



Survey Report:

**The Clinical Review Process
Conducted by Group Purchasing
Organizations and Health Systems**

Prepared for:

The Health Industry Group Purchasing Association

April 2002

The information provided in this report is based upon interviews conducted by The Lewin Group with representatives of selected group purchasing organizations (GPOs) and health systems. This approach is consistent with the terms of the engagement requested by the Health Industry Group Purchasing Association. The scope of this study did not include on-site audits or other independent confirmation of the findings of the interviews.

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EXECUTIVE SUMMARY

On behalf of the Health Industry Group Purchasing Association, The Lewin Group conducted a survey to determine the extent to which group purchasing organizations (GPOs) and health systems employ clinical review processes to inform technology decision-making. HIGPA's central question to Lewin was whether these clinical review processes support timely adoption and evidence-based, cost-effective use of health care technology.

Five health systems and six major GPOs—an illustrative sample—were contacted during February and March 2002. This survey revealed that GPOs and health systems conduct extensive and rigorous clinical reviews when deciding which health care technologies will be listed in purchasing contracts and made available for use. The exact locus of the clinical review process can vary – sometimes more is done at the GPO level, and sometimes more is done at the health system level – but in any event these processes employ widely accepted methods for assessing the clinical value of health care technologies. Notable findings include:

- Clinical review processes of health systems and GPOs rely upon comprehensive systems of expert committees.
- Recognized independent technology assessment resources are used.
- Health systems and GPOs have functions for monitoring and incorporating “breakthrough” and other novel technologies.
- Mechanisms for ongoing review are in place. Some GPOs have in place “perpetual” review of new technologies as part of their regular contracting process.
- Information is shared among clinical review functions. Certain separate clinical review functions related to review of clinical practices and technologies are linked within health systems and GPOs, which serves to strengthen them.
- GPOs can facilitate clinical trials.

Most health systems use a decentralized approach for identifying products and technologies for review, coming often from their centers of excellence, specialty areas, and departments. GPOs surveyed do not generally contract for experimental or investigational technologies, but they have mechanisms for monitoring what is in the pipeline, through continuous market assessment. Staff contract directors are expected to stay current and bring products to review to the appropriate subcommittees, which are normally organized around service lines.

Pharmaceuticals, particularly, are monitored closely from the experimental phase through the standard-of-care phase. A GPO will examine the whole range of therapeutic agents, even though it may not contract for the whole range. Certain GPOs do not perform clinical reviews, but act as the prime contractor for other member GPOs, who have direct contact with health systems and alternate care sites that constitute their membership.

Health systems and GPOs identified the following comprehensive list of attributes and impacts of technologies that generally are incorporated into the clinical review process:

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- Technical properties and performance
 - Safety and risk to patients and health care workers
 - Efficacy and effectiveness
 - Economic attributes
 - Acceptability to patients and clinicians (comfort, ease of use, utility)
 - Risk of liability
 - Potential for standardization
 - Impact on market share/competitiveness
 - Requirements for facility modification/work flow
 - Manufacturer reputation and support
 - Capacity of vendor to provide sufficient and reliable supply.

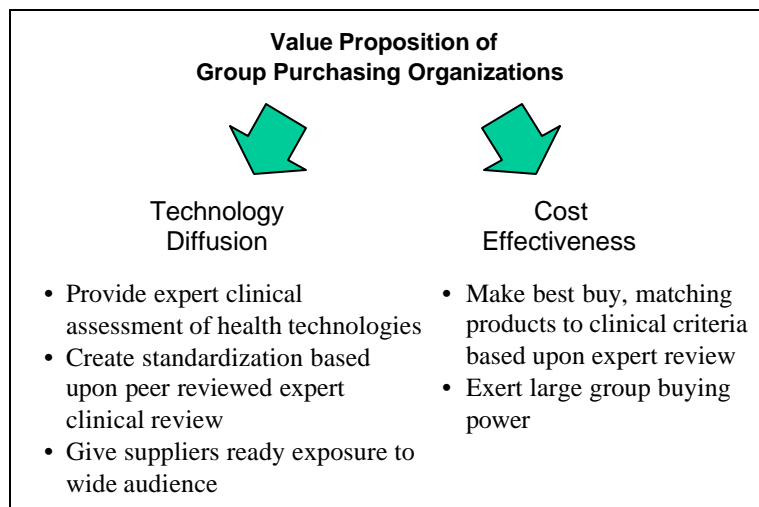
For both health systems and GPOs, reporting mechanisms range from standard change-of-product forms (for commodities) to white papers and formal reports (mostly for pharmaceutical and therapeutic products) to reports containing extensive analysis for capital equipment.

Health systems and GPOs expressed that there are many mechanisms to acquire technology beyond the GPO, and that these avenues are increasing. This is leading GPOs to offer new programs and services and to modify existing ones in order to remain the preferred purchasing channel.

I. BACKGROUND AND OBJECTIVE

The Lewin Group was engaged to assist the Health Industry Group Purchasing Association (HIGPA) in determining the extent to which group purchasing organizations (GPOs) and health systems employ clinical review processes to inform technology decision-making. Of particular interest was whether these clinical review processes support timely adoption and evidence-based, cost-effective use of health care technology. For the purposes of this study, “clinical review” refers to processes to assess or examine attributes of health care technologies, particularly pharmaceuticals, medical-surgical devices, and equipment, for the purpose of making acquisition decisions.

As requested by HIGPA, Lewin performed a survey to accumulate evidence to examine objectively selected aspects of the value proposition offered by GPOs in the context of these processes, as depicted below.



II. METHODOLOGY

Five health systems and six major GPOs were surveyed during February and March 2002. The interview sample is not considered to be statistically representative, but rather, illustrative. Health system interviewees were purchasing managers, administrative officers, and medical officers. GPO representatives interviewed were clinical operations directors, chief executives, or other senior company executives. The interviews were conducted by telephone, using a detailed interview guide (see Appendix A) which was sent to all participants in advance of the calls. The Lewin Group developed the guide with input and comments by HIGPA.

In cooperation with HIGPA and executive staff at these organizations, Lewin sought to identify interviewees who would be most familiar with the clinical review processes and their roles in technology acquisition. In general, interviewees were knowledgeable and forthcoming with information pertaining to the topics discussed during the telephone discussions. Most interviewees appeared to have reviewed the interview guide prior to their call and were prepared to respond to questions. Consistent with the content of the interview guide, proprietary aspects such as contract terms, financial arrangements, and business tactics, were not discussed during the interviews; however, non-proprietary attributes of and approaches to the clinical review process were addressed.

Table 1 below provides information about the characteristics of hospital/health system participants and GPO participants. The health systems were promised that they would not be identified by name. Table 2 illustrates significant characteristics of the GPOs that participated in the survey.

Table 1
Characteristics of Surveyed Hospitals and Health Systems

Hospital	System	Location	Teaching
A	4-hospital regional system 1 large, 3 small hospitals	Mid-size city Midwest	Yes (medical school affiliate)
B	One hospital was interviewed; part of a 52-hospital Catholic System, 442 beds	Urban/suburban East	No
C	2-hospital academic medical center system, 775 beds & numerous clinics	Large urban/ suburban West	Yes (own medical school)
D	Major System: 19 hospitals & health plan	Urban/suburban East	Yes (own medical school)
E	Stand-alone, 399 beds & 18 clinics	Urban—"almost inner city" Midwest	No

Table 2
Characteristics of Surveyed GPOs

GPO	Size	Purchasing Focus	Ownership Structure
AmeriNet	14,315 members: 1,924 hospitals, 3,840 clinics 1,086 ambulatory surgery centers, 1,806 Long-term care centers 103 integrated delivery networks 4,814 physicians (hospital based) 863 other \$5.2 billion/year	Full range of products	Cooperative Three Shareholders: AmeriNet Central, Warrendale, PA, Intermountain Health Care, Salt Lake City, UT and Vector, Providence, RI
Consorta Catholic Resource Partners	2,000 sites: 455 hospitals 1,500 other facilities	Full range of products	Cooperative Owned by 12 Catholic health systems; each holds equal shares
Magnet	Primarily the NE quadrant of the US; represents 7 other GPOs	Capital equipment and niche products (surgical instruments, food service mgmt., IV infusion pumps, uniforms). Does not handle pharmaceuticals.	"Group of groups"; unique umbrella role for 7 other GPOs

GPO	Size	Purchasing Focus	Ownership Structure
Novation	2,200 health care organizations (VHA) 78 major academic medical center organizations plus affiliates (UHC)	Full range of products	Supply chain management company for and owned by VHA (75%) and University Health System Consortium (25%)
Premier	203 health systems composed of 892 hospitals plus 669 hospital purchasing affiliates Many additional “alternate sites” purchase through Provider Select	Full range of products	Owned by 203 health systems
Shared Services, Healthcare Inc.	1,000 members \$330 m in sales 10 SE states	Full range of products	Cooperative Members pay a nominal annual fee to become shareholders. Members comprise board and advisory board

III. FINDINGS

This study revealed that GPOs and health systems conduct extensive and rigorous clinical reviews when deciding which health care technologies will be listed in purchasing contracts and made available for use. The exact locus of the clinical review process can vary – sometimes more is done at the GPO level, and sometimes more is done at the health system level – but in any event these processes employ widely accepted methods for assessing the clinical value of health care technologies.

Specific elements of clinical review processes that prevailed in the organizations interviewed are summarized below.

Clinical review processes of health systems and GPOs rely upon comprehensive systems of expert committees. These committees cover a broad array of clinical and administrative areas, and comprise a range of clinicians, technicians, managers, and others drawn from the member health systems themselves and outside experts.

Recognized independent technology assessment resources are used. Information gathering for the clinical review processes tends to draw upon many of the same widely recognized sources used by other types of technology evaluation processes present in the health care sector, including independent assessment groups such as ECRI and Hayes, and databases of peer-reviewed literature such as MEDLINE. For example, Premier makes extensive use of assessment reports and related services of ECRI, and Consorta provides access to Hayes assessments for its member institutions.

Health systems and GPOs have functions for monitoring and incorporating “breakthrough” and other novel technologies. Although much of their purchasing activity is devoted to acquisition of “commodity” products of demonstrated quality, most health systems and GPOs have dedicated functions or other provisions for incorporating new and unique technologies into their purchasing contracts. These functions include the capacity to respond to initiatives from technology companies/vendors, as well as actively seeking out novel technologies with the potential to be added to contracts or supplant technologies under contract. Consideration of such technologies is subject to the demonstrated safety, effectiveness, cost-effectiveness, reliability of supply, and other attributes that pertain to other technologies.

Mechanisms for ongoing review are in place. Some GPOs conduct ongoing or “perpetual” reviews of new technologies as part of their regular contracting process. In addition to reviewing technologies as part of their regular contracting cycles (typically three to five years), these contracts often have provisions for replacing/upgrading these technologies in mid-contract when a vendor places a new model on the market or when a GPO identifies a preferable alternative.

Information is shared among clinical review functions. Certain separate functions related to review of clinical practices and technologies are linked within health systems and GPOs, which serves to strengthen them. For example, one of the surveyed GPOs has a clinical technology service that undertakes repair, maintenance, and upgrading for many types of capital equipment. The GPO arranges for the clinical technology service to provide its practical field experience with capital equipment to the GPO’s technology assessment process and its technology contracting process.

The breakthrough technology function of one of the GPOs is linked to the broader technology assessment group, so that information about breakthroughs can be fed into considerations of technology choices. In turn, the technology assessment group can provide information resources and expertise in support of analyses of the breakthrough technology function.

GPOs can facilitate clinical trials. A separate avenue by which GPOs can support clinical research involving health care innovation is by helping to facilitate clinical trials. One of the surveyed GPOs has a clinical trials index that serves to link technology companies (and other research interests) that want to conduct clinical trials with provider institutions interested in serving as trial sites.

IV. SUMMARY BY TOPIC

A. Structure and Role of the Clinical Review Process

Health systems and GPOs were queried about steps in the technology review process for medical/surgical devices, pharmaceutical products, and capital equipment, and the extent to which the process was used to support or inform the acquisition, procurement, or use of health care technology.

Health Systems

Regarding the process, the response of one hospital executive is representative of the entire sample:

“The process is similar in all three cases (devices, pharmaceuticals, capital equipment). The end users are after a change or a new product, and pass their requests through the various committees. The process is stimulated by physicians, front-line staff, or by an outside entity like a manufacturer or vendor.”

Similarly, health systems were largely consistent with regard to the structure of relevant committees, as follows.

- **Medical-surgical devices** are handled through a product evaluation committee, value analysis committee, product acquisition management committee, or comparable entity. The committee may be specific to particular clinical specialties or departments, or may have multi-disciplinary oversight over the entire health system’s acquisitions. There are other types of specialized committees devoted to particular products or aspects of certain types of products, such as sharps committees for reviewing products that present a risk of percutaneous injury from contaminated hypodermic syringes and other sharp medical devices. Task forces with outside experts may be formed to assess specific products and report their findings to these committees. There is usually a dollar limit to the unit costs of products addressed by the product evaluation/value analysis committee; products whose costs exceed a set threshold fall under the purview of a capital committee.
- **Pharmaceuticals** are typically handled through a pharmacy and therapeutics (P&T) committee, typically chaired by the director of pharmacy and comprising primarily clinicians and pharmacists. P&T committees perform independent reviews of pharmaceuticals being considered for the formulary. P&T committees in multi-hospital systems involve members from across those institutions.
- **Capital equipment** is managed by capital committees that primarily review and assess technologies having high unit costs such as radiology equipment, or large multi-item purchases such as movable bedside equipment, taking into consideration the impact of acquisition on space and facility requirements, personnel, patient flow, and other institutional impacts. Capital committee assessments provide input to the capital purchasing and annual budgeting processes.

Table 3 provides an overview of the committee structure as reported by health systems in the survey sample.

Table 3
Health Systems' Committee Structures for Clinical Review

Health System	Category of Technology		
	Med/Surg Devices	Pharmaceuticals	Capital Equipment
A	Value Analysis Committee	P&T Committee, chaired by pharmacy director	Capital Committee
B	Product Evaluation Committee	Pharmacy Department/ P&T Committee	Capital Committee
C	<\$1m: Value Analysis Committee >\$1m: Executive Committee Clinical Services Committee contributes to process	P&T Committee	Capital Purchasing, Budget Committee (all items >\$50,000)
D	Each subspecialty has a multi-disciplinary Product Acquisition Management (PAM) Committee. Each hospital in system has an equal vote.	P&T Committee for each hospital system	PAM Committees for each subspecialty
E	Product Standards Committee involved in all purchases Sharps Committee also reviews certain products	P&T Committee	Total Quality Management teams focus on large multi-item purchases or new technologies. Representatives are mostly clinical staff.

Group Purchasing Organizations

The surveyed GPOs have established comprehensive committee structures and related processes to review new products. Committee members are generally drawn from the clinical, pharmacy and technical staff of GPO member institutions, supplemented by GPO staff and other outside experts. Numerous committees, typically arranged by clinical specialty areas, pharmaceutical products, capital equipment, and others, evaluate contract opportunities and formulate recommendations to the governing committee (e.g. a contract and program committee). In general, committees are charged to evaluate clinical and related technical properties first. If these elements are consistent with expectations for quality, then the committees consider relevant economic and other impacts of a product.

Aside from evaluating commodity technologies, GPOs have provisions for monitoring breakthrough technologies and for incorporating these technologies in purchasing contracts when they meet the relevant purchasing/acquisition criteria. For example, one GPO described how its breakthrough technology function evaluated the “camera pill,” a new diagnostic technology from a small company. Approved by the FDA in 2001 and available by prescription only, the device is used to visualize the inside of the small intestine to detect polyps, cancer, or causes of bleeding and anemia. The FDA cleared the device for use in conjunction with, not as a substitute for, other endoscopic and radiological evaluations of the small intestine. Despite its considerable unit cost, the GPO conducted an analysis that determined that it can be cost-effective. In deciding to include this type of technology in its purchasing contracts, the GPO can serve as a means for widespread diffusion of the technology.

Table 4
Structure of Clinical Review Process in GPOs

GPO	Features of Clinical Review Process		
	Process	Constituents	Comments
AmeriNet	Five Program Development Teams manage and review specific contract categories. Each team manages Centers of Excellence staffed by contract managers or market experts.	Program Development Team Constituents: GPO and Shareholder staff specific to the contract category.	Areas of purchasing covered: 12 Centers of Excellence: <ul style="list-style-type: none"> • Administrative services • Diagnostic imaging • Environmental services • Information resources • IV solutions and supplies • Laboratory • Medical supplies • Nutrition • Office supplies • Pharmacy • Plant engineering • Surgical supplies
	Member Advisory Groups seek health system input, experience, and advice.	Select Member Health Systems	Provide member input, experience and advice
Consorta	Contract and Program Committee receives recommendations from nine clinical subcommittees . Separate Pharmaceutical Advisory Committee (PAC) .		Medical devices reviewed by clinical subcommittees or task forces; results go to Contract and Program Committee, then contract strategy and bid process begins 80% of pharmaceutical portfolio is rebid every other year, looking at clinical effects and potential for substitution. Remaining 20% (mostly products in use a long-term use) is reviewed more in depth, with white papers distributed throughout the membership.
Magnet	No internal technical review process; receives input from members regarding equipment and devices.	N/A	Role is to determine what they can offer to their member groups in terms of better price for a set product chosen by the health systems.
Novation	Formal 8-step review process for all products going out for bid.	Multiple committees	Steps: <ol style="list-style-type: none"> 1. Identify member needs 2. Develop bid/define product and evaluation criteria 3. Bid analysis 4. Decision-making based on non-financial and financial factors 5. Resolution and clarification of issues 6. Finalize the award; develop launch package 7. Launch phase 8. Record retention

GPO	Features of Clinical Review Process		
	Process	Constituents	Comments
Premier	<p>Member Committee structure for medical/surgical devices for each major product category (e.g., med/surg, pharmacy and equipment).</p> <p>Clinical Technology Assessment Group looks at products going on contract. Reports to appropriate Member Committee.</p> <p>Separate Breakthrough Technology Group looks at “challenges” to existing products. Scans proactively for new technologies.</p> <p>Strategic Advisory Committee works on overall strategy for group purchasing services.</p>	<p>Member health systems (including clinicians and supply chain executives)</p> <p>Bioengineers and technicians</p> <p>Member health systems</p> <p>Member health systems</p>	<p>Member Committee makes final decision on whether to contract for a product</p>
Shared Services, Inc.	<p>Seven Advisory Committees review products under 3 scenarios:</p> <ul style="list-style-type: none"> • Vendors present new products • Committees bring needs to SSI • Existing products come up for review 	<p>Clinical, technical, and administrative staff from member health systems</p>	<p>Types of purchases covered:</p> <ul style="list-style-type: none"> • Pharmacy • Laboratory • OR • Radiology • Dietary • Materials management and services

B. Identification, Responsibility, and Locus for Review

The Lewin Group asked respondent health systems and GPOs to describe the way in which their clinical review process identifies and accommodates technologies to assess the types of technologies that are considered, and whether the review is conducted internally or externally. In addition, the participants were asked to identify the types of staff and experts who become involved in the process.

“Types of technologies” were defined by their physical nature (pharmaceuticals, devices, etc.) as well as in terms of their maturity:

- Experimental: undergoing laboratory or animal testing
- Investigational: undergoing clinical studies; prior to FDA approval

- Established: standard approach, in mainstream use
- Potentially obsolete/outmoded.

Another distinction was made among:

- Pure commodities, where price is the main difference among alternatives
- “Me too” products largely similar to others but which may have certain distinguishing characteristics (e.g., differing side-effect profiles among drugs of similar molecular structure in the same class)
- Breakthrough products where there is no alternative having the same effects.

Health Systems

Most health systems have a decentralized methodology for identifying products and technologies for review, coming often from their centers of excellence, specialty areas, and departments. They rely on physicians and other clinicians as well as technicians and business partners to define the agendas of the collective groups of committees that perform the review. Each teaching and research hospital surveyed reported that they review the full range of products, from experimental to potentially obsolete or outmoded. One hospital representative stated that “Obsolete technology is a function of default; it becomes apparent during the review process.”

Little of clinical review activity concerns experimental technology. Particularly at hospitals that have major research programs, some clinical review activity involves investigational technologies, including clinical trials of products that are not FDA-approved or that are FDA-approved but being investigated for new indications. Much of the clinical review is devoted to pharmaceuticals, devices, and other products that are recently FDA-approved, or whose approval is imminent. Regarding established technologies, products to be reviewed are often identified by the “value added” potential of the product. One example cited was new models of CT scanners. During the previous year, a health system “purchased new CT scanners which performed in 14 seconds what the old CT scanners used to do in 45 minutes, resulting in less trauma for the patient, better imaging, and more equipment time for patients.”

One hospital medical director stated that the distinctions between commodities, “me too” products, and breakthrough technologies are often made *de facto*, as follows.

“Mostly, we see breakthrough products – the latest and greatest. The pulse oximetry device is kind of a commodity – but a new feature could make it a me-too or a breakthrough. The committee’s job is to distinguish among these. Me-toos are usually not worth it.”

This medical director went on to state:

“Every single case involves an extensive financial analysis. It used to be that the analysis was not rigorous; most products were looked at as replacements. But most are not one-on-one replacements. They require focus on how they change care, payer mix, and the program impact.”

Across the sample, most reviews are conducted internally, with the use of benchmark data from external sources. In the larger health systems, a member of the responsible value analysis committee is designated as the internal reviewer, often leading a special task force. Vendor-supplied information is always validated against external review sources and internal expertise.

Most clinical review processes involve people who bring differing types of expertise. Managers, clinicians, pharmacists, laboratory and radiology technicians, clinical/biomedical engineers, risk managers, and attorneys are consistently represented on committees and task forces charged with clinical review. Economists, epidemiologists/biostatisticians, and ethicists participate on occasion. Patients and community representatives are less commonly included.

GPOs

GPOs surveyed do not generally contract for experimental or investigational (i.e., prior to FDA approval) technologies, but they have mechanisms for monitoring what is in the pipeline, through continuous market assessment. Staff contract directors are expected to stay current and bring products to review to the appropriate subcommittees, which are normally organized around service lines. Most contracts have terms ranging from three to five years, but if membership wants to look at a product in the middle of a contract (particularly something that looks like a promising breakthrough product), the GPO will reexamine the product or service line. Thus, the three-to-five-year duration of these contracts provides continuity of purchasing and supply while enabling GPOs to track availability of upgrades and emerging technologies, and to amend their product lists if appropriate within the scope of the current contracts or at the time of contract renewal.

Pharmaceuticals, particularly, are monitored closely from the experimental phase through the standard-of-care phase. A GPO will look at the whole range of therapeutic agents, even though it may not contract for the whole range. New brand names of drugs as well as those going off patent will be reviewed, and GPOs often produce their own papers or other reviews of specific drugs that may have significant clinical or economic impacts.

GPOs often will contract on a line-item basis, not for bundles of products. Each GPO that carries out clinical reviews reported that it has developed written analytical tools, which are employed to determine if products are clinically equivalent.

Certain GPOs do not perform clinical reviews, but act as the prime contractor for other member GPOs, who have direct contact with health systems and alternate care sites that constitute their membership. These GPOs deal only with products that are already on the market, and depend on the health system/hospital community for the locus of clinical review. They look for best practices among their membership and make this information available to their membership on their websites. While some GPOs maintain extensive internal databases regarding utilization and repair histories, all GPOs surveyed commonly use external sources of technology assessments and related evaluations, such as ECRI, Hayes, and Zynx Health as well as other sources for utilization and other market research data, health outcomes, and other input to their clinical review processes.

Similar to health systems, a full range of staff and outside experts are involved in the GPO review process. Participants include internal executives and managers, physicians, nurses, and other clinicians, pharmacists, technicians, clinical/biomedical engineers, economists, attorneys, and others.

C. Attributes Evaluated

The Lewin Group asked health system and GPO respondents to describe the types of attributes that are commonly evaluated for each category of technology that is assessed (medical/surgical devices, pharmaceutical products, and capital equipment). These attributes may be characteristic of the product itself or may result from the product's use.

Health Systems

Health systems identified the following comprehensive list of attributes and impacts of technologies that generally are incorporated into the clinical review process:

- Technical properties and performance
- Safety and risk to patients and health care workers
- Efficacy and effectiveness
- Economic attributes
- Acceptability to patients and clinicians (comfort, ease of use, utility)
- Risk of liability
- Potential for standardization
- Impact on market share/competitiveness
- Requirements for facility modification/work flow
- Manufacturer reputation and support
- Capacity of vendor to provide sufficient and reliable supply.

Each of these factors is used to differentiate products if other aspects are similar when conducting a review. Sometimes the risk of liability is explicitly considered; for example, a lower infection rate associated with a product can offset a high unit cost. The potential for standardization was mentioned consistently, especially by multi-hospital systems, as the need to have a unified organizational approach becomes necessary.

The performance capacity of manufacturers “is critical” and “key.” The longitudinal impact of the manufacturer's reputation and relationship as a supplier are important factors. Any doubts regarding the ability of a vendor to provide a reliable adequate supply of a product diminish the likelihood of that product being listed in a contract, even if the product itself is comparable in quality to others that are listed.

GPOs

GPOs surveyed gave responses that were consistent with those of health systems/hospitals with regard to attributes assessed during the clinical review process. In addition, GPOs mentioned “green” (i.e., environmentally friendly) sources and products as a sought-after attribute, such as in the use and disposal of mercury and the use of latex. Product conversion strategies were mentioned as an enhancement to the potential for standardization when considering a product. Most contracts with manufacturers contain performance criteria specific to a product, as well as indemnification clauses, which protect one party from a failure of performance by the other party.

D. Reporting and Link Between Review and Purchasing Action

Interviewees were asked about the reporting mechanisms that are used to communicate findings of technology reviews to decision-makers and about the link between the clinical review findings and the purchasing action to follow.

For both health systems and GPOs, reporting mechanisms range from standard change-of-product forms (for commodities) to white papers and formal reports (mostly for pharmaceutical and therapeutic products) to reports containing extensive analysis for capital equipment. Committee minutes and reports of proceedings are distributed to the parties involved and the leadership of the organization. One hospital stated, “We make a serious systematic attempt at reporting—it’s not haphazard—but there is no template. Each application has a core set of reported material.”

Table 5 summarizes GPOs’ reporting mechanisms, and the linkage between the results of a review and the purchasing or contracting action taken as follow-up. If a supply item is on the list of products carried by a GPO, the purchasing health system is expected to purchase from the list (some lists distinguish “preferred” and “acceptable” products). Health systems consider the financial implications of choosing “acceptable” versus “preferred” products, as well as going off the list, i.e., purchasing products directly from vendors, if enough evidence exists about the capabilities of unlisted products.

As the industry changes, particularly with large multi-facility systems, health systems go directly to manufacturers and suppliers. “Just because it’s the GPO doesn’t mean you always get the best price,” said one health system. This health system reported that it goes through a prime distributor for medical supplies and also has a wholesaler for pharmaceutical products; the GPO is their first source, then the prime distributor, and then the manufacturer.

Table 5
GPOs' Reporting Mechanisms and Linkages between
Clinical Reviews and Contracting Activities

GPO	Reporting	Link Between Technology Review and Contracting Action
AmeriNet, Inc.	Reports on research and member input as described in Table 4 are directed to the appropriate Program Development Team for evaluation and consideration in portfolio development.	AmeriNet welcomes opportunities to evaluate new technologies. Members are free to access product outside AmeriNet contracts, however, AmeriNet encourages members to bring new technologies to their attention for evaluation and possible portfolio inclusion.
Consorta Catholic Resource Partners	Information from technology reviews is transmitted to decision-makers via: e-mails, website (posts relevant clinical information), meeting minutes, benchmarking studies, white papers, and newsletters	Health systems are free to purchase items through other sources. Consorta generally has two types of contracts — preferred contracts and committed contracts. In the preferred contracts, it is recommended that the health system purchase a certain product or pharmaceutical from a particular vendor, but it is not a requirement. Even in a committed contract, hospital systems have some flexibility in purchasing items from non-committed entities. Consorta also encourages members to bring new technologies or products to their attention. If there is enough interest among hospitals systems to change product contracting, Consorta will do so.
Magnet	As noted above, Magnet does not have a technology review process (they rely on their members' review processes)	If a member wants an item that is not under contract, most likely Magnet will not be able to get the product immediately, but they will look into contracting with the suggested vendor at the time of renewal. However, the hospital/health system is free to go outside the GPO and purchase the item.
Novation	Nonfinancial and financial decision criteria are measured and reported through the decision criteria award matrix, customized for each bid and with input by members.	Invitations to bid are made public; if new technology has come to market, Novation will evaluate it. New technology clauses are present in contracts, subject to the award cycle.
Premier	Information from technology reviews is transmitted to decision-makers via: in-depth written reports (white papers) and meeting minutes. The Pharmacy Group does a worldwide literature search and detailed review to decide if they should more forward with a contract. This information is made available to members as well.	Premier's contracts do not require that members buy 100% through Premier, but they typically consider buying through Premier first Members are encouraged to come to Premier with suggestions for new products.
Shared Services, Healthcare Inc.	Minutes and reports from advisory committees.	Members are free to acquire items through other sources, but they can often get a better price if they commit to buying a certain quantity from a vendor under contract. These members will not be penalized if they choose to buy from an off-contract vendor.

Health systems and GPOs expressed that there are many mechanisms to acquire technology beyond the GPO, and that these avenues are increasing. This is leading GPOs to offer new programs and services and to modify existing ones in order to remain the preferred purchasing channel. One medical director of a health system characterized the relationship among GPOs, health systems, and manufacturers as follows.

“GPOs are not locking out ‘newer cusp’ technologies. Together with health systems, they evaluate products on the merits, they do a trade-off of costs and effectiveness, and they use best evidence. Purchasing consortia get the best price on command, and they don’t make it so innovation cannot occur.”

Appendix A

Survey Questions for Health Systems and GPOs

Survey Questions for Health Systems and GPOs

Background

What are the basic characteristics of your organization (size, purchasing focus etc.)?	
Describe the nature of the relationship between your organization and hospitals/health systems.	
Does the relationship include purchasing/acquisition of : <ul style="list-style-type: none"> • Medical/surgical devices (items used in diagnosis and treatment of patients, ranging from hypodermic needles to metering devices to implantable prosthetics)? • Pharmaceutical products? • Capital equipment used in patient care? 	

Technology Review Process

Does your organization have one or more processes for reviewing/evaluating health care technologies – particularly medical/surgical devices?	
Various organizations with such processes refer to them as clinical review processes, technology assessment/evaluation programs, pharmacy & therapeutics (P&T) committees, etc. If you do have one or more such processes, what are they?	
(GPO) Describe the contracting process for drugs and medical devices.	

Role of Process

How to what extent is this process used to support or inform the acquisition, procurement, or use of health care technology in your organization?	
(GPO) Do you have any programs for identifying and assessing new technologies?	

Timing of Process

Approximately how much time (range of number of days, weeks or months) is required to conduct a typical technology review?	
When does the review process occur in relation to the timing of product acquisitions – before purchase, or after products are in use?	
If the review process occurs before product acquisition, do you also monitor/assess the performance of technologies after they are in use in your organization?	

Attributes Evaluated

<p>What attributes/impacts of technologies does your process usually assess? For example:</p> <ul style="list-style-type: none"> • technical properties/performance • safety or risk <ul style="list-style-type: none"> ➤ for patients (e.g., adverse effects) ➤ for health care workers and other staff 	
<ul style="list-style-type: none"> • efficacy/effectiveness (health outcomes) 	
<ul style="list-style-type: none"> • economic attributes <ul style="list-style-type: none"> ➤ costs, prices, charges ➤ cost-effectiveness, cost-benefit, cost-utility 	
<ul style="list-style-type: none"> • acceptability <ul style="list-style-type: none"> ➤ to patients (e.g., compliance, comfort) ➤ to clinicians (e.g., ease of use) 	
<ul style="list-style-type: none"> • risk of liability 	
<ul style="list-style-type: none"> • potential for standardization 	
<ul style="list-style-type: none"> • impact on market share/competitiveness 	
<ul style="list-style-type: none"> • requirements for facility modification/reorganization/work flow 	
<ul style="list-style-type: none"> • manufacturer reputation and support (e.g., training, customer service) 	

Identifying Technologies for Review

<p>Given the diversity and volume of new and existing health care technologies, how does your process identify technologies for review?</p>	
<p>Given that technologies have their own life cycles or stages of maturity, which of the following types of technology does your process generally review?</p> <ul style="list-style-type: none"> • Experimental: undergoing laboratory or animal testing • Investigational: undergoing clinical studies; indications not FDA-approved (if appropriate) • Established: standard approach, in mainstream use • potentially obsolete/outmoded 	
<p>Technologies can range from being pure commodities – where price may be the main difference among alternatives – to being “me-too” products that are largely similar to others but that may have slightly differing attributes (e.g., in design, materials, side effect profiles), to being “breakthrough” or truly unique technologies – where there is no alternative having the same health effects or other outstanding attributes. Does your identification of technologies for review consider distinctions such as these?</p>	
<p>Does your process use any criteria or other means for setting priorities among technologies to be reviewed? If so, could you provide some examples?</p>	

Responsibility/Locus for Review

<p>Is your review conducted internally, outsourced, or some combination or variation of these?</p>	
<p>If external sources are used, what are they – technology review vendors/services (e.g., Blue Cross Blue Shield Association, ECRI, Hayes Inc.), other?</p>	

<p>If your process is internal, where is it managed in your organization and/or what parts of the organization are involved (departments, inter-department committees, etc.)?</p>	
<p>If your process is internal, what types of staff and expertise are involved in the review process? For example, these might include:</p> <ul style="list-style-type: none"> • managers (e.g., executive staff, accounting, risk management, purchasing) • clinicians • pharmacists • laboratory and radiology technicians • clinical/biomedical engineers • patients and community representatives • epidemiologists/biostatisticians • economists • lawyers • ethicists 	

Methods and Sources

<p>To what extent does your process rely on either or both of the following?</p> <ul style="list-style-type: none"> • Primary data collection (collect original data, e.g., using clinical studies, surveys) • Secondary data analyses (combine/integrate data from existing sources using, e.g., literature reviews, group judgment) 	
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<p>What types of information/data sources does your process use?</p> <ul style="list-style-type: none"> • Databases of published literature (e.g., MEDLINE) • clinical and administrative data (e.g., from Medicare, your organization) • reports/monographs of government agencies and research institutes • FDA, OSHA and other regulatory documents/policies • third-party payment policies (e.g., Medicare, Medicaid, health plans) • health professional association reports and guidelines • market research reports • vendor/manufacturer reports, press releases, and product labeling • health newsletters and newspapers • colleagues and investigators • web sites (as a primary source) 	
<p>Does your process use any approach to grade or weigh the quality of evidence (e.g., its methodological rigor, validity) pertaining to technologies under review? If so, please describe.</p>	

Reporting

<p>How and in what form are the findings of technology reviews transmitted to decision-makers?</p>	
<p>How are these findings used in decision making? Can you give examples of where the technology review process was crucial to the purchasing decision?</p>	

Link Between Technology Review and Purchasing Action

<p>If a hospital/health system selects a particular medical/surgical item that you do not normally supply, will you obtain it for them anyway?</p>	
<p>If you will not supply a specific item, is the hospital/health system free, under the terms of the GPO contract, to acquire the item through other sources? In your experience, hospitals/health systems made many such off-contract purchases?</p>	

<p>Have hospitals/health systems changed product selections based on your influences? Was this because:</p> <ul style="list-style-type: none">• Your organization furnished compelling evidence of a product's clinical superiority?• Your organization explained that the manufacturer would be unable to supply the desired product quickly enough, or in sufficient volume?• The costs of circumventing your organization were too high?• Other influences?	
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