2012 IMDA Annual Conference

Value analysis professionals do the math

NASHVILLE, TENN--Cindy Christofanelli says she's a gatekeeper. But she's not like any gatekeeper you've seen before. She's got a master's in nursing, and she's a certified materials and resource professional. She is also a value analysis professional.

Christofanelli and her value analysis colleagues – many of them registered nurses -- are the clinical voice of the supply chain. "We translate the business and clinical side of healthcare to decisionmakers across the healthcare organization," says Christofanelli, who is corporate director of supply chain management, SSM Health Care, St. Louis, as well as central region director for the Association of Healthcare Value Analysis Professionals (AHVAP).

Christofanelli was a keynote speaker at the 2012 IMDA Annual Conference and Manufacturers Forum.

As a value analysis professional, Christofanelli can be the specialty distributor's best friend or worst enemy, she said. "If you have a product that is safer and whose clinical outcomes are better, and we can prove it, value analysis professionals will take those projects to the top of the heap." But if the vendor can't produce proof that his or her product produces superior outcomes at the same or lower cost than what the institution is currently using, then Christofanelli is less likely to support it. In either case, "We will do the math," she said.

AHVAP began with seven nurses exchanging e-mails about the work they were doing in their hospitals. Today, the organization has about 200 members, of whom roughly 60 percent have a master's degree of one sort or another. Many have dual master's degrees, in nursing as well as business administration.

In a recent survey, 80 percent of AHVAP members indicated they had "strong" to "very strong" support from their senior leadership. "Value analysis is growing, it's not retracting," said Christofanelli. In fact, it's a safe bet that IMDA members will continue to deal with value analysis professionals in their accounts for the foreseeable future.

What is value analysis?

Healthcare value analysis is a systematic process to review clinical products, equipment and technologies to evaluate their clinical efficacy, safety and impact on organizational

resources, said Christofanelli. “We are data-driven, quality-driven and safety-driven,” she said, speaking of value analysts.

“In the past, you might have gone to purchasing, and worked with the materials [staff], who may or may not have understood the product you were carrying,” said Christofanelli. Many times, materials professionals had just one question: “How much does it cost?” But that’s changing.

Value analysis looks at far more than purchase price, said Christofanelli. It takes into consideration the potential or expected clinical outcomes of any device or piece of equipment prior to its acquisition. To the dismay of some in the audience, Christofanelli said that she and her colleagues look with a skeptical eye on studies funded by manufacturers. IMDA members responded that oftentimes, the only clinical data on new technologies is that which has been collected by the manufacturer.

The value analysis professional also explores how the cost of a new device or piece of equipment will affect the profitability (or lack thereof) of specific DRGs. Usage is another important factor. If a new product costs less, but the hospital or IDN must use more, then it might not be cost-effective. Then there’s the cost of training RNs and others on new devices. If clinical outcomes associated with a new device are the same as the incumbent product, but hundreds of nurses have to be inserviced for an hour each, then it’s probably not going to happen, she said. In this case, the pain of converting outweighs the gain.

Value analysis professionals are also skeptical of claims that a new product or device may save the nurse or clinician 15 or 20 minutes per procedure. “If I can’t reduce FTEs, I can’t count it,” she said.

The next frontier for value analysis professionals – and one that suppliers need to be aware of – is evaluating the performance of a new device after it has been brought into the hospital or IDN, said Christofanelli. Questions to ask are, “Did we really save the money we thought we would?” “Did our patients really have reduced lengths of stay?” “Did we get the results we thought, and were we able to document them?”

A matter of necessity

As frustrating to specialty distributors as it might be, the fact is, hospitals and IDNs simply can’t be on the cutting edge of every technology in every service line, said Christofanelli. There is a time and cost to implementing new technologies, and that must be weighed against the potential benefits. “We have to strategically understand where we will invest our resources.”

Value analysis professionals will continue to be out front in helping their organizations balance clinical and financial outcomes. Studies show that healthcare reform could lead to reduced inpatient Medicare payments by as much as 18 percent, said Christofanelli. “If you knew your income was going to go down 18 percent, would you keep doing business the same way? You’d start to evolve.” That’s what healthcare organizations are doing. Suppliers should do the same.

Vendor credentialing: A glimmer of hope

One down, 49 to go. That's how IMDA Past President Shawn Walker of Bay State Anesthesia summed up the Indiana Hospital Association's work in drawing up recommended standards for vendor credentialing for its members. She made her comments at the IMDA Annual Conference.

For the first time, there may be a hint of light at the end of the tunnel for vendors wrestling with expensive and duplicative vendor credentialing standards, said Walker, who has served as IMDA's point person on the vendor credentialing issue for several years. She cited not only the work of the Indiana Hospital Association, but a recent clarification about credentialing from The Joint Commission, and ongoing work by an IDN that, at press time, was preparing a paper in support of a universal and portable set of requirements for credentialing.

Speaking at the Conference, Walker brought members up to speed on the issue. Hospitals originally pursued credentialing in order to ensure patient health, safety, confidentiality and conformance to government guidelines, she said. "But they were under the impression that Joint Commission required that non-contract employees be credentialed, and they interpreted that to mean sales reps." Many vendors believe hospitals also seized upon credentialing as a way to limit reps' access to clinicians.

Some hospitals and IDNs set up their own credentialing systems, but many others turned to a growing number of third-party credentialing companies. "Since then, vendor credentialing has evolved into a huge market," said Walker, adding that third-party credentialing firms claim hundreds of thousands of reps in their databases.

The problem for IMDA members and other vendors is many-faceted. For one, the cost of credentialing is borne by distributors and manufacturers, not hospitals. Second, the cost to vendors of getting their reps credentialed grows along with the number of facilities they call on and the number of vendor credentialing firms with which they have to deal. Third, the requirements of credentialing vary from hospital to hospital; there are no standards. And fourth, the criteria for credentialing have multiplied, increasing cost to the entire industry in terms of time and money, and actually presenting some threats to patient safety.

"The more hospitals ask you to read and sign off on, the less likely the rep is to remember it all," said Walker. "That can present repercussions." What's more, there have been reports of service personnel being denied access to certain areas of the hospital because they lacked credentials.

Several years ago, supplier organizations, including AdvaMed, a trade association for medical products manufacturers, worked with provider groups to try to iron out industry standards, said Walker. But the economic downturn and then healthcare reform forced the issue to the back burner. "But it's starting to be addressed now," she added.