Selling to Today's Value Analysis Committee

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Executive Summary

In the course of our work at Market-Partners, we talk with many executives who operate business that seek to sell their offerings into hospitals and Integrated Delivery Networks (IDNs). These company leaders have a strong belief that their offering provides tremendous value to their target market, and rightfully so. The vast majority of the offerings we see are well thought out and indeed have excellent value propositions that match what hospitals and IDNs perceive to be valuable. However, we also hear that selling into hospitals and IDNs has become much more difficult over the past few years. Sales cycles have lengthened, and customers often either hesitate to buy an offering that does have clear value or indefinitely postpone the decision to buy.

We have also observed that executives and their sales teams tend to approach these challenges by selling harder, i.e., spending more time trying new ways to convince hospital personnel, and particularly the Value Analysis Committee (VAC), of the value of their offering, or simply trying to avoid or bypass the VAC. We often hear sales reps and company leaders say things like, "Success is just around the corner…if we keep pushing, they will eventually understand our value proposition and once they see it, they will buy".

In fact, hospital personnel and VACs usually do understand the value of offerings that they are hesitating to commit to. This begs the question of why a VAC would reject an offering that they know can create value for the hospital, even when a doctor recommends it as being beneficial for a patient. Some believe that the reason behind the answer lies with the passage of the Affordable Care Act (ACA). However, the reasons behind why VACs reject offerings that clearly have value have less to do with the ACA than we may think.

In order to understand why VACs behave the way they do, and how we can more effectively navigate a hospital's Customer Buying Journey, we must consider the history behind hospital buying behaviors and the root causes of why a VAC may reject an offering whose value is clear. This paper explores the evolution of hospital and IDN buying behaviors, the emergence of the modern VAC and how understanding the significance of the Customer Buying Journey can help companies successfully sell their offering into hospitals and IDNs.

Whereas we don't believe that there is a straightforward and/or simple approach to selling to VACs we believe there is great value in understanding the origins of the modern VAC and how they developed.

History

It is a common belief that the ACA has been driving complexity in the way that hospitals evaluate and buy devices, and especially physician preference items. While it is true that the Affordable Care Act (ACA) has caused disruption and has had a significant impact on many aspects of the healthcare industry, it is important to set the context that hospitals have actually been trying to contain costs for years. The first GPO, albeit primitive, was formed in 1909.[1]

Further, the push by hospitals to contain costs started accelerating prior to the ACA, when Diagnostic Resource Groups (DRGs) were integrated into Medicare's reimbursement structure as a method of capping reimbursements for medical services. DRGs came out of a Yale study designed to create a "casemix" classification system that would identify medical "product lines" for Medicare. It was later discovered that categorization of clinical care could be matched with the use of resources, and from there evolved into today's DRG structure. DRGs were adopted into the Medicare reimbursement structure in 1982, nearly 30 years before the passage of ACA. Today, DRGs (or some form thereof) are used globally, with Australia being an early pioneer along with the United States.[2]

The use of DRGs introduced the concept of tying hospital reimbursement levels and caps to a market basket index and political process.[3] As reimbursements were capped based on the DRG and various complexities surrounding each specific case, the costs of hospital labor were rising. Since labor costs were so difficult to reduce, hospitals began focusing on reducing the costs of devices and equipment. This led to the formation of Product Evaluation Committees, which were the forerunners of modern-day Value Analysis Committees or VACs.[4] [5]

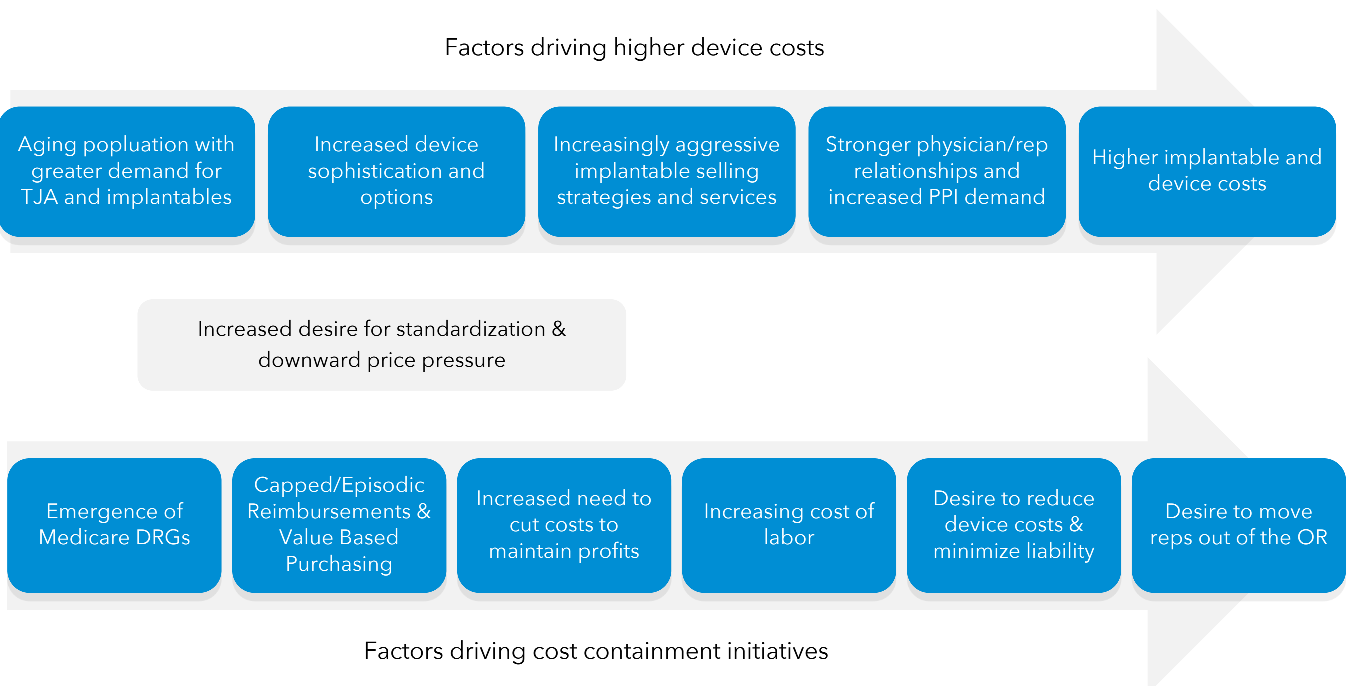
Around the same time, a number of factors were driving up the costs of medical devices. The first was an aging baby boomer population with an increasing demand for joint replacements and implantable devices.[6] The growing need for implantables resulted in increasingly aggressive selling strategies and tactics where device salespeople sought to provide even more profitable devices, implants, and value-added services to surgeons. A key factor that drove the more highly aggressive selling strategies is that the devices themselves became more sophisticated, requiring more training for surgeons. In many cases, training was left to the device sales rep, who would not only provide education prior to the surgeon first using the device but would also join the surgeon in the Operating Room (OR) and provide guidance on how to use the device on a particular case. [7]

As sales reps spent more time in the OR, surgeons' reliance on the sales reps grew. Since surgeons are paid for performing operations, they favor reps who can provide a high level of support that reduces the amount of time they must spend on a particular case. Spending less time on a case allows a surgeon to complete more cases in a day and thus increases their ability to generate revenue. As such, surgeons who see a rep as being particularly helpful tend to favor the device that the rep sells. Thus, sales reps drive physician preference by helping surgeons to complete more cases and generate more revenue. The confluence of an aging population with a greater need for devices, more sophisticated devices that require more education, and sales reps who are able to help surgeons work faster and complete more cases, has increased demand for Physician Preference Items (PPIs) and led to higher device costs.

In the late 1990's through 2010, sales reps were often touted as an important part of the surgical team. [8] However, since 2010, hospitals, and the healthcare industry overall, began to question the role of the sales rep in the operating room.[9] Two key factors drove this change. Firstly, hospitals took note of the impact that PPIs had on profits, especially when considered against the backdrop of capped

reimbursement. Secondly, there was heightened awareness of the potential liability of having a sales rep in the operating room, as courts ruled that the “captain of the ship” doctrine could be applied to the actions of a sales rep. Under the “captain of the ship” doctrine, a surgeon can be held responsible for accepting poor or inaccurate advice from a sales rep who is providing guidance on the use of a device, as the surgeon is ultimately responsible for the actions of those in the operating room.[10] However, “captain of the ship” doctrine does not shield sales reps in all cases. For example, those who are found to have practiced medicine without a license while working alongside the surgeon.

The diagram below shows the confluence of factors that have driven higher device costs and those that have driven cost containment initiatives. Higher device costs started with an aging population and a higher demand for Total Joint Arthroplasty (TJA) and implantables. This drove device companies to develop increasingly sophisticated devices that called for more guidance from sales reps that naturally led to more aggressive selling strategies and value-added services. The services provided by sales reps, in many cases, allowed the surgeon to increase their case volume and thus revenue which strengthened surgeon/sales rep relationships and drove greater physician preferences for items sold by favored reps. The resulting increase in PPIs has driven up device costs, such that they are now a greater percentage of the overall cost of care.



The factors that drive cost containment initiatives started with the emergence of Medicare DRGs and a capped/episodic reimbursement structure. Capped reimbursements increased the need to reduce costs in order to maintain profits. Later, with the ACA, came Value Based Purchasing which further drove down reimbursements by factoring in various performance metrics that are related to quality of care as

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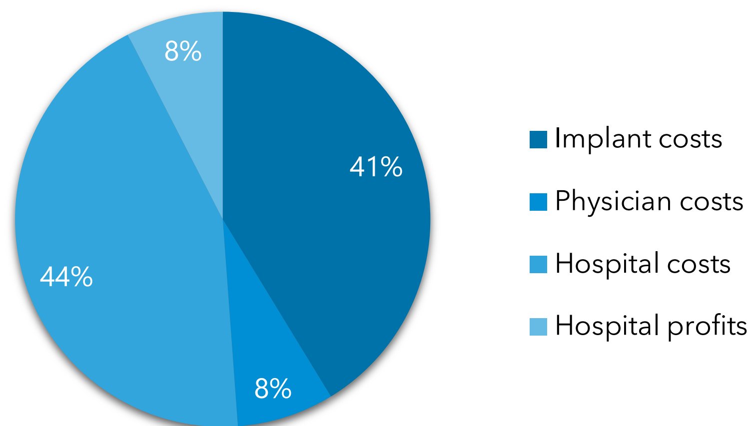
defined within the Centers for Medicare and Medicaid Services (CMS). Faced with ever-increasing labor costs, hospitals were (and still are) forced to look for additional ways to cut expenses. The increasing cost of implantables and devices as a percentage of the overall cost of procedures such as joint replacements, became a focus of attention. Physician/rep relationships and increased PPI demand was seen as a reason for higher device and implantable costs, so there has been an increasing desire to move reps out of the operating room.

Ultimately, the desire to minimize costs and liability combined with the higher cost of implantables and devices has created downward price pressure on devices and has increased the desire to standardize on specific devices for various procedures. This has led to greater scrutiny of PPIs and the role of the rep in the operating room by bodies such as Value Analysis Committees. This trend is expected to continue, given recent industry costs analyses. A study by Veterans Administration showed that the cost of devices increases between 14% and 16% when a sales rep is in the operating room.[11]

TJA Cost Breakdown (Source Intralign Corporation)



The Modern VAC

Early Value Analysis Teams (VATs) often were composed of purchasing and administrative staff members, with minimal physician participation. However, the relationship between physicians and VATs quickly became contentious, as physicians called for greater input into the process of evaluating what devices are adopted as standards within a facility or IDN. Hospital administrators quickly learned the importance of physician representation, although many physicians were initially skeptical of participating in VATs.

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Over time, however, physician participation in VATs became par for the course, and today is an expectation. VATs became even more inclusive, bringing in representation from nursing and other areas of the hospital. The inclusion of more stakeholders led to the formation of what we now know as Value Analysis Committees, or VACs.[12]

The role of the VAC has also evolved over time. Initially its purpose was to keep costs down, and place limits on PPIs. However, its role has increased in complexity, balancing the quality of care, cost control and profitability, supply chain management, and standardization. The modern VAC is both a political body and a team that plays a key role in the management and profitability of the hospital.[13]

Impact on Product Adoption & Selling

Despite hospitals' desire to move sales reps out of the operating room and the emergence of VACs, having a rep in the OR is still a common practice. There are an estimated 94,752 medical device sales reps in the U.S., with many in high cost, high touch physician preference item categories. Although sales

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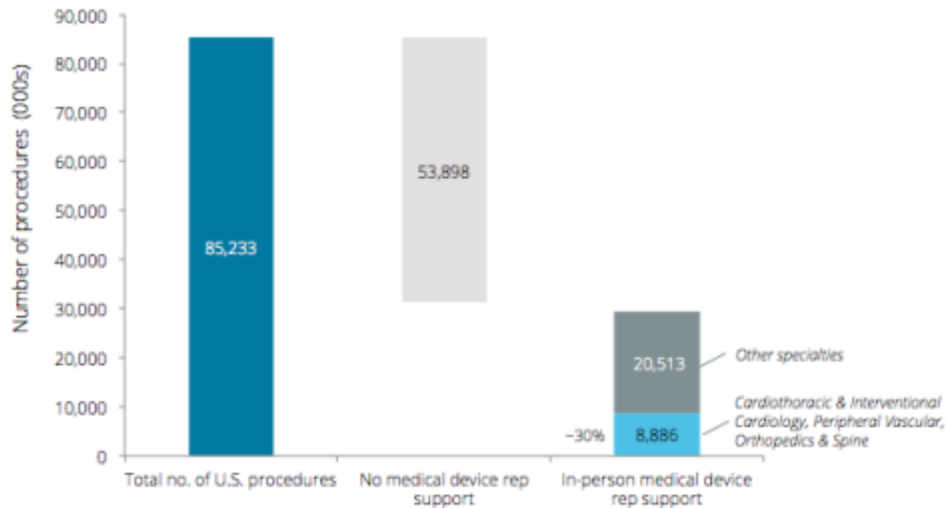
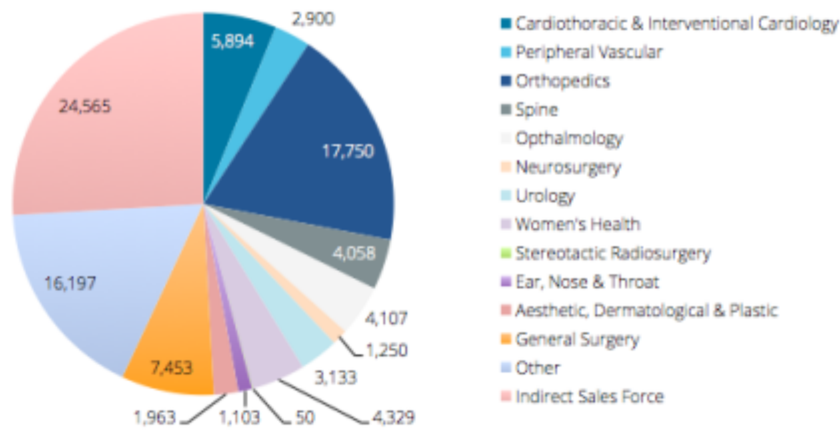
reps are present in the operating room for less than half of all procedures that are performed, their presence is not infrequent.[14]



As of 2015, an estimated 31 million procedures (37% of total US procedures) have a sales rep present in the operating room during the procedure.[15]



However, this is expected to change for a variety of reasons. Firstly, medical device companies themselves are taking steps to move sales reps out of the OR by providing surgeons with touchscreen devices that can provide guidance on how to use a device.[16] Secondly, the Customer Buying Journey

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that hospitals engage in, i.e., the process by which a hospital acquires and adopts a particular offering, is becoming inherently more complex due the sheer number of stakeholders and competing interests.

While the VAC is not the only element of the Customer Buying Journey, it is highly influential, and at least a portion of its members are likely to want to limit sales rep access to the OR. Further, the VAC adds a level of complexity that can be difficult to navigate, even for an insider such as a surgeon. As a result, it often appears to the sales rep that the purpose of the VAC is simply to block new products, PPIs, and sales reps themselves from coming into the hospital. However, this is not the case.

VAC members generally want to provide the best possible care for the patient and feel a duty to look critically at new products and devices, particularly when there already is a device that serves a particular purpose. Frequently, VAC members do not believe, at least initially, that swapping one product for an equivalent one will result in better patient care or outcomes.[17] In fact, VACs may often engage in what some call the "my science vs. your science debate", seeking to show that the science behind the product that is currently in use is optimal for "our environment" and that a study done somewhere else "works there, but may not work as well here".

Another challenge the rep faces when working through a VAC, is that VAC members have "day jobs", and can become overwhelmed with new offerings that claim to provide lower costs and better outcomes. For some VAC members, it is becoming harder to find the time needed to evaluate everything that is brought before them.[18] As a result, many great offerings that the supplier believes is a 'no-brainer' for a hospital to adopt, are rejected due to a lack of time or a belief that the existing method is good enough and doesn't need to be replaced.

While VACs may be willing to adopt a lower priced product if they truly believe that it is equivalent to a higher priced product such that the patient can get the same quality of care at a lower cost, they also consider the total cost of supplies, using functional matrixes to evaluate costs.[19] This presents challenges to early-stage companies who are launching one product or a set of closely related products. Consider that a large company with many products has much more ability to spread discounts across a wide range of supplies by bundle pricing. Thus, even when a small company presents a lower cost equivalent to a product that is offered by a larger company, the larger company can provide discounts across other product lines to offset the cost savings that are offered by the smaller competitor. This is why many smaller and newer companies are sorely disappointed when they try to compete on price against a large organization or a GPO that offers a higher priced equivalent product. Although counterintuitive, offering a lower price to a VAC may not yield a successful outcome.

The factors of time and risk also present a challenge to those who wish to gain adoption of their product by a VAC. Time and risk are not only elements that impact the seller, but the buyer. Hospitals are notoriously slow to adopt new practices or products, and out of history and necessity have inclusive mind sets that make getting anything done slow due to the number of people that need to be involved and their political environment. In the vast majority of cases, at least one influential medical champion is

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required to get through a VAC evaluation. Navigating the hospital's buying journey and VAC is time-consuming not only for the sales rep, but also for the champion. Additionally, depending on the political landscape, championing a new product can entail a level of personal and professional risk.

Many physicians simply do not have the time required to champion a new offering, nor do they want to take the risk of championing something they are not convinced will make it through the scrutiny of the VAC. Even when a well-intended physician decides to act as a champion, they may not be able to invest the time and energy it takes to navigate the buying journey or may not understand how to do so successfully.[20]

Navigating the Hospital's Customer Buying Journey & Role of the Salesperson

Most experienced sales reps understand that the hospital Customer Buying Journey is complex and time-consuming. However, despite this understanding, we often observe sales reps attempting to sell around the VAC, jumping to work with the first champion they find, or being carried away by their optimism and thinking that the VAC somehow won't be involved, all of which almost always will lead to an extended sales cycle that yields marginal results. We have seen many cases where the rep forgets that when selling to hospitals, speed kills while taking a deliberate approach to discover the inner workings of the VAC at a given facility or IDN actually saves time and generates a higher rate of success.

For a given offering, hospitals and IDNs generally will engage in the same Customer Buying Journey. For any offering, different buyers will share similar concerns that may slow or stop the Customer Buying Journey, alternatives and stakeholders. However, every VAC is, at least to some extent, unique and each organization has its own subtleties that are important to be aware of. These may be based on factors that include organizational size, culture, region, patient population, institution type (e.g., academic, community hospital) or specialties.

Mapping the Customer Buying Journey is the first critical step that a company must take in order to enable the sales rep to improve their odds of success, navigate that Customer Buying Journey as quickly as possible, and maximize hospital spend. It is important too that the sales rep becomes conversant in, and understands, the unique elements of the Customer Buying Journey. At that point, the rep is in a position to choose the most effective possible champion and help the champion minimize their time requirements and personal or professional risk.

Developing a clear understanding of the Customer Buying Journey also will clarify those things that stop or slow the process of evaluating and adopting a new product (i.e., the "buying concerns"), so they can be planned for and addressed up front, rather than become unpleasant surprises that derail what appears to be a great opportunity. For example, a need to train hospital employees on a new device or process could provide the hospital with a reason to stick with the status quo. In this case, taking the time to develop early knowledge of how individual VAC members perceive such a Buying Concern

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allows both the rep and champion to gain buy-in from the VAC more efficiently and avoid many of the pitfalls that are unique to a particular institution or IDN.

It is important for sales to remember that VACs see and turn down great products all the time, and the primary reason for rejecting a great product is not because of the value or price, but because the seller fails to fully grasp the buying concerns and Customer Buying Journey. One example is Ascent Medical, who developed medical reprocessing technology, i.e., technology that facilitates the reprocessing and re-using or items that are otherwise only approached for single use. At first glance, reprocessing seems like a no-brainer, as it can save a hospital large sums of money on items that ordinarily would be disposed of at a cost. When the Ascent reps first started selling reprocessing technology, they simply promoted the cost savings and trivialized the buying concerns. The problem was that hospitals did not want to have to retrain their staff to manage reprocessed devices and engage in reprocessing activities themselves. This type of buying concern is something that typically would be detected when mapping the Customer Buying Journey for reprocessing technology, however, in this case, the sales team had to find out by trial and error.

Ultimately, Ascent repackaged their offering as a service so that hospitals did not have to train their staff on reprocessing or attend to the many details that make a reprocessing system work. Ascent offered reprocessing as an end-to-end service where they provided the upfront expertise to set up the required processes, and then would pick up used items and drop off reprocessed ones. The hospital enjoyed the benefits of the cost savings without disrupting their processes, systems or staff. Ascent was later acquired by Stryker Corporation of Kalamazoo, Michigan.

In summary, the key to success in navigating a hospital's Customer Buying Journey and engaging a VAC is to resist the temptation to shortcut the process. Instead, it is important to invest the time not only in discovering needs and value drivers, but to gain an in-depth understanding of the nuances of the particular Customer Buying Journey and VAC dynamics. Below are a few basic rules of selling to hospitals and IDNs in today's business environment, and particularly VACs:

DO NOT

- Simply sell the offering, its benefits and value
- Believe that the VAC won't be involved
- Try to convince the VAC of the efficacy of the offering simply using your own clinical evidence and science
- Rely on strength of the offering alone to win the business
- Leave any unanswered questions that the VAC may have about the adoption of your offering across their organization

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DO

- ✓ Understand the end-to-end Customer Buying Journey for your offering to determine who will be involved, when they will be involved, and especially what concerns they may have with acquisition and adoption
- ✓ Take the time to decode each prospective customer's organization and individual concerns
- ✓ Develop champions and sponsors across the organization
- ✓ Understand who is on the VAC and how the VAC typically meets and reviews new offerings
- ✓ Treat the sales campaign more like a political campaign of gaining support from different factions rather than a traditional sales campaign of simply selling the benefits of the offerings to certain individuals (however influential you think they may be)
- ✓ Understand that your role is to support your champion(s) as they navigate the Customer Buying Journey
- ✓ Ensure that your champion(s) is able to communicate a clear picture of how your product or service will be implemented and/or adopted across then organization
- ✓ Ensure that when the VAC reviews any proposal to adopt your offering is it 100% complete with all possible questions answered…anything less than this is almost certainly going to get slowed or stopped

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