

# Outsource or In-House: A Complex Equation



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**For hospitals deciding whether to outsource some or all of their biomedical services, there is no one-size-fits-all answer**

George Gyurtsak, director, biomedical services, Community Health Systems, is becoming rather an expert at insourcing: that is, converting biomedical service departments from those that use outsourcing models to those that bring services in-house.

In fact, of the 208 affiliated hospitals (in 29 states) that the Franklin, Tenn.-based hospital company owns, leases, or operates, about 190 have in-house biomedical departments. And, according to Gyurtsak, the majority of these 190 departments have been converted to an in-house operation in just the past 6 years.



George Gyurtsak

Why this massive shift from outsourcing to in-house? Considering the less than optimal financial environment hospitals are dealing with, it's inevitable leadership is looking for ways to cut costs. "And I think there is just a lot more focus on the part of upper management to look at service expenses much more closely," Gyurtsak says. "And any time there is an opportunity to reduce your costs and expenses, while you're improving services, management is going to be interested in [going in-house]."

Considering the size of Community Health Systems, it isn't surprising that it has decided to take the in-house servicing option.

“There’s a size where it always makes sense to outsource and a size where it never makes sense,” says David Hargraves, MBA, CPM, CMRP, vice president, clinical supply chain, and vice president operations, BioTronics Inc.

BioTronics (formed in the early 1980s) is a subsidiary of the University of Pittsburgh Medical Center (UPMC), and as such is the clinical engineering services provider for UPMC. It also



David Hargraves

provides equipment management and clinical engineering services to a number of other hospitals in the region.

“The fact is, the smaller the healthcare facility in terms of the number of beds, pieces of equipment, and FTEs (full-time employees) in the clinical engineering department, the more likely service is going to be outsourced,” Hargraves says. “In the case of UPMC and BioTronics, we have over 145 employees, so there is almost no scenario in which we would outsource that business, because we are large enough, and have the capacity, the cross-training, the

redundancy, and the ability to float technicians between facilities, so we can achieve a much lower cost-to-service ratio.”

On the other hand, he points out, if a facility has a biomedical services department with two or three employees, it’s unlikely to spend thousand of dollars to get one of them trained to maintain and service a computed tomography scanner.

That’s precisely the kind of situation that Izabella Gieras, MS, MBA, CCE, director, clinical technology, at Huntington Memorial Hospital in Pasadena, Calif, faces in her department.

The size and competency of her staff will determine her department’s ability to maintain and service specific pieces of equipment or maintain it through service contacts.



Izabella Gieras

“If we have just one MRI—and that’s what we have at Huntington (which is a 625-bed, nonprofit, regional medical center)—we’re obviously not going to train one person to be an MRI specialist to maintain that one machine,” Gieras says.

And there are other variables as well, such as accessibility to training, the cost of the training, the age of the equipment in question, and its service history, she says. “So we’ll take all of those different variables into consideration before deciding whether we can take a piece of equipment in-house, or it’s better to take a service contract.”

### **One Size Does Not Fit All**

According to Ramy Boghdadi, director of consulting at Siemens Healthcare, Malvern, Pa, the first thing organizations need to consider is not necessarily the question of insourcing versus outsourcing, but how they can effectively “life cycle manage” their equipment.

“You have this installed base of invested assets,” Boghdadi points out. “So how do you get the maximum utilization, productivity, and longevity of those investments, and what’s the appropriate time to turn them over?”

The point is that “biomedical departments should be an integral part of an organization’s life cycle management and capital planning process,” he says. “Because if [an organization] looks at biomed as just a break/fix part of the organization, and just a cost center, then it doesn’t really have the vision and insight to truly maximize those programs and departments, and it might make sense to outsource services in those organizations.”

If, however, an organization “is really interested in developing an in-house program and committing to it,” Boghdadi says, “I believe there would be quantifiable return on investment associated with it.” And the organization will have to look at issues like staffing, competencies, and training, as well as issues related to dispatching, part sourcing, and standardization, “which are a big part of cost containment.”

The advantages with the in-house model are that “you have resources that are right there at your fingertips,” he says. “So you have better response time and reduced down time, and you don’t have to depend as much on third parties or OEMs to service an asset.”

In addition, with a high-performing in-house program, a hospital should see increased satisfaction among users in areas like cardiology or radiology, Boghdadi says. “And if done correctly, this program should be a very strategic component in your organization’s efforts to the maximum utilization out of its investments.”

There are going to be challenges involved with going in-house as well, Boghdadi adds. For example, it will take time and resources to find and train people who are competent enough to maintain and service an organization’s biomedical equipment. And departments will have to make sure they have staffing redundancies so that in the case of vacation or illness, they have qualified personnel available to service any piece of equipment.

“There’s also the problem of attrition,” Boghdadi says. “You invest in training these individuals with the risk that they are going to leave and go elsewhere.”

### **The Importance of Flexibility**

Ultimately, Boghdadi adds, a “hybrid” model—a combination of insourcing and outsourcing—makes sense for a lot of organizations in that it provides the best way to get the advantages of bringing things in-house, while mitigating the risks involved.

Bud DeGraff, general manager of diagnostic and clinical services for GE Healthcare, Waukesha, Wis, agrees that when it comes to the in-house/outsourcing question, “there probably isn’t a one-size-fits-all solution.”



**Bud DeGraff**

But there is a series of questions that biomedical departments should ask themselves, he says, before making a decision on a model they want to follow.

“Where do they stand from a skill set and labor standpoint, and what can someone else help me with on solutions that I may not have myself?” he asks. “Are there technology tools that I can utilize with either of these models?” And there should be questions about scalability, as well as quality and compliance, he adds.

Then, DeGraff says, biomedical departments should be able to assess exactly where things stand today as far as the service model they prefer, as well as where they plan to go and how they are going to get there.

For example, an organization might be interested in bringing CT services in-house, DeGraff says, but an honest evaluation of its situation might go like this: “We know there are a lot of costs in the tube, we know that preventive maintenance can take hours and hours, and that uptime is so important for the hospital, so if we ever get to that point—great—but we’re also very comfortable outsourcing for another 2 years, if necessary.”

DeGraff says that about 5 years ago, GE took a look at the biomedical market and decided there was an opportunity to partner with organizations that are looking for “flexibility.”

“We looked at the market and saw that there are a lot of very capable hospital systems and care providers out there that are capable of [handling an in-house program], but could still use help,” DeGraff says. “They can use help on technology tools, training their people, and everybody needs help on parts.”

DeGraff says they also need flexibility on the length of contracts and on the types of services they actually need, whether it’s parts ordering or technical support. So in the case of a healthcare organization that is looking to start moving toward an in-house program, DeGraff says, a flexible partner should be able to help a organization assess where it is starting from, the steps it needs to take to get there, and the means to let that organization “choose how aggressive it wants to be in pursuing that business model.”

### **Making the Transition**

In making the transition from outsourcing to in-house, several factors are in play, Gyurtsak says, depending on the biomedical department in question. One has to do with simply having the right equipment in place—for example, the equipment that biomedics will need to test items like defibrillators or electrosurgical units—as well as equipment management software.

Then there’s staffing. “There are two big keys to having a highly efficient and effective biomedical program department, and that’s management and staffing,” Gyurtsak says. “You

have to have the right personnel, and that means not only having the proper staffing, but the right levels of staffing with the right kind of training.

“This is an area where departments can actually leave themselves open to getting outsourced,” Gyurtsak says. The critical question is whether the staffing level is optimized: On the one hand, he says, if “there’s overstaffing, it’s going to result in high costs for the hospital, and you could end up with a vendor coming in who’s willing to do things for less. On the other hand, if you are understaffed, you become vulnerable because you may not be able to service enough of the higher-end equipment, and that will end up being outsourced.”

Hargraves says that staff training can be a tricky issue. “Most manufacturers provide it, but what does it cost?” he asks. “What is its availability, and do they train you the exact same way they train their own technicians, or is it a watered-down version?”

In the end, training is critical because biomedical departments have to pay attention to the “professionalism and quality of repair,” Hargraves says. “It’s one of the best defenses against being outsourced.

“And if you are an [organization] that is going to outsource, you can’t assume that just because a company has a good trade name that the specific people they are going to put on your account have been properly trained and have the right degree of professionalism,” Hargraves says, adding that organizations that rush too quickly to outsourcing could end up “being surprised” at the quality of service they end up getting.

Hargraves recounts a situation in which he had a discussion with a potential client who wanted to outsource services to BioTronics, but at a very low cost. “Well, I could meet that [potential client’s] very low offer by giving them a person who graduated college 2 months ago and knows absolutely nothing. I could meet his number, but what would he receive in terms of quality and professionalism from that person?”

“You see that a lot,” Hargraves says. “Where people who are considering outsourcing are focused solely on the dollars and not what they are actually getting for it.”

The reason for transitioning a Community Health System facility to an in-house servicing and maintenance model varies case by case, Gyurtsak says. Often it’s simply a situation where a contract affecting one or more hospitals is coming to an end.

“So we have to make a decision on what is the most efficient and cost-effective way to go,” he says. “We would typically do an analysis and compare the costs of doing things in-house versus outsourcing, with the added benefit of having more management control over the program.”

In other cases, it could be a situation where there are service-related issues that warrant bringing a program in-house, Gyurtsak says, or it could simply be a decision that the program could be more cost-efficient by bringing things in-house.

Of course, there are situations in which it makes sense to go in the other direction—from in-house to outsourcing. “You may have a very small facility in a very remote location where you really won’t have the opportunity to share resources,” Gyurtsak says. “In that kind of scenario, you may want to look for a vendor that can provide you with 1, 2, or 3 days of service at a lower overall cost.”

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