Dr. Clay Nuelle: Welcome Everyone. I'm Dr. Clay Nuelle with the University of Missouri. Today, I have the privilege of speaking with Dr. Laith Jazrawi. Dr. Jazrawi is a professor at NYU Langone and the Chief of the Division of Sports Medicine, as well as the Director of the Sports Medicine Fellowship. He was the senior author on a paper entitled, A Preferred Vendor Model Reduces the Costs of Sports Medicine Surgery, which was published in the April 2021 edition of the Arthroscopy Journal. Laith, thank you very much for joining me today.

Dr. Laith Jazra...: Thanks Clay. It's a pleasure, and I really appreciate you reaching out to me about discussing this paper.

Dr. Clay Nuelle: Absolutely. So let's start with the basics and the impetus and the background of the study and how you guys got involved with setting this up and then your main conclusions and outcomes.

Dr. Laith Jazra...: Yeah. So I think, all of us, in this world and certainly in medicine, the idea of being more cost-conscious has all hit us. When we look at the prices of some of these things that we use, particularly in sports medicine, sometimes it's almost a shock that we actually pay that much for an implant or a shaver or anything. So I think one of the big things that certainly at our university that came up, could there be cost savings in this. And I think in the private world with a lot of the ambulatory surgery centers and non-academic institutions where surgeons are invested into it, it became very clear that there was at least a willingness that physicians in the setting of potentially saving money, that they would utilize instrumentation that was more cost-conscious, compared to some of the more expensive brands.

So the university came to us and said, "Look, we want to save money on some of these things. Is there a way that you can do this?" So I think the first thing that we did was, and this was about a decade ago, reach out to the different companies and say, "Hey, look, if you want to work at the hospital, you're going to have to come to some sort of baseline costs. So if there's an anchor, that's the same anchor that company Y uses, then you have to have the same cost, unless there's a specific reason why your anchor is technologically different, better, or offers some unique aspect of it." So we went through that, that took about a year to get that down. So what we ended up coming up with was overall reducing costs, but at the same time, keeping all the vendors there.

So we realized that, "Well, if we can do that, we can potentially go to a single vendor model," meaning that one vendor that can probably provide about 75 to 80% of the products that we want to utilize. And we gave that wiggle room of about 20%, to allow us that if there were surgeons that wanted to use other things, that there would be an option to do that. So in the preferred vendor model, and these are most preferred vendor models, that there's a critical 75 to 80% utilization of stuff to hit the target cost reductions and cost savings. So that's what we did. And we instituted this about, I would say, actually four years ago, where we went with a preferred vendor model. And for us, it was easy in

sports. The idea was to pick a vendor that could supply that 80% mark of what we use in sports.

So that first step was easy Clay, because there was only one vendor that can provide literally 80% of the stuff without doing a significant change within the system, meaning getting rid of shaver boxes and other things which would drive up costs too, to get a lot of more capital expense in and actually buying some of these hard items. So, that was the first step. And then the other thing was we met with all the surgeons to get buy-in from them. And a majority of the academic surgeons with us, there was going to be, "Well, where were those cost-savings going to go?" "Well, it was going to go back into a lot of back into a lot of our research programs." That was sort of the second step, to get buy-in from these surgeons. So while they wouldn't make money, some of the private guys did in their own ambulatory surgery center, they would make money in a different way by cost savings, by getting it driven back into their education and research funds, so that incentivization was extremely important.

And then the third thing was to talk to those physicians who potentially would be resistant, meaning that they were absolutely not going to change, were going to be adamant about utilizing specific devices. And when we really came down to it and spoke, there were only a handful of surgeons like that, who were using, and they really, the products where they were using were very specific products. It wasn't the whole line. So when we looked at the numbers, we were easily in the 90% to 10%, where 90% of the stuff was used by a preferred vendor. So we were able to do it. And so that's how it started. Then we said, "All right, well, let's see if there's going to be a change when we changed everything over, to get to this 90% mark with a specific company."

So we looked at it. We looked to see one, in a retrospective review, was there going to be a cost decrease? And we definitely found that. There was definitely a cost decrease across the board. Now that made sense, right, because our preferred vendor model, the reason that we got him into the hospital was, "Hey, if you're going to be our preferred vendor, we're going to require you to come down with some of your costs," because that's how it goes. And that's a volume thing. So the more volume you do, these companies are able to decrease costs. It's a simple economic law. So, that was the first thing we noticed. We noticed that we cut costs. The second thing we looked at was, well, are there surgeons that are using some new things? In our case, we shifted out the shavers and the wands that were out, that we used during arthroscopic surgery.

And was that change going to be a big deal in terms of time in the OR? Also, safety issues. Were there going to be any problems because surgeons are using different devices? And we really focused on time and any other outstanding problems that may arise. And we really noticed that there was no difference. So it was a very small increase, but nothing significantly in terms of time per case. So that was really our goal. The goal was to show that we could save money, that it was safe and it didn't add any major time in terms of OR efficiency. And that's what we proved with the study.

So we were able to prove that and showed that a preferred vendor model can work in sports medicine surgery. Now, has that been successful across the board in other aspects of trauma and things like that, where there are a lot of different implants and maybe a company can't supply the so-called best or what we perceive as the best plater options? It's been a little more challenging to hit that mark, and certainly at our institution with trauma, with everyone being very particular about some of their trauma devices. And you could say the same thing about sports, but with the company that we utilized, it has a lot of innovative and really a broad scope and a broad perspective in sports medicine with a lot of implants and a lot of different ways to do things for us, it was very easy.

Dr. Clay Nuelle: That makes sense. That's a really terrific summary, and thank you for that. And this was a really interesting article. I was especially interested in it. I have similar experience in my practice where I was previously in a private practice setting. We did the same thing actually, and went to a preferred vendor model. I think for any practitioners out there or surgeons out there who are considering this type of thing, or who are evaluating this type of thing, the semantics are important and you elucidated it very well. And so it's a preferred vendor model. It's not necessarily a single or sole vendor model, and you mentioned that you all have set a threshold. I think you said you started at 80% for disposables and that sort of thing and in our group at our surgery center, we did the same type of thing. We set a threshold of utilization of 80% with a preferred vendor. Now, for you all, that did not include all implants and graphs and everything, correct? The preferred usage was primarily disposables and things like that, or did it include all sports medicine implants as well?

Dr. Laith Jazra...: It included all the implants like anchors, screws. So yeah, it was pretty much everything, not allograph and things like that. That falls under another subset. And most of these companies that do implants and stuff, they're working with some of the main graft companies anyway. So, that's sort of a different thing. No, but it was every anchor, every screw. So it was really-

Dr. Clay Nuelle: All inclusive.

Dr. Laith Jazra...: Yeah, it was all inclusive. There are graphs that are made like for the superior capsular reconstruction that kind of goes along with some of the particular company's screws and stuff, so that you see, that's different, even that tissue comes from a different company, meaning they work with this specific company. So for us, we didn't include that. It was really the implant that we were looking at.

Dr. Clay Nuelle: Yeah. Well, it was really impressive. Like you said, you guys decreased your per case and disposable costs by 12%, but only increased operative time by 3.2 minutes, which is really negligible across such a wide range. So you mentioned it, you're at a very academic and a large academic multi-center, academic center where you guys, I think you guys do upwards of 25,000 cases a year. And in the paper there was over, I think, 10,000 cases included in this particular study

alone. And so that's obviously a very busy place and our surgery center where I was is a similar type of thing, with doing 10,000 plus cases at a very large private practice group. Do you think this type of setup can translate to the community setting or to maybe smaller hospitals locally, whether they be academic or just hospital owned or even private practice surgery centers that obviously don't do 10,000 to 25,000 cases a year, but maybe do 3, 4 or 5,000 cases a year?

Dr. Laith Jazra...: Yeah, my feeling is, I thought it was going to be more challenging in the academic setting because, the idea of a preferred vendor model is to sort of streamline things and save money in the end. Now, in these smaller private settings, there's usually a buy-in from some of the physicians that in terms of getting more money in their pocket and that economic incentivization to me, would always play a major role in a group of physicians coming together. Now at our academic institution, we don't have that option of getting money like that. It would go back into research, but, we also have a large volunteer cohort that was present as well. That while they wouldn't directly benefit from the education and research one, they were involved in some of our research clinical outcome studies.

So maybe that played a role, but, we had a broad spectrum. There could have been voluntary physicians that could have resisted, but the numbers were clearly on our side, on the academic side, in terms of that, look, this is what we're doing. That 20% ability to that 80/20% split, that gave us that little leeway, that if we had guys that were more resistant into going over, definitely was going to be of help. And the company that we utilized, really had great products. There were certainly products that we didn't like from that specific company, but everyone didn't like them across the board. So, that carve out of 20% was helpful to allow us to utilize these other instrumentations that we thought were just better in general, and they came from another company. So I think that this education process, doing this paper and seeing what we went through the university, if we can do it, it could really be applicable anywhere.

And it was easy because the company that we utilize really is this technologically savvy company with very innovative implants that makes sports medicine surgery a lot easier. Now, it hasn't translated some of the other things, particularly trauma at our institution. But, that I think has a lot to do with maybe a trauma surgeon, they're used to specific implants, and they're more comfortable with it. I don't know the answer to that yet because I haven't researched it, but for us and I think this could be replicated in other places. I don't know Clay, you were mentioning that at your institution, did you have trouble hitting that 80% mark?

Dr. Clay Nuelle: Most surgeons did not in the group as a whole, absolutely did not. They had no trouble hitting that 80% mark, similar to the way you guys did. It sounds like you guys are a very cohesive group of partners and surgeons, which I think is certainly helpful and key too, and you got a lot of buy-in. Our experience was, you have some individual outliers and you have some folks who are just, this is the only type of company, or this is the only type of implant they're going to

use. And our experience compared to yours in that in the sports medicine realm, it was very easy. Everybody hit the benchmark, no problem. We did it also for arthroplasty and for trauma. And those two areas were much more difficult, because as you said, there's some folks that are just married to their implant company and their arthroplasty primary prosthesis.

And there are some folks that are married to their certain trauma implants. And it was very hard to get them to come off that, or in some cases, maybe the other company did have better products. And that's what the 20% carve out was for, but it would be hard to get them to come off it, other than that. And so our experiences, it sounds like it mirrored yours a lot. And that the sports medicine, it was not hard to hit that kind of 80% benchmark, but some of the other subspecialties, particularly arthroplasty and trauma, was a little bit more difficult, and there may be a variety of reasons, as you also elucidated.

Dr. Laith Jazra...: Yeah. Arthroplasty, they went at our institution, they went with this type of, initially, this was about a decade ago, where they tried to see what the 80/20% cut. It just didn't work out because when you gave the surgeon the options and look, there were surgeons that, it's a lot harder. You do a total knee replacement, 10 years the same way, may be a lot harder to change. So finally the university just said, "Well, this is the only implant you can use." And they got the price down so low that they just said, "We're not having any other trade. If you don't want to work here, then I'm sorry. This is the only implant you could use if you work at our specific hospital."

And you know what, it worked out. Even though that that was not necessarily the main implant that was used, you know what, people all kind of fell in line and started using it. And over the years, they were able to make the preferred vendor model for arthroplasty work out. There are obviously revision cases and things like that, there is a carve out for that. But we've been successful in the arthroplasty world saving a lot of money and really reducing the cost of that implant significantly.

Dr. Clay Nuelle: Yeah, absolutely. That makes sense. How did you guys handle maybe the few surgeons that already had prior industry relationships, if they were different than what your preferred vendor was, or maybe some of those outlier surgeons? I guess you answered it a little bit already in that you told them, if they didn't want to use the arthroplasty implant, that they could maybe look elsewhere. But for those surgeons, that wasn't the case, how did you handle some of those surgeons that maybe had some of those prior relationships?

Dr. Laith Jazra...: Yeah. So, that's a great question. It was easy because they had no choice. There was no shaver boxes there, right? So that's a big part of the... A lot of shavers are used in arthroscopic surgery, so they had no choice. Even though they didn't like it, we did trial it. And there were complaints. You know what, you know how many complaints there are now Clay? Zero, about the shavers. So, you know what, it's like anything. There's a difference between not being a good quality instrument and you just not being comfortable with it. So I think we learned

that very clearly. So they were forced to do that, the same thing with the electrocautery for arthroscopic surgery. One's a little better than the other, but quite honestly, they were forced to use this.

And again, complaints initially from some of these guys or girls in the end, nothing. So everyone as a group is okay with. It when it came down to implants and specific rotator cuff anchors and things like that, whatever was in, was fine, meaning, there were only a few guys that used other outside implants and that had relations. So the one thing, if they had a financial relationship with these companies that had to be known, verbalized to the committee, and they weren't able to necessarily if they were an inventor of that implant or anything like that, make any money on the utilization of that implant at our university. The other thing was that as new products came in from that specific company, they just didn't get approved. We could not have those other products, new products that where there was an existing product that was there, that was just as good or did the same thing.

Gradually, those surgeons over time, started to use the preferred vendor products, and started to get comfortable with it because they had no other choice, because the newer versions of these anchors, they weren't allowed to get into the hospital. So, it's interesting over time, there've been little to no complaints and that carve out of the 20%, has made it even easier. So, we're hitting close to 90% now and I anticipate over time, that it'll probably stay that way, because there are just certain products that one company, and it's probably because of patents and things like that, they just can't overcome some of the more superior products that these other companies have.

Dr. Clay Nuelle: That makes total sense. So you have really extensive experience with this from start to finish. For surgeons or maybe even hospital CEOs or group presidents that are really just starting to look at this, because I think this is going to become a lot more prevalent in the next 5 to 10 years. But for those that are just starting to kind of look at this and set up preferred vendor model, what would be your one to two pearls that you would give them from lessons learned and success with this?

Dr. Laith Jazra...: Okay. Pearl number one, pick the right company. I think that's key, that has experience with this, and it has done this before. I think that's the key and look at their spectrum of products and make sure that they can hit that model. You don't want to preferred vendor model that only provides 30% of the products in sports medicine or whatever you're doing. So I think that's the first thing. The second thing is get buy-in from the physician, meet with them, trial the products, get them comfortable with the product, go through a phase where they're allowed to critique the products, write down their reasoning, why they wouldn't or would have these products. And I think that engagement is very helpful.

And I think the third pearl would be whether you're at an academic institution or a private institution, whether it's get surgeon buy into it. Whether it's

economic buy-in, whether they're saving money overall at the cost of the overall total cost of running an ambulatory surgery center, or the money saved by doing this preferred vendor model, will then go into research and education for their particular division. I think those three pearls, if you do, you can be extremely successful getting a preferred vendor model into your system and getting the surgeons to buy into it.

Dr. Clay Nuelle: Those are really outstanding pearls. Dr. Jazrawi's article, A Preferred Vendor Model Reduces the Cost of Sports Medicine Surgery can be found in the April 2021 edition of the Arthroscopy Journal or online at www.arthroscopyjournal.org. Laith, thank you very much for joining me today, that's really outstanding.

Dr. Laith Jazra...: All right. Thanks Clay. Great job with this series. I really enjoy your commentary on a lot of these things. Thank you.

Dr. Clay Nuelle: Thank you. That concludes this edition of the Arthroscopy Journal Podcast. As always, if you enjoy the podcast, please remember to give us a five star review on your podcast device. The views expressed in this podcast do not necessarily represent the views of the Arthroscopy Association of North America or the Arthroscopy Journal.