How physician preference items affect your organization

The Association for Healthcare Resource & Materials Management (AHRMM) predicts that around the year 2020, medical supplies will outpace labor as the biggest expense for hospitals and health systems.\(^1\) So what’s driving the increase in supply costs? The rampant proliferation of expensive devices, or what’s commonly known as physician preference items.

Physician preference items (PPIs) now account for 60% of med/surg spend, compared with 40% a decade ago.\(^2\) More than half of orthopedic procedures now use implantable devices, as do more than one-third of cardiac procedures,\(^3\) with the costs of a single item or construct dominating the total inpatient cost of a surgical procedure.\(^4\) That means PPIs have the single largest impact on supply and procedure costs.

Yet, even for hospitals that have a good handle on costs for general supplies, PPIs can be a challenge.\(^5\) Their acquisition often bypasses the organization’s usual purchasing process,\(^6\) i.e., the “official” materials management information system (MMIS) and procedure. The items are typically non-catalog, and the transactions (known as bill-only, consignment, scrub POs, walk-ins, trunk stock, etc.), take place “after the fact.”

These practices leave hospitals with a lack of visibility, control and volume aggregation over some of their most expensive supply items. The result can have a devastating effect on an organization’s bottom line (see figure 1).

Potential impact of not capturing your high-cost PPIs

The lack of visibility and control of non-catalog PPIs negatively affects an organization in many key areas.

**Dilutes cost-savings initiatives:** Value analysis and standardization initiatives can’t reach their full savings potential when high-cost PPIs are missing.

**Reduces contract compliance and bargaining power:** Low visibility creates a pricing and contract data “black hole” when it comes to aligning items to available contracts. This lack of data can result in non-contract purchases, overpayment and inability to leverage items in new contract negotiations.
Step 1: Purchasing and the supplier negotiate and create a series of blanket “open-to-buy” orders.

Step 2: The sales representative promotes new products and technologies directly to physicians.

Problem: Items are often outside of previously contracted products.

Step 3: Surgery is scheduled.

Step 4: The procedure takes place, often with the sales representative in attendance.

Step 5: After the case, the representative creates a bill of the supplies consumed. This “charge list” is approved by the charge nurse.

Problem: Pricing is assumed to be the contract price, but because the items are normally non-catalog and the vendor created the bill, there is no validation.

Step 6: The supplier creates an invoice and submits it to accounts payable for payment.

Step 7: The invoice is compared to the standing order and requisition to validate the transaction and ensure that there are sufficient funds encumbered to pay.

Problem: This comparison only validates the funds, not the price. Contract price validation must be done manually by the buyer or the OR supply coordinator.
**Encourages duplication:** The same item may be purchased multiple times without the organization realizing it, reducing contract leverage and utilization information.

**Compromises physician buy-in:** Physicians want the facts. An organization must have in-depth financial and clinical data to present to clinicians to gain and maintain support for standardization efforts.

**Restricts automation efficiencies and savings:** The manual PPI process (from requisition through payment) means purchases circumvent the “checks and balances” inherent in an automated system, leading to non-catalog, off-contract purchases, and possible pricing and charge capture errors.

“Offline” purchases also add processing costs. Significant costs are incurred in the manual, and often inaccurate, capture of implantable medical device data during surgical procedures, which causes higher downstream costs in billing, accounts payable and other areas.  

**Increases potential for price variation:** Out-of-system purchases increase the chance for pricing errors, especially for large IDNs — creating as much as a 5-15% price variance for the same products when compared across an IDN. In addition, networks lose the ability to validate line items to purchase orders, align items to available contracts, police new items entering the system and maintain proper pricing in the Item Master file, especially due to kit or procedure pricing.

**Contributes to lack of control of high-cost consigned items:** The convenience and financial advantage of “pay as you go” makes consignment a growing choice for providers; however, the hospital shoulders the liability of properly recording usage. If an item is missing from the consignment area, the vendor will charge for the item, regardless of whether that item is included on a clinical case or patient bill.

**Affects inventory spoilage and expired items:** Without limitations on new products entering the system, existing on-hand inventory is affected, increasing the risk of expired product and the associated inventory write-offs.

**Growing need for PPI cost containment and improved data**

**Rise in procedure costs driven by PPI:** Supply costs are growing faster than wages or benefits, driven by the rampant proliferation of expensive devices.  

**Increase in number of procedures due to active, aging population:** Overall, total hip and total knee revisions are projected to grow by 137% and 601%, respectively, between 2005 to 2030.

**Falling reimbursement/bundled payments:** Because the price the hospital must pay for medical devices accounts for 30-80% of the reimbursement it receives from public and private insurers, the management of device choice is central to the hospital’s supply-chain efficiency and financial well-being.

**Payment tied to performance:** Increased emphasis on quality outcomes and value-based product choices requires better product data and decisions — providers need the right product for the right use at the right price.
Steps to capture and control PPIs

The good news is that there are steps you can take to help bring PPIs into view — and therefore under control. It requires a multi-faceted approach:

**Gain more detailed data on purchases and contracts**
- Isolate your top PPI vendors and ask for line item detail. If not available, hire a temp to pull invoices and audit transactions.
- Get contracts out of the drawer and entered into a database or spreadsheet.
- Compare PPIs purchased to your PPIs charted/charged during a clinical case to confirm you are using and accounting for what you buy.
- Compare the contracted price to the line-item detail for price variance.
- If you are part of an IDN, compare your line-item pricing between facilities.

**Determine inventory turns**
Complete an inventory of your PPIs and confirm associated inventory movement. If inventory is not moving and there is corresponding invoicing, it is typically a sign that alternative products (new technology) have been introduced and your current inventory is at risk of becoming obsolete.

**Outsource**
- Hire an independent auditor or forensic accountant.
- Engage a content management company that can convert your invoices and paper contracts into actionable information.

**Implement an automated formulary-managed sourcing solution**
- Capture, normalize and rationalize data on your entire med-surg supply spend.
- Analyze for standardization opportunities through the system’s ability to identify/group functionally similar items.
- Engage the assistance of physicians to help define functionally equivalent items to support standardization efforts.

**Work toward best-in-class analysis**
Those organizations that can distinguish themselves as “best in class” not only extract, cleanse, classify and analyze their spend data from multiple sources, but also leverage spend analysis as a predictive measure to improve spend compliance and reduce supplier risk.12

**Engage cooperation of physicians through better data**
- Solicit input of physicians, especially on value analysis committees.
- Benchmark internal data against national and regional data.
- Present detailed clinical and financial data to support standardization of product selection and pricing, especially regarding outcomes.

**Conclusion**
Certainly there are good reasons PPI usage is growing — potentially lower inventory cost with consigned items, desire to adopt the newest technology, maintaining physician satisfaction, physician practice variance and unpredictable demand. However, to remain fiscally sound moving forward, it is paramount that providers capture and control their PPI spending, both to save dollars and to better understand how product choice affects clinical outcomes.

Healthcare organizations already have their backs to the wall to reduce costs — needing to take 20%-30% out of their operating costs in response to declining reimbursement and focusing emphasis on reducing non-labor expenses.13 With PPI-driven supply costs increasing faster than other expenses and projected to overtake labor as the leading expense for healthcare organizations in less than a decade, PPI control is your first and best opportunity to achieve savings.
Endnotes


8 McKesson/Meperia healthcare marketplace data, 2013.


