Hospitals Need Engaged Physicians to Manage Supply Preferences

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The impact of physician preference items (PPIs) on a hospital's expenses, revenue and margins can be considerable; although such items typically represent just 3% of purchase orders, they represent 20% of total supply chain spend.[1]

New payment models, such as those involving bundled payment, are exerting pressure on hospitals and health systems to reduce expenses of high-volume, high-cost procedures in service lines such as cardiology, orthopedics and neurosurgery. Focusing on managing costs of physician preference items (PPIs) associated with these procedures is a good place to start, yet many organizations' supply chain departments have limited resources to address this issue. An important solution is to engage physicians to help with such efforts. Physician engagement in reducing costs associated with PPIs has never been more important, given the intensified need for healthcare organizations to control costs as they struggle with the profound financial fallout from the COVID-19 pandemic.

Aligning physicians' supply preferences with the organization's quality and cost goals is an essential aspect of a hospital's or health system's strategy for reducing supply chain costs and maintaining profitable service lines; but, the organizations should be mindful that PPIs almost always reflect physicians' desire to deliver high-quality care. Short- and long-term strategies for achieving such alignment include shared incentives and co-management of service lines.

Two alignment models that can work well separately or in tandem are gainsharing and co-management. Each has its pros and cons and the choice of model depends on each organization's unique challenges.

Gainsharing

In gainsharing, the savings physicians achieve through efforts to reduce PPI spend is shared with the physicians under a formal agreement. The physicians agree to help the hospital or health system execute favorable contracts, including fair pricing, and adhere to them.

Before signing a gainsharing arrangement, physicians will want to know the savings potential, which the organization can calculate by comparing current spend to best pricing seen nationally. For example, in the neurosurgical-spine service line, one of the most-often-purchased supplies is the pedicle screw. Pricing for these screws can be as low as $500 and as high as $3,000. Savings would be calculated by comparing the hospital's average price to the $500 price. The same comparison should be performed for all other major supplies in the service line (i.e., rods, spaces, biologics). Physicians can assist in creating the needed comprehensive list of supplies.

[1] Statistics are based on data in a proprietary database representing 142 hospitals over the past 10 years.

Physicians then begin to take an active part in reducing costs for PPIs. In this example, the goal would be to arrive at a price for the pedicle screw as close to $500 as possible to maximize savings.

This goal can be achieved through various tactics:

- Directly negotiating with the vendor;
- Submitting requests for proposal to multiple vendors;
- Standardizing pricing, where physicians agree on substantially equivalent products and establish a standard price all suppliers must meet in order to provide products; and
- Putting vendors on a short list of preferred vendors in exchange for better pricing.

In some organizations, the supply chain executive will drive this process, but other organizations find it beneficial for the physicians to do so. In every case, however, physicians should be actively involved in the process, either by negotiating directly or providing guidance to the supply chain leader.

Gainsharing disadvantages

Gainsharing has some downsides. Care is required to ensure the arrangements comply with legal regulations, which in the past often inhibited use of this model; however, the Office of Inspector General has provided guidance on acceptable approaches in a series of 19 published *advisory opinions*. The federal government also grants waivers on these regulations to organizations that participate in a CMS bundled payment program.

In addition, the benefits of gainsharing last from two to four years, after which there is a point of diminishing returns. Once the barriers of supply chain are resolved, the savings expire. Without further measures, progress made in addressing supply chain issues related to high-cost PPIs may fall back as well. (See the *sidebar* for a discussion of supply chain barriers.)

Co-management

To help sustain further hospital physician alignment achieved through gainsharing, a co-management agreement or service-line management services agreement can be established either at the same time or as a next step. In such an agreement, physicians are paid to manage PPIs, as part of a wider agreement that encompasses the entire service line.

Accordingly, co-management requires a broader commitment by physicians to perform both administrative work in addition to clinical work. Physicians thus are involved in financial as well as clinical and operational decision-making.

Compensation under a co-management arrangement is twofold:

1. Base (fixed) compensation is paid according to the hours of effort devoted to administrative tasks.
2. Incentives are paid according to physician performance on agreed-to metrics (e.g., quality, patient satisfaction and efficiency).

Under such an agreement, the physician must demonstrate hourly or project-based work to fulfill terms of the agreement, while performance metrics are defined, tracked and reported to support incentives.

To ensure physicians address PPI costs in a co-management agreement, cost-reduction goals should be clearly defined. The agreement also should clearly define the supply chain tasks required of physicians (e.g., participating in a value analysis committee) and the quality metrics associated with their performance, such as first-case on-time starts, unplanned return to the operating room and adherence to the patient pathway or protocols.

Constructing a co-management agreement has a number of essential steps, as follows:

- Engaging in multiple, substantive discussions with the physicians involved to lay the groundwork and obtain agreement on selected roles and performance metrics targeted by all parties;
- Determining the governing structure; and
- Defining and agreeing upon clear and accurate metric definitions as well as the tracking and reporting mechanism for those metrics.

If these areas are not adequately addressed, then the co-management agreement is likely to fail. But working on these issues upfront helps ensure a successful arrangement for the health system and physicians.

Assessing strategies

In determining which alignment strategy to employ, the first line of questions should be: What is the goal? Is it to improve supply chain only, or is it a broader strategy to impact physician alignment?

Some organizations may want to achieve cost savings to reinvest those dollars back into the service line — with the goal of purchasing the latest laser or software, for example.

Other goals may involve physician alignment and compensation incentives. The answers will translate to gainsharing, co-management or another alignment strategy. Understanding the broader strategic plan and the role of the physicians within this plan is essential for sustainable alignment models.

Hospitals and health systems should use criteria such as their cost profile and physician preference decisions to determine which strategy makes the most sense.

For example, under gainsharing physicians must be actively involved, but tracking those hours is not necessary. That consideration may make gainsharing preferable to co-management for organizations that do not have enough work for physicians beyond the supply chain to justify a more comprehensive agreement. Gainsharing also offers the advantage of being better financially supported at the beginning of the arrangement through realized cost savings.

On the other hand, if physicians have an interest in governance, that interest would be better served by a co-management as opposed to a gainsharing agreement. Under co-management, improvements can extended beyond the supply chain. The greater the ability to identify the metrics that impact quality of

care, the greater the opportunity to improve population health and value-based purchasing efforts through higher-quality care, with the added benefit of improved operational and financial performance.

Moving from gainsharing to co-management has been an effective strategy for hospitals and health systems. One option is to pursue both strategies — carving out supply chain goals under a gainsharing agreement and using co-management for the rest of the service line. Another option is to employ a co-management agreement only. The choice of strategy ultimately depends on the size and scope of the clinical program, considering potential returns and the ability to secure alignment.

Other strategies for combatting high PPI costs

Hospitals and health systems also can engage physicians in other ways, within and outside the supply chain, to better manage PPI costs. The following are two options organizations should consider.

Value analysis program (VAP). One remedy is to enhance resources by establishing a robust VAP, in which a team of operational, financial and clinical representatives, including physicians, oversees the selection and purchase of PPIs. Typically, a VAP comprises a procurement specialist, a product technician, a contract specialist and clinical personnel. The team's role is to help educate stakeholders, employ creativity in decision-making and develop greater alignment with physicians across the PPI selection, contracting and implementation process.

Full-time PPI oversight. Another option is to create a full-time role charged with overseeing PPIs. Candidates for such a role should have more clinical experience than a supply chain procurement specialist. Examples include a supply chain technician based in the operating room, a surgical technician or even a nurse. This approach also presents downsides, however. Filling the role can be challenging because of the likelihood that person may soon leave for a better position as they gain more experience.

These options can be helpful in dealing with the serious challenge of physician resistance to managing PPIs; yet even with a strong VAP or a more experienced supply chain team, physician resistance can pose a seemingly insurmountable obstacle because physicians drive supply chain purchasing based on devices they want to use. This reality underscores the need for involving physicians in the creation of a comprehensive and long-term solution aimed at managing this level of expense.

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