the dominant suppliers will be able to control the cost of products. Industry consolidation is not good for the pipeline or for pricing.”

AdvaMed, another manufacturer group in Washington, DC, which represents larger companies, is also opposed to gainsharing.

“Even with regard to products developed by large companies, gainsharing is a threat to medical progress,” said Stephen J. Ubl, president of AdvaMed, in a news release. He said gainsharing penalizes physicians who are early adopters.

Not all doctors love it, either

The MSI study also notes that physicians who do not participate in gainsharing are more suspicious of the practice. Many are concerned that such an agreement will require them to use less costly devices that will ultimately result in compromised patient care.

Joane H. Goodroe, CEO of Goodroe Healthcare Solutions in Norcross, GA, developed the only gain-sharing model that the Office of Inspector General has approved.

Quoted in the MSI report, Goodroe said she understands the manufacturers’ concerns, but believes that comprehending how the program works would alleviate those concerns.

Many physicians and device manufacturers do not have a complete understanding of how current gain-sharing programs work, Goodroe said. “Physicians should be the engineers of these arrangements.”

Physicians who participate in gainsharing say they still have choices about the devices that they use, according to the MSI study.

It is only when physicians consider certain devices as interchangeable that they are willing to use less costly devices.

However, Leahey says if the products were truly interchangeable, doctors would make that choice on their own, without financial incentives.
About 40% of respondents said they now favor reusables, but disposables still have their fans. “They eliminate laundering and distribution costs,” one respondent explained.

Custom packs affect pricing
Another variable that affects average prices and changes for scrubs is that hospitals do not always purchase them alone, but rather as part of surgical packs and kits.

Typically, the packs carry a single price that covers all items, and hospitals purchase them from a third party that assembles them from items that it obtains from manufacturers. Thus, bundled pack prices may hide the individual scrub prices.

On average, the hospitals in this survey that replied to a question about custom packs reported deriving 30% of their surgical scrubs and gowns from packs.

The cost of surgical gowns is related both to the level of protection that their material affords and to their useful life. In recent years, impermeability has become a more pressing issue. Better protection tends to mean higher pricing.

New labels reflect protection factor
One vendor has begun using color-coded labels to help surgeons select gowns and scrubs based on their barrier levels. In June, Cardinal Health in Dublin, OH, began modifying the way it packages and marks its Convertors® surgical gowns to reflect standards established by the Association for the Advancement of Medical Instrumentation (AAMI).

The company adopted a color-coded system on its packaging and added latex-free stickers on each gown that indicate its type, size, and AAMI level.

In 2004, the AAMI issued a standard to address the liquid barrier performance of protective apparel and drapes used in healthcare facilities.

AAMI PB70 classifies gowns by levels 1 through 4, with level 4 indicating the highest rating that offers impervious protection. The level of barrier protection needed depends on the potential for exposure to blood, body fluid, and other potentially infectious materials.

Cardinal Health’s color-coding system corresponds to these classifications: Green indicates level 1, orange indicates level 2, blue indicates level 3, and purple indicates level 4.

The company did not disclose any projected price changes related to the improved packaging.

Who pays?
Another price factor for hospitals is who pays for the apparel.

In a cost-cutting effort that began several years ago, many hospitals require employees to purchase their own scrubs, especially those worn outside of the operating room.

Hospitals in this month’s survey reported various policies for furnishing protective apparel to clinicians. Some pay only for sterile procedure apparel, but ask employees to buy their own lab coats and other garments. One hospital says it limits clinicians to two hospital-paid outfits per year.

Although the survey concentrated on surgical protective apparel, contracts tend to cover these items along with various other textiles (e.g., patient gowns, exam gowns, and bed sheets). The table on pp. 4–5 includes some of those prices.

Choice of vendors
The big three in hospital apparel and textiles are Kimberly-Clark in Norcross, GA; Medline in Mundelein, IL; and Cardinal Health. Others fill niche markets or compete as alternative sources.

In this month’s survey, respondents also report using the following suppliers:
- Davol, a division of C.R. Bard in Murray Hill, NJ
- Sage Products in Cary, IL
- Standard Textile in Cincinnati

Group contracts are plentiful, and they are usually multisource.

However, tier pricing and rebates can motivate hospitals to standardize on one supplier. Meanwhile, about 40%—a relatively large proportion—of this month’s respondents represent hospitals or IDNs that have negotiated their own contracts.

Terms range from three to five years. Among the incentives are administrative fees—both for groups and IDNs—and technical support (e.g., software programs). Others are rebates, volume discounts, and in one case, a 10% bonus for converting from another vendor.
## Protective apparel

Average protective apparel prices are listed below, given in the price per unit. Prices from ECRI are listed in a separate column to the right.

<table>
<thead>
<tr>
<th>Product no.</th>
<th>Description</th>
<th>2006 price</th>
<th>2005 price</th>
<th>% change</th>
<th>2006 ECRI</th>
<th>2005 ECRI</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1255</td>
<td>Venturi mask</td>
<td>$1.52</td>
<td>–</td>
<td>–</td>
<td>$2.07</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>2474</td>
<td>Gown, breathable impervious (ca 20)</td>
<td>4.48</td>
<td>4.56</td>
<td>–1.7%</td>
<td>3.05</td>
<td>4.61</td>
<td>–33.9%</td>
</tr>
<tr>
<td>2475</td>
<td>Gown, Optima X-large impervious</td>
<td>3.45</td>
<td>3.42</td>
<td>+1.0%</td>
<td>3.54</td>
<td>3.68</td>
<td>–3.8%</td>
</tr>
<tr>
<td>4852</td>
<td>Shoe cover, Dura Fit (pair)</td>
<td>0.22</td>
<td>–</td>
<td>–</td>
<td>0.12</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>9041</td>
<td>Surgical gown, X-large</td>
<td>5.65</td>
<td>–</td>
<td>–</td>
<td>3.14</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>9575</td>
<td>Surg gown, Optima X-large disposable</td>
<td>3.30</td>
<td>3.31</td>
<td>–0.4%</td>
<td>3.44</td>
<td>3.79</td>
<td>–9.2%</td>
</tr>
<tr>
<td>19010</td>
<td>Essentials surg gown, impervious</td>
<td>2.52</td>
<td>2.27</td>
<td>+10.9%</td>
<td>–</td>
<td>4.86</td>
<td>–</td>
</tr>
<tr>
<td>19349</td>
<td>Bed sheet, 3/4 sterile latex-free</td>
<td>1.53</td>
<td>1.61</td>
<td>–4.8%</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>19350</td>
<td>Bed sheet, reinforced 3/4 latex-free</td>
<td>2.28</td>
<td>2.20</td>
<td>+3.4%</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>19545</td>
<td>Essentials surg gown, large latex-free</td>
<td>2.25</td>
<td>2.37</td>
<td>–5.2%</td>
<td>–</td>
<td>–</td>
<td>–</td>
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<tr>
<td>39575</td>
<td>Trimax surgical gown disposable</td>
<td>4.18</td>
<td>4.32</td>
<td>–3.2%</td>
<td>4.24</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>46851</td>
<td>Crossover shirt</td>
<td>5.59</td>
<td>5.39</td>
<td>+3.7%</td>
<td>–</td>
<td>–</td>
<td>–</td>
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<tr>
<td>46856</td>
<td>V-neck tunic</td>
<td>4.86</td>
<td>4.86</td>
<td>0</td>
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<td>–</td>
<td>–</td>
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<tr>
<td>46857</td>
<td>Scrub pants</td>
<td>5.39</td>
<td>5.39</td>
<td>0</td>
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<td>–</td>
<td>–</td>
</tr>
<tr>
<td>46858</td>
<td>Scrub pants</td>
<td>5.25</td>
<td>5.72</td>
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<td>–</td>
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<tr>
<td>1200CV</td>
<td>Coverall, blue</td>
<td>1.85</td>
<td>–</td>
<td>–</td>
<td>1.59</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>9571CE</td>
<td>Surg gown sterile latex-free</td>
<td>3.82</td>
<td>4.20</td>
<td>–9.1%</td>
<td>3.61</td>
<td>5.64</td>
<td>–36.0%</td>
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<tr>
<td>AT4453</td>
<td>Isolation gown</td>
<td>0.92</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>AT73035</td>
<td>Surgical mask, sensitive</td>
<td>0.54</td>
<td>–</td>
<td>–</td>
<td>0.65</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>DC3764</td>
<td>Splash shield</td>
<td>16.10</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>10065</td>
<td>Extra protection coverall</td>
<td>2.47</td>
<td>2.49</td>
<td>–0.7%</td>
<td>–</td>
<td>2.53</td>
<td>–</td>
</tr>
<tr>
<td>69025</td>
<td>Disposable patient gown</td>
<td>1.66</td>
<td>2.03</td>
<td>–18.1%</td>
<td>1.74</td>
<td>2.03</td>
<td>–14.1%</td>
</tr>
<tr>
<td>69600</td>
<td>Comfort gown</td>
<td>0.99</td>
<td>1.00</td>
<td>–1.7%</td>
<td>1.00</td>
<td>1.24</td>
<td>–19.5%</td>
</tr>
<tr>
<td>75631</td>
<td>Protective coverall</td>
<td>2.29</td>
<td>2.30</td>
<td>–0.6%</td>
<td>–</td>
<td>2.54</td>
<td>–</td>
</tr>
<tr>
<td>95121</td>
<td>Sterile Ultra gown</td>
<td>2.85</td>
<td>2.66</td>
<td>+7.5%</td>
<td>2.82</td>
<td>2.94</td>
<td>–4.2%</td>
</tr>
<tr>
<td>95211</td>
<td>Impervious large</td>
<td>2.99</td>
<td>2.79</td>
<td>+7.5%</td>
<td>3.02</td>
<td>3.00</td>
<td>+0.6%</td>
</tr>
<tr>
<td>95421</td>
<td>Impervious specialty</td>
<td>4.05</td>
<td>4.02</td>
<td>+0.8%</td>
<td>3.90</td>
<td>4.20</td>
<td>–7.2%</td>
</tr>
<tr>
<td>95521</td>
<td>Impervious specialty</td>
<td>4.50</td>
<td>3.91</td>
<td>+15.1%</td>
<td>4.54</td>
<td>4.28</td>
<td>+6.0%</td>
</tr>
<tr>
<td>600NTH4XL-CM</td>
<td>Reversible scrub pant, med blue</td>
<td>7.82</td>
<td>7.72</td>
<td>+1.2%</td>
<td>6.73</td>
<td>6.54</td>
<td>+2.9%</td>
</tr>
<tr>
<td>600NTJL-CM</td>
<td>Reversible scrub pant, med jade</td>
<td>7.25</td>
<td>5.83</td>
<td>+24.3%</td>
<td>6.20</td>
<td>6.16</td>
<td>+0.6%</td>
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<tr>
<td>610NTH4XL-CM</td>
<td>Reversible scrub top, blue</td>
<td>6.88</td>
<td>6.64</td>
<td>+3.5%</td>
<td>7.61</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>61NTJM-CM</td>
<td>Reversible scrub top, jade</td>
<td>3.94</td>
<td>3.94</td>
<td>0</td>
<td>5.11</td>
<td>–</td>
<td>–</td>
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<tr>
<td>700PTJL-CM</td>
<td>Linen scrub pant, unisex drawstring</td>
<td>4.70</td>
<td>4.61</td>
<td>+1.8%</td>
<td>4.31</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>720PRYXXL-CM</td>
<td>Scrub top, royal</td>
<td>5.44</td>
<td>5.73</td>
<td>–5.1%</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>720PTJL-CM</td>
<td>Linen scrub top, large reusable jade</td>
<td>3.95</td>
<td>4.40</td>
<td>–10.3%</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>750PHM</td>
<td>Staff jacket, med cardigan</td>
<td>8.14</td>
<td>8.92</td>
<td>–8.8%</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>849NTHL</td>
<td>Warmup jacket polyester/cotton knit</td>
<td>9.79</td>
<td>7.48</td>
<td>+30.9%</td>
<td>7.10</td>
<td>–</td>
<td>–</td>
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## Protective Apparel (cont.)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Price 1</th>
<th>Price 2</th>
<th>Price 3</th>
<th>Price 4</th>
<th>Price 5</th>
<th>Price 6</th>
<th>Price 7</th>
<th>Price 8</th>
</tr>
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<tbody>
<tr>
<td>MDT011088L</td>
<td>Patient pant cotton/polyester</td>
<td>$3.11</td>
<td>$3.11</td>
<td>$0</td>
<td>$4.21</td>
<td>-</td>
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<tr>
<td>MDT0110GRPS2</td>
<td>Scrub shirt unisex, med v-neck</td>
<td>$8.25</td>
<td>$8.25</td>
<td>$0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDT011119</td>
<td>Patient gown cotton/polyester adult</td>
<td>$3.23</td>
<td>$3.08</td>
<td>+ 4.8%</td>
<td>$3.30</td>
<td>$4.28</td>
<td>- 22.9%</td>
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<td></td>
</tr>
<tr>
<td>MDT011147XXZ</td>
<td>Patient gown, oversize adult tie side</td>
<td>$6.48</td>
<td>$7.73</td>
<td>- 16.2%</td>
<td>$7.59</td>
<td>$7.51</td>
<td>+ 1.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDT011207</td>
<td>Isolation gown, fluid-resistant</td>
<td>$10.50</td>
<td>-</td>
<td>-</td>
<td>$8.40</td>
<td>-</td>
<td>-</td>
<td></td>
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<tr>
<td>MDT011262L</td>
<td>Flame-Fighter brushed flannel pediatric gown</td>
<td>$5.73</td>
<td>$7.01</td>
<td>- 18.3%</td>
<td>$6.33</td>
<td>$6.12</td>
<td>+ 3.4%</td>
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<tr>
<td>MDT011269</td>
<td>Teen patient gown, polyester</td>
<td>$4.73</td>
<td>$5.20</td>
<td>- 9.0%</td>
<td>$5.13</td>
<td>$5.87</td>
<td>- 12.7%</td>
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<tr>
<td>MDT012062XL</td>
<td>Surgeon's gown, extra-large</td>
<td>$16.64</td>
<td>-</td>
<td>-</td>
<td>$17.07</td>
<td>-</td>
<td>-</td>
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<tr>
<td>MDT012796XXL</td>
<td>Scrub pant elastic waist</td>
<td>$10.29</td>
<td>$10.29</td>
<td>$0</td>
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<td>-</td>
<td>-</td>
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<tr>
<td>MDT021847</td>
<td>IV telemetry gown</td>
<td>$3.86</td>
<td>-</td>
<td>-</td>
<td>$4.92</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDT042644M</td>
<td>Tunic shirt elite, med criss-cross</td>
<td>$10.78</td>
<td>$10.78</td>
<td>$0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDT042812L</td>
<td>Pant unisex elite, lg</td>
<td>$10.19</td>
<td>$10.19</td>
<td>$0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDT042982S</td>
<td>Tunic shirt elite, sm</td>
<td>$9.24</td>
<td>$9.24</td>
<td>$0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDT2112551</td>
<td>Baby slipover torso shirt</td>
<td>$0.99</td>
<td>$1.08</td>
<td>- 8.2%</td>
<td>$0.99</td>
<td>$0.95</td>
<td>+ 3.9%</td>
<td></td>
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<tr>
<td>MDT2112552</td>
<td>Patient shirt, 0–6 month slipover</td>
<td>$1.12</td>
<td>$1.28</td>
<td>- 12.8%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
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<tr>
<td>MDT2112571</td>
<td>Baby slipover torso shirt, 3 months</td>
<td>$1.66</td>
<td>$1.66</td>
<td>$0</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>MDT211396Z</td>
<td>Incontinence diaper, cotton, 27 in.</td>
<td>$0.95</td>
<td>$0.95</td>
<td>- 0.2%</td>
<td>$0.91</td>
<td>-</td>
<td>-</td>
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<td>MDT211398R</td>
<td>Incontinence diaper, cotton, 16.5 in.</td>
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<td>-</td>
<td>-</td>
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<tr>
<td>MDT211460B</td>
<td>Baby blanket, cotton, 40 in. x 30 in.</td>
<td>$0.99</td>
<td>$0.99</td>
<td>$0</td>
<td>$0.82</td>
<td>$0.96</td>
<td>- 14.6%</td>
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<tr>
<td>MDT217296R</td>
<td>Wash cloth, cotton</td>
<td>$0.10</td>
<td>$0.10</td>
<td>$0</td>
<td>-</td>
<td>$0.12</td>
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<td>MDT217335Z</td>
<td>Hand towel, cotton</td>
<td>$0.89</td>
<td>$0.89</td>
<td>$0</td>
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<tr>
<td>MDT217350</td>
<td>Bath mat, cotton, extra-heavy, 6.5 lb.</td>
<td>$3.06</td>
<td>$3.06</td>
<td>$0</td>
<td>-</td>
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</tr>
<tr>
<td>MDT218132</td>
<td>Bath blanket, 72 in. x 90 in.</td>
<td>$4.83</td>
<td>-</td>
<td>-</td>
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<tr>
<td>MDT218147WHI</td>
<td>Bath blanket flannel, 100 in.</td>
<td>$8.18</td>
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<td>$0</td>
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<tr>
<td>MDT218160</td>
<td>Bedspread, 90 in.</td>
<td>$14.52</td>
<td>$14.52</td>
<td>$0</td>
<td>-</td>
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<tr>
<td>MDT218240</td>
<td>Bath blanket</td>
<td>$3.83</td>
<td>-</td>
<td>-</td>
<td>$3.82</td>
<td>-</td>
<td>-</td>
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<tr>
<td>MDT218665</td>
<td>Flat sheet, 60 in. x 110 in.</td>
<td>$4.74</td>
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<td>-</td>
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<td>-</td>
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<td></td>
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<tr>
<td>MDT2184064</td>
<td>Restraint vest, Koolnit, large</td>
<td>$17.89</td>
<td>$18.72</td>
<td>- 4.4%</td>
<td>$17.78</td>
<td>-</td>
<td>-</td>
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<tr>
<td>MSC214000</td>
<td>Sahara underpad, 34 in. x 36.2 in.</td>
<td>$9.44</td>
<td>-</td>
<td>-</td>
<td>$9.03</td>
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<tr>
<td>NON24245</td>
<td>Patient gown polyester, disposable</td>
<td>$0.37</td>
<td>$0.36</td>
<td>+ 1.8%</td>
<td>$0.45</td>
<td>-</td>
<td>-</td>
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<tr>
<td>NON27114</td>
<td>Isolation gown impervious, latex-free</td>
<td>$1.04</td>
<td>$0.98</td>
<td>+ 6.6%</td>
<td>$1.34</td>
<td>$0.92</td>
<td>+ 45.4%</td>
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<tr>
<td>NON27143</td>
<td>Boot cover, Hi Guard</td>
<td>$0.47</td>
<td>$0.39</td>
<td>+ 20.0%</td>
<td>$0.51</td>
<td>$0.58</td>
<td>- 12.1%</td>
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### Sage Products

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<tr>
<th>Code</th>
<th>Description</th>
<th>Price 1</th>
<th>Price 2</th>
<th>Price 3</th>
<th>Price 4</th>
<th>Price 5</th>
<th>Price 6</th>
<th>Price 7</th>
<th>Price 8</th>
</tr>
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<tbody>
<tr>
<td>7855</td>
<td>Wash cloth, medium weight</td>
<td>$0.24</td>
<td>-</td>
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<td>$0.24</td>
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<tr>
<td>7987</td>
<td>Wash cloth, standard</td>
<td>$0.22</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
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<tr>
<td>8576</td>
<td>Isolation gown, latex-free, disposable</td>
<td>$0.87</td>
<td>-</td>
<td>-</td>
<td>$0.78</td>
<td>-</td>
<td>-</td>
<td></td>
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### Standard Textile

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Price 1</th>
<th>Price 2</th>
<th>Price 3</th>
<th>Price 4</th>
<th>Price 5</th>
<th>Price 6</th>
<th>Price 7</th>
<th>Price 8</th>
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</thead>
<tbody>
<tr>
<td>8501</td>
<td>Cargo pant</td>
<td>$14.01</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
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<tr>
<td>7250422</td>
<td>Stretcher sheet</td>
<td>$5.99</td>
<td>-</td>
<td>-</td>
<td>$5.45</td>
<td>-</td>
<td>-</td>
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<tr>
<td>93177100</td>
<td>Disposable pillow</td>
<td>$2.59</td>
<td>-</td>
<td>-</td>
<td>$2.64</td>
<td>-</td>
<td>-</td>
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<tr>
<td>97652100</td>
<td>Terry robe</td>
<td>$26.41</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>8219BGP</td>
<td>Large top</td>
<td>$15.00</td>
<td>-</td>
<td>-</td>
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<tr>
<td>8320RPP</td>
<td>Large pants</td>
<td>$15.00</td>
<td>-</td>
<td>14.16</td>
<td>-</td>
<td>-</td>
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</tbody>
</table>

**Average change:** 0 – 6.3%
The overall pharmaceutical index was 104.21 in the first quarter of 2006, showing an increase of 3.09% from the previous quarter, and 4.21% from one year previously.

The “cephalosporins and related” category rose sharply by 12.62% to 111.64 from 99.13 in the fourth quarter of 2005.

For the year, this category again took the lead with an index increase of 11.64%.

Cardiovasculars up just 1%

Given the higher increases in other categories, the cardiovascular index was relatively stable during the first quarter of 2006, rising just 1%. Over the year, it rose 2.98%.

The psychotherapeutics increase was even higher, at 3.10% for the year.

Non-cephalosporins, with an index of 102.49, rose 1.11% for the quarter and 2.49% for the year.

HMM obtains its indices from IMS Health in Plymouth Meeting, PA. The base period for this report is the fourth quarter of 2004.

IMS changes the base period each quarter and sets the index for one year earlier at 100.
Materials managers are used to paying for supplies. But there is also a revenue side to the process, as patients or third-party payers will receive a bill for many—but not all—of the supplies used in a procedure.

Coding and billing specialists are beginning to turn to materials management for help in establishing guidelines for when and how much to charge for the supplies that patients use.

**Briefings on Ambulatory Payment Classifications**, an HCPro, Inc., publication, spoke with a pair of financial experts who recommend setting hospital-wide policies for the billing of supplies, with the help of materials management.

All providers should draft a policy to justify how they bill supplies, say **Keith Siddel, MBA**, president and CEO of HRM, a consulting firm in Creede, CO, and **John Settlemyer, MBA**, director of financial services and charge description master (CDM) for 843-bed Carolinas Healthcare System in Charlotte, NC.

“In today’s world, you have to be able to justify your charges,” Siddel says. “There’s a lot of gray area and a lot of discretionary decisions to make, but the more comprehensive your policy is, the better. If you can’t explain where your charges are coming from, sooner or later you’ll have some problems.”

Creating a supplies policy is beneficial, even though the Centers for Medicare & Medicaid Services (CMS) has no definitive, all-inclusive list, Settlemyer adds.

**Know what supplies you can charge for**

The following are guidelines for developing a supplies policy and ensuring that you properly bill for them.

Historically, hospitals used to bill for “everything and the light bulb,” Siddel says, because they used to be paid a percentage of their charges.

Teams of consultants and financial analysts scoured bills to see whether billers overlooked any charges or supplies, etc. But the list of separately billable supplies narrowed because of the following factors:

- CMS switched to prospective payment systems
- Certain insurance companies (e.g., BlueCross BlueShield) issued lists of which supplies to bill for and which ones not to bill for
- Medicare introduced the term “inherent to a procedure”

These factors led to the creation of a loose set of rules for which supplies you can and cannot bill for, Siddel says. Essentially, do not bill for supplies that are

- not medically necessary
- nonspecific to a patient (e.g., disposable supplies that do not have a cost for each preparation)
- not ordered for the patient or not documented
- issued in bulk to the floor, which nursing staff draw from to use for many patients (e.g., a box of bandages, sponges, syringes, etc.)
- inherent to a procedure

“In other words, if 80% of the time when a physician performs procedure A, he or she uses supply A, build the price of the supply into the procedure,” Siddel explains. For example, an endotracheal tube is used each time staff place a patient under general anesthesia; therefore, do not bill for it. The same goes for x-ray film.

Some insurance companies and fiscal intermediaries have lists of supplies that they consider to be routine, Settlemyer says, so it’s a good practice to check with these sources before you develop your own list.

“But there is no repository, especially at the federal level, as to what is routine and what is not,” he says. “A really good, basic definition of nonroutine is that you can track the cost of an item back to a specific patient [and thus bill for it].”

**Centralize supply location**

How and where you dispense and bill for supplies is facility-specific, but Siddel recommends a centralized location run by materials management. This department should distribute supplies, create the line items in the CDM, and add the charges to the patient’s bill.

“A lot of smaller hospitals can’t do that and have to take a team approach, which can work fine,” notes Settlemyer. However, some hospitals allow each department to bill for its own supplies, and materials management acts as a distributor only. This practice

(See Accounting controls, continued on p. 8)
ACCOUNTING CONTROLS (continued from p. 7)

can lead to inconsistent pricing (e.g., the emergency department may charge $50 for a Foley catheter and the cardiac catheter lab may charge $30 for the same item) and complaints from patients who note this difference on their bills, Siddel says.

Departments will occasionally bypass materials management and have materials sent directly to them via mail. However, this is a surefire way for hospitals to lose money. “The best way to get the best deal is purchasing in volume and contracting,” Siddel says. “My recommendation is that supplies management should be centralized and the supply should only be listed in the CDM once.”

Expand role of materials management

Ideally, materials management should handle the role of centralized supply and CDM maintenance to ensure that these items are billed properly, explains Settlemyer, whose hospital’s materials management department plays a successful role in helping decide how to code supplies.

To make the process work, materials management staff must learn how to review coding manuals and be familiar with coding guidelines.

“I think materials management is the department that is in the best position to determine how to code supplies,” he says. “They do have the better understanding of what an item is and what it’s used for, so they really could be a good resource to use to try to get things coded properly.”

Hospitals have high overhead and must spread costs across billable items. When setting prices, Siddel says the best practice is to mark up items using cost as a basis.

Also consider establishing a threshold for separately billable supplies. Siddel recommends a minimum of $25 and says “anything that costs less is not worth messing with.” Some hospitals opt for a higher threshold—$100 or even $500—but Siddel says this can lead to problems. “If you get above $100, you better have good internal controls, or your supplies will start disappearing and you’ll never know it.”

Conduct an annual CDM review and make sure that your prices are aligned with current costs, because the cost of supplies can fluctuate from year to year, Siddel says.

“If you can buy an item over the counter—an Ace® bandage, for example—you better sell it almost at cost,” he says.

Many hospitals mark up higher-priced items at a higher percentage than lower-priced items, but Siddel warns against this practice because it promotes inconsistency and can throw up a red flag during an audit.

Check for pass-through items

Watch for items designated with pass-through status. These are items for which CMS has not collected sufficient cost data, and therefore hospitals can report them in addition to a procedure using a separate C code. “As items come out, they get assigned a new code, and if you aren’t putting these into your chargemaster and billing them, you’re losing out on potential reimbursement,” Siddel says.

“The general rule of thumb from a Medicare outpatient perspective is, if the supply has a legitimate code, code and bill it separately,” Settlemyer says.

WHO asks for donations of supplies for care of Indonesia earthquake victims

One way to dispose of unneeded supplies and equipment is to donate them.

The World Health Organization (WHO) is seeking specific items to supply healthcare workers serving victims of the May 27 earthquake in Central Java, Indonesia.

Sari Setiogi, press officer for WHO in Jakarta, Indonesia, told HMM via e-mail that materials managers at U.S. hospitals should contact him with questions about how to make donations. Contact him by telephone at 62/21 520 5349, by fax at 62/21 520 5349, or by e-mail at setiogis@who.or.id.

According to a WHO news release, medical relief workers need the following supplies:

- Orthopedic supplies
- Anesthetics
- Antibiotics
- Bed sheets
- Mattresses
- Sterile kits for surgeries
- Sutures
- X-ray film

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Although cardiac stents have been the focus of strong market competition, especially in their drug-eluting forms, manufacturers and physicians are increasingly finding new ways to use the technology. Recently, HMM obtained prices for models used in various parts of the body. Along with treatment of blocked arteries, other uses for stents include the following:

- Keeping blocked or damaged ureters open
- Relieving blockage in large blood vessels
- Permitting bile flow in blocked bile ducts
- Permitting air flow in obstructed bronchi, such as from a tumor

The following table shows some of the more commonly used noncardiac stents and average prices that materials managers and contracting specialists have reported.

<table>
<thead>
<tr>
<th>Product no.</th>
<th>Description</th>
<th>2006 price</th>
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<tbody>
<tr>
<td>H965440100</td>
<td>Esophageal, 100 cm, 18 fr, wall stent</td>
<td>$1,878.83</td>
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<td>H965456060</td>
<td>Tracheobronchial, 60 mm, unistep plus delivery system</td>
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<tr>
<td>M00513730</td>
<td>Esophageal, 10 cm, self-expanding</td>
<td>1,548.33</td>
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<tr>
<td>M00515440</td>
<td>Vascular, 10 mm, 4 fr</td>
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<td>M00532030</td>
<td>Ureteral, 15 cm, 7 fr, pigtail</td>
<td>60.67</td>
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<tr>
<td>M00532050</td>
<td>Biliary, 10 cm, 10 fr, pigtail</td>
<td>60.67</td>
</tr>
<tr>
<td>M00533680</td>
<td>Biliary, 10 cm, 10 fr, drain</td>
<td>58.33</td>
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<tr>
<td>M00533780</td>
<td>Ureteral, 10 cm, 7 fr, Amsterdam kit</td>
<td>103.33</td>
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<tr>
<td>M00539380</td>
<td>Biliary, Microvasive, 12 cm, 11.5 fr</td>
<td>104.01</td>
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<tr>
<td>M00545690</td>
<td>Biliary, plastic, 15 cm, 8.5 fr, rapid exchange</td>
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<tr>
<td>M00557380</td>
<td>Colonic, 117 mm</td>
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<tr>
<td>M00565560</td>
<td>Enteral, bare disposable, 60 mm</td>
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<td>M00565620</td>
<td>Duodenum, 60 mm, noncoated, noncovered delivery system</td>
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<td>M00568940</td>
<td>Tracheobronchial, 95 cm, 10 fr, ultra flex</td>
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<td>M00569040</td>
<td>Airway, 30 mm, covered distal release</td>
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<td>M00569640</td>
<td>Biliary stent delivery system sterile, disposable</td>
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<td>M00569800</td>
<td>Endoprosthesis, 100 mm, rapid exchange</td>
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<td>Biliary, 100 mm, 10 fr</td>
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<td>Airway, 40 mm, silicone polyflex self-expanding</td>
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<td>00707C</td>
<td>Urethral 7 cm, 7 fr, curved</td>
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<td>01205A</td>
<td>Ureteral 5 cm, 12 fr, angled</td>
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<td>Urethral 9 cm, 12 fr, plastic angled</td>
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<tr>
<td>1209CK</td>
<td>Urethral, 9 cm 12 fr, curved, sterile kit</td>
<td>38.00</td>
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Politics interfere with smooth transition to adoption of new device reporting system

Pressure from all sides of the healthcare industry is causing the Department of Health and Human Services and its Centers for Medicare & Medicaid Services division to change the way the government pays hospitals for treatment.

The change also would make it easier to account for new technology in supplies and devices. However, the basis for the change is an international agreement that Congress must ratify.

As of late June, the Health Information Technology Promotion Act of 2005 (HR 4157) remained in the House Ways and Means Committee, where the House of Representatives had voted to send it at the time of its introduction in October 2005.

On May 24, a group of leading healthcare associations, including medical device vendors, issued a joint statement urging passage of HR 4157. Its interest in the measure is a provision calling for the adoption of the latest international coding system for conditions and treatments by 2009.

The International Classification of Diseases (ICD) promotes international comparability in the collection, processing, classification, and presentation of mortality statistics. It translates reported causes of death into medical codes. The World Health Organization publishes the ICD, with periodic updates. The latest is ICD-10. However, the U.S. healthcare system and Medicare currently follow ICD-9, which is 30 years old.

The May 24 statement that AdvaMed, the American Health Information Management Association, the American Hospital Association, the American Medical Informatics Association, and the Federation of American Hospitals issued urges Congress to adopt ICD-10.

The reason, the groups say, is that ICD-9 no longer reflects current knowledge of diseases, medical terminology, or the modern practice of medicine. As a result, reimbursement may not be accurate for newer procedures and devices.

The National Committee on Vital and Health Statistics first made a formal recommendation to implement ICD-10 coding in November 2003.

The current proposed October 2009 implementation deadline is long overdue and reflects a realistic compromise between the demand for better data and the time needed to complete the transition, according to the statement.

A deadline is necessary, according to the statement, because hospitals will then be able to dedicate resources to complete the detailed planning and development process to use the new codes.

Approved but not perfect: New FDA policy would keep track of device performance

Publicity regarding medical device defects and recalls has led the Food and Drug Administration (FDA) to start tracking performance of medical devices following market approval.

For example, Guidant, a cardiology device manufacturer in Indianapolis, has recalled many of its implantable cardioverter-defibrillators and pacemakers because of reported defects. Complaints that the company did not properly report the defects led to numerous lawsuits.

The publicity led to greater scrutiny of other medical devices already on the market, and the FDA’s response was to begin a yearlong evaluation of the way that it monitors the postmarket safety of medical devices.

The FDA’s Center for Devices and Radiological Health says it plans to track postmarket problems with devices and establish policies for alerting the public of defects.

Tufts plans to install new cancer treatment unit from American Shared Hospital services

Tufts-New England Medical Center in Boston, 515 beds, agreed to purchase an image-guided radiation therapy system, a computed tomography simulator, and related services from American Shared Hospital Services in San Francisco, a company that outsources Gamma Knife stereotactic radiosurgery services. Installation will begin in early 2007.

It is part of a complete radiation therapy department upgrade for Tufts-New England Medical Center. The parties did not disclose estimated spending under the agreement.

Beware of inadequate cleaning process for ultrasound equipment, FDA warns hospitals

The Food and Drug Administration (FDA) on June 19 issued recommendations for properly cleaning and sterilizing reusable ultrasound transducer assemblies used for biopsy procedures.

The move follows a report by the Department of
Veterans Affairs warning that inadequate reprocessing procedures may be causing problems with some of the transducers.

The FDA is asking healthcare workers to examine reprocessing instructions and, if they seem inadequate, contact the manufacturer and the FDA’s voluntary MedWatch reporting program.

**New research offers potential of avoiding pediatric pacemakers with tissue substitute**

Pacemakers, at $3,000–$4,000 each, are among the most expensive patient supplies that hospitals buy (see the August 2005 HMM), so it is good news when a substitute is in development.

According to a report published in the June 19 online edition of the *American Journal of Pathology*, a team of researchers at Children’s Hospital Boston, the pediatric teaching hospital of Harvard Medical School, has replicated tissue that can conduct the electricity needed to pump the heart.

Investigators wanted to create a biological substitute for defective atrioventricular nodes. They succeeded in obtaining skeletal muscle from rats and creating myoblasts that they could culture and stimulate to produce electrical impulses.

If successful in humans, the implants could replace pediatric pacemakers, the researchers hope.

**New drug-eluting stent from Cordis receives European marketing approval**

The Cordis division of Johnson & Johnson in New Brunswick, NJ, will launch its latest drug-eluting stent in Europe in September.

In June, the Cypher Select Plus won market approval from European regulators.

It is the first third-generation drug-eluting stent to receive Communauté European Mark approval. The U.S. Food and Drug Administration has not yet approved the stent for use in this country.

The Cypher Select Plus features hydrophilic coating technology, which is more lubricious than previous Cypher stent products, increasing a physician’s ability to navigate challenging coronary arteries.

**Defective capacitors lead to recall of Guidant pacemakers, defibrillators**

Boston Scientific Corporation in Natick, MA, the new owner of Guidant in Indianapolis, on June 26 announced that it is recalling some of Guidant’s defibrillator and pacemaker models because of an electrical defect.

Boston Scientific asked hospitals to return certain units representing six product models because of possibly faulty low-voltage capacitors that store electrical charges.

They include Insignia and Nexus brand pacemakers; Contak Renewal TR/TR2 cardiac resynchronization pacemakers; and Ventak Prizm 2, Vitality, and Vitality 2 cardioverter defibrillators.

The hospital says it selected the XactiMed product because of its ease of use and ability to improve payment of claims.

The hospital did not release price or savings information, but said claims productivity has improved since it began using the system.

**Louisiana hospital improves claim acceptance**

Lincoln General Hospital in Ruston, LA, 160 beds, has installed revenue cycle software from XactiMed in Dallas.
GROUP PURCHASING

Illinois hospitals begin organizing group purchasing affiliate of Premier

Following the path of a highly successful New York–based alliance, the Illinois Hospital Association (IHA) in Naperville has formed a group purchasing cooperative for its 200 members.

Called the Illinois Purchasing Collaborative (IPC), it resembles Greater New York Hospital Association (GNYHA) Ventures, a subsidiary of the GNYHA. IPC members will combine their purchasing volume to bargain for lower supply prices.

Similar to GNYHA, IPC will be the local representative of Premier in Charlotte, NC, marketing Premier contracts to Illinois hospitals.

Therefore, the founding members of IPC are current Premier hospitals located in Illinois. Several large member hospitals and health systems have said they are interested in joining IPC and converting to Premier contracts, IHA said in a news release.

Because most Premier contracts reward high levels of compliance with lower prices, the sooner that IPC brings in more members, the greater the financial benefits will be.

New Amerinet pact features supplies for newborns and premature infants

Amerinet in St. Louis selected Children’s Medical Ventures in Norwell, MA, to provide supplies that clinicians use in treating newborns and premature infants.

The three-year deal covers ventilators, positioning and handling devices, pacifiers, tubs, and bathing supports. However, the parties did not disclose financial terms. The award followed a request for proposals by Amerinet.

Diversity program nets veteran-owned supplier of patient scales for Novation

Novation in Irving, TX, awarded a contract to SR Instruments in Tonawanda, NY, for patient scales.

The one-year deal covers the company’s line of standing and wheelchair scales, including a bariatric scale with a 1,000-lb. capacity that lists for $2,292. SR is veteran-owned, and the agreement is part of Novation’s supplier diversity program.

In 2005, members spent a total of $1.4 billion with small businesses, including $56.4 million with diverse businesses.

Premier adds physician to lead consultants responsible for preference products

Premier in Charlotte, NC, is taking a direct approach to contracting for physician preference items by putting a doctor on its team.

The group purchasing organization has hired a physician to represent its supply chain strategies at member hospitals. Roger John Billman, MD, MBA, will lead a team of consultants that will work with hospitals and health systems to improve both clinical and financial performance. Before joining Premier, Billman was medical director for CareGuide in Coral Springs, FL, a company that works with health plans to manage highly complex patients.

Novation issues 17 deals that offer price protection on medical-surgical supplies

This fall, Novation hospitals will implement a package of five-year contracts that cover a wide variety of medical-surgical products.

Novation, a group purchasing organization in Irving, TX, awarded 17 deals that contain provisions locking in current shipping charges. The price protection will help hospitals budget in the face of rising costs of petroleum, labor, and raw materials.

Members of VHA in Irving, TX, and University HealthSystem Consortium in Oakbrook, IL, purchase $4.5 billion in medical-surgical products through Novation annually, with distributors delivering 60% of those products. The following distributors will share most of that business:

- American Medical Depot in Miami, a full-line regional distributor
- Buffalo (NY) Hospital Supply, a $90 million regional distributor that covers New York State and Northwest Pennsylvania
- Cardinal Health in Dublin, OH, a national distributor
- Claflin Company in Warwick, RI, a specialist in just-in-time inventory management
- Hardin’s-SYSCO Food Service in Memphis, TN

Questions? Comments? Ideas?

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Kreisers in Sioux Falls, SD, a $24 million regional distributor with four warehouse locations
- McKesson Medical-Surgical in Richmond, VA, a national distributor
- Medline Industries in Mundelein, IL, a national distributor
- Midland Hospital Supply in Fargo, ND, a regional distributor
- Midland Medical Supply in Lincoln, NE, a regional distributor that covers Nebraska, South Dakota, Kansas, Iowa, Colorado, and Wyoming
- MMS, formerly Midwest Medical Supply, in St. Louis, a regional distributor that covers the Midwest and Guam
- Low & Co. in Glendale, NY, a regional distributor that covers New York, New Jersey, and government facilities throughout the world
- Owens & Minor in Richmond, VA, a national distributor
- Professional Hospital Supply in Temecula, CA, which covers California, Nevada, and Arizona
- Seneca Medical in Tiffin, OH, a regional distributor that covers Ohio, Michigan, Indiana, Kentucky, Tennessee, and West Virginia
- Shared Services Systems in Omaha, NE, a regional distributor that covers Iowa, Nebraska, Kansas, and Missouri
- The Burrows Company in Wheeling, IL, a regional distributor that covers the Midwest

The contracts all specify what Novation terms a “one-cost plus approach,” which separates the cost of a product from the cost of delivering it. Distribution charges are limited to a single, fixed percentage of each product’s base contract price.

Novation said in a news release that the percentage charge for distribution services varies by distributor and is based on volume.

To participate, a member hospital must select one primary distributor. The distributor must then provide the percentage markup to both contracted and non-contracted products for that hospital, allowing it to forecast medical-surgical supply costs with greater certainty.

Broadlane schedules series of group buys providing discounts on capital equipment

Broadlane in Dallas will offer a series of group buys in coming months, featuring deep discounts on capital equipment in return for up-front commitment. Scheduled group buys and products include the following:
- **August**: Angiographic suites
- **September**: Ultrasound
- **October**: Computed tomography
- **November**: Radiography and fluoroscopy

Amerinet continues reorganization with acquisition of Vector’s purchasing business

Amerinet in St. Louis has completed its acquisition of one of its regional shareholders, Vector in Providence, RI.

The move, Amerinet says, is part of a conversion to a new business model, in which the group purchasing organization (GPO) will absorb its regional divisions into a single national GPO.

Amerinet also announced a new board of directors chaired by Bert R. Zimmerli, senior vice president and CFO of Intermountain Healthcare. In addition, Victor E. Samolovitch is the new CEO of Amerinet, and Todd Ebert is now president and COO.
Price index trends mixed in May; most up for the year

The finished goods component of the Producer Price Index for May 2006 was up 0.4% from April, and up 4.5% for the year. In the medical-surgical categories surveyed, the average change for the month was +0.1%. Only irradiation apparatus declined during the month, and the category of clinical laboratory instruments was unchanged. The other categories rose in May.

One CPI component declined in May

On the consumer side, the May 2006 unadjusted medical care commodities component of the Consumer Price Index (CPI) was 286.3, up 0.4% from April and 4.3% for the year.

Prescription drugs and medical supplies were up by 0.4% compared with April.

Nonprescription drugs and medical supplies rose 0.3% for the month, and internal and respiratory over-the-counter medications rose 0.5%.

Only nonprescription medical equipment and supplies declined in May, by 0.5%.

Recent price surveys

- **July 2006: Stents.** As competition increases among stent manufacturers, prices will continue to decrease.
- **June 2006: Endoscopic instruments.** Despite continuing issues regarding physician influence and reprocessing, the upward march of endoscopic instrument prices came to a halt in late 2005.
- **May 2006: Knee implants.** The prices of knee implants are on the rise, HMM’s first price survey of these products reveals.
- **April 2006: Sutures.** Overall prices for sutures held steady in 2005, but the newest contracts feature increases.
- **March 2006: Needles and syringes.** The modest price increases that marked 2004 have ended, but the decreases predicted for 2005 did not materialize.
- **February 2006: Gloves.** Materials managers reported an average price decline of 18% for selected products.
- **January 2006: Paper.** As long as energy prices continue to rise, so will the price of paper, materials managers say.
- **December 2005: Foley catheters.** Even with several new contracts on the books, Foley catheter prices have remained stable during the past year and are expected to stay that way.
People on the move
QHR in Brentwood, TN, promoted Beverly Slate to associate vice president of the QHR materiel resource group. In this position, she oversees regional directors of supply chain consulting services. Previously, Slate was regional director of the material resource group in Richmond, VA. HealthTrust Purchasing Group, also in Brentwood, recently affiliated with QHR.

Robert Baker retired as president and CEO of University HealthSystem Consortium (UHC) in Oak Brook, IL. He was the only president and CEO in UHC’s 22-year history.

Under Baker’s leadership, UHC grew from a coalition of 34 hospitals into an alliance of 95 academic medical centers and their affiliated hospitals. The UHC governing board is conducting a national search for Baker’s successor.

Members of VHA in Irving, TX, elected Gerald Miller, president and CEO at Crozer-Keystone Health System in Springfield, PA, as chair of the VHA board. Miller replaces Joseph Zaccagnino, former president and CEO at Yale-New Haven (CT) Health System. VHA also named four new board members to three-year terms on the 19-member board. They are Frank Alvarez, president and CEO of TMC Healthcare in Tucson, AZ; Linda Keene, executive vice president of marketing at Scholastic, Inc., a children’s books publisher in New York City; Arthur Klein, senior vice president and chief physician officer of Lifespan in Providence, RI; and Alfred Stubblefield, president and CEO of Baptist Health Care in Pensacola, FL.

People available
An experienced buyer is seeking a position in east Texas. E-mail sheila.darcey@healthsouth.com or call 903/510-7015 or 903/849-2740.

Positions available
Overlake Hospital Medical Center in Seattle is seeking a director of resource management. Send your résumé to jennifer.garrepy@overlakehospital.org.

Apria Healthcare in Lake Forest, CA, is seeking a vice president of national purchasing and a buyer of home medical equipment. Submit your résumé to Apria Healthcare, Professional Staffing, 26220 Enterprise Court, Lake Forest, CA 92630-8400.

Parkland Health and Hospital System in Dallas is seeking a lead commodity buyer. Send your résumé to Parkland Health and Hospital System, 5201 Harry Hines Blvd., Dallas, TX 75235, attn: Tanisha Freeman; or e-mail tfreem@parknet.pmb.org.

Bayhealth Medical Center in Dover, DE, 374 beds, is seeking a clinical value analyst with an RN, BS, or BA in nursing. To apply, go to www.bayhealthb.org or fax your résumé to 302/744-7469.

University of Iowa Hospitals and Clinics in Iowa City, 762 beds, is seeking a department director of procurement services. To apply, visit the University of Iowa Web site at http://jobs.uiowa.edu and search for requisition number 52777.

Loyola University Medical Center in Maywood, IL, 545 beds, is seeking a manager of materials management. Contact Human Resources, Loyola University Medical Center, 2160 S. First Ave., Maywood, IL 60153; or e-mail loyolajobs@lumc.edu.

University Hospital and Medical Center in Tammarac, FL, 317 beds, is seeking a supply chain director. Apply online at www.sharedservicescareers.com or e-mail your résumé to efsc.hr@hcabhealthcare.com.

Duke University Hospital in Durham, NC, 1,124 beds, is seeking an associate director of materials management. To apply, e-mail your résumé to Christopher.beenan@duke.edu.

Beth Israel Deaconess Medical Center in Boston, 673 beds, is seeking a contracting data analyst to manage supply inventory data for entry into the PeopleSoft item master. Contact D. Falvey, Human Resources Department, Beth Israel Deaconess Medical Center, 330 Brookline Avenue, Boston, MA 02215; or visit www.bidmc.harvard.edu to apply online.

Hollister, Inc., in Libertyville, IL, a manufacturer of wound care products, is seeking a manager of contract development and administration. Apply online at www.bollister.com.
Health experts prepare to counter pandemic

The severe acute respiratory syndrome (SARS) outbreak of 2002 may be history now, but history is likely to repeat itself with other diseases if the healthcare community does not take steps to prepare itself, according to a new report from the World Health Organization (WHO).

One of the lessons from SARS was that governments have to give their healthcare providers the resources needed to protect the public. Helping countries prepare for future pandemics—especially avian influenza—was a major topic on the agenda of the May 22–27 World Health Assembly that WHO hosted in Geneva, Switzerland.


They give countries much broader obligations to build national capacity for routine preventive measures and detect and respond to public health emergencies. They prescribe public health policies at ports, airports, and land borders.

Meanwhile, U.S. analysts warn that because of the way bird flu spreads, and the large number of travelers and immigrants entering the country daily, the country is especially vulnerable to any future pandemic.

According to an Associated Press report, shutting U.S. borders in case of outbreaks in other countries might not be effective because the disease is contagious for 24 hours before a victim shows symptoms. An estimated 1.1 million people enter the U.S. legally each day, so a carrier could arrive before an international outbreak occurred.

Hospital execs face JCAHO policy changes

As many hospitals have already discovered, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL, is changing its way of doing business. Among the changes are new accreditation review processes and standards, as well as a proposal to give doctors more say in hospital governance.

Since January, the JCAHO has conducted unannounced surveys on a regular basis. It has always allowed inspectors to appear unannounced for random, one-day visits, but now its policy is to almost never plan ahead with subject hospitals.

Then, in March, the JCAHO gave hospitals a break by increasing the number of deficiencies that they may have before they lose accreditation.